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Behavioural and cognitive-behavioural interventions for outwardly-directed aggressive behaviour in people with intellectual disabilities (Review)

Ali A, Hall I, Blickwedel J, Hassiotis A

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[Intervention Review]

Behavioural and cognitive-behavioural interventions for outwardly-directed aggressive behaviour in people with intellectual disabilities

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ABSTRACT

Background

Outwardly-directed aggressive behaviour is a significant part of problem behaviours presented by people with intellectual disabilities. Prevalence rates of up to 50% have been reported in the literature, depending on the population sampled. Such behaviours often run a long-term course and are a major cause of social exclusion. This is an update of a previously published systematic review (see Hassiotis 2004; Hassiotis 2008).

Objectives

To evaluate the efficacy of behavioural and cognitive-behavioural interventions on outwardly-directed aggressive behaviour in people with intellectual disabilities when compared to standard intervention or wait-list controls.

Search methods

In April 2014 we searched CENTRAL, Ovid MEDLINE, Embase, and eight other databases. We also searched two trials registers, checked reference lists, and handsearched relevant journals to identify any additional trials.

Selection criteria

We included studies if more than four participants (children or adults) were allocated by random or quasi-random methods to either intervention, standard treatment, or wait-list control groups.

Data collection and analysis

Two review authors independently identified studies and extracted and assessed the quality of the data.

Main results

We deemed six studies (309 participants), based on adult populations with intellectual disabilities, suitable for inclusion in the current version of this review. These studies examined a range of cognitive-behavioural therapy (CBT) approaches: anger management (three studies (n = 235); one individual therapy and two group-based); relaxation (one study; n = 12), mindfulness based on meditation (one study; n = 34), problem solving and assertiveness training (one study; n = 28). We were unable to include any studies using behavioural interventions. There were no studies of children.

Only one study reported moderate quality of evidence for outcomes of interest as assessed by the Grades of Recommendations, Assessment, Development and Evaluation (GRADE) approach. We judged the evidence for the remaining studies to be of very low to low quality. Most studies were at risk of bias in two or more domains: one study did not randomly allocate participants and in two studies the process of randomisation was unclear; in one study there was no allocation concealment and in three studies this was unclear; blinding of assessors did not occur in three studies; incomplete outcome data were presented in one study and unclear in two studies; there was selective reporting in one study; and other biases were present in one study and unclear in four studies.

Three of the six studies showed some benefit of the intervention on improving anger ratings. We did not conduct a meta-analysis, as we considered the studies too heterogeneous to combine (e.g. due to differences in the types of participants, sample size interventions, and outcome measures).

Follow-up data for anger ratings for both the treatment and control groups were available for two studies. Only one of these studies (n = 161) had adequate long-term data (10 months), which found some benefit of treatment at follow-up (continued improvement in anger coping skills as rated by key workers; moderate-quality evidence).

Two studies (n = 192) reported some evidence that the intervention reduces the number of incidents of aggression and one study (n = 28) reported evidence that the intervention improved mental health symptoms.

One study investigated the effects of the intervention on quality of life and cost of health and social care utilisation. This study provided moderate-quality evidence, which suggests that compared to no treatment, behavioural or cognitive-behavioural interventions do not improve quality of life at 16 weeks (n = 129) or at 10 months follow-up (n = 140), or reduce the cost of health service utilisation (n = 133).

Only one study (n = 28) assessed adaptive functioning. It reported evidence that assertiveness and problem-solving training improved adaptive behaviour.

No studies reported data on adverse events.

Authors' conclusions

The existing evidence on the effectiveness of behavioural and cognitive-behavioural interventions on outwardly-directed aggression in children and adults with intellectual disabilities is limited. There is a paucity of methodologically sound clinical trials and a lack of long-term follow-up data. Given the impact of such behaviours on the individual and his or her support workers, effective interventions are essential. We recommend that randomised controlled trials of sufficient power are carried out using primary outcomes that include reduction in outward-directed aggressive behaviour, improvement in quality of life, and cost effectiveness.

PLAIN LANGUAGE SUMMARY

Behavioural and cognitive-behavioural therapies for treating aggressive behaviour in people with intellectual disabilities

Review question

This review is an update of a previous version.The aim of the review was to find out whether behavioural and cognitive-behavioural therapies are more effective in reducing aggressive behaviour in adults and children with intellectual disabilities, compared to a control group that received no intervention.

Background

Challenging behaviour is a significant cause of social exclusion for people with intellectual disabilities. There is no firm evidence about which therapies are most helpful in reducing aggressive behaviour in people with intellectual disabilities.

Study characteristics

We searched a number of electronic databases in April 2014 to ensure that the review was up-to-date. We included six studies in the review with a total number of 309 participants. Three studies examined anger management, one study examined assertiveness training and problem solving, one study examined 'mindfulness' based on meditation, and one study examined modified relaxation. All the studies were conducted in community settings apart from one, which was conducted in a forensic inpatient setting. Five of these studies were small, comprising between 12 and 40 participants, and one was a large study of 179 participants, which was funded by the National Institute for Health Research (NIHR) Health Technology Assessment (HTA) programme. Information on funding was not available for the other studies. Follow-up data were available only for two studies.

Key results

We found improved outcomes in five studies, including reduction in anger ratings and in aggressive incidents, at the end of treatment. One study found improvements in anger coping skills as reported by key workers at 16 weeks and 10 months, but no other long-term benefit. One large study did not find improvements in quality of life or reduced costs to health services. Due to differences in the types of interventions, populations and assessments, we could not combine the results of the studies.

Quality of evidence

There was one large study which presented moderate-quality data on the outcomes of interest. The other included studies were small and of poor methodological quality. Based on a 'Grades of Recommendation, Assessment, Development and Evaluation' (GRADE) assessment, we judged the quality of evidence on the outcomes of interest to range from very low to moderate quality. Moreover, the diversity of the interventions and participant groups makes it difficult for us to draw firm conclusions about the effectiveness of any particular approach. Therefore, more good-quality studies with longer-term follow-up data are needed.