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BRIEF COGNITIVE BEHAVIOR THERAPY FOR SIBLING OF CHILDREN WITH DEVELOPMENTAL DISABILITY

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ABSTRACT **Background:** Siblings are the support of each other, regardless of disabilities. Despite that, they suffer from various mental health issues and remain unnoticed. The present study focused on improving the coping and attribution style of healthy developing siblings of children with developmental disabilities with brief cognitive behavior therapy techniques. **Methodology:** A total of 12 cognitive behavior therapy (CBT) sessions were given over a period of 3 months. Each session targeted cognitive restructuring & problem-solving techniques focusing on improving the coping and attribution style. **Result:** Overall finding reveals that the healthy sibling showed improvement in their coping, attribution style, and attitude towards their disabled siblings, and improvement was also seen in their parents' perception towards the situation. **Conclusion:** Brief CBT can be used successfully to improve coping, attribution style, and attitude of healthy siblings towards their developmentally disabled siblings, which in turn will improve the outcome of these special populations.

KEYWORDS : Autism, Intellectual disability, attribution, coping, and attitude.

INTRODUCTION

Siblings are the support of each other, regardless of disabilities. Yet, it has impacted their mental health. Research exploring the impact of disability on typically developing siblings has been mixed. These healthy developing (HD) siblings are also at risk of developing mental illnesses.[1] More than 50 international studies show that about 8% of children and adolescents living with children with developmental disabilities (DD)suffer from mental disorders.[2]Within the literature, there is evidence that having a sibling with DD may affect siblings who do not have DD.[3]Various studies have also shown that these HD siblings of children with DD have shown poor coping, well-being,[4] stress,[5,6] adjustment issues,[7]negative attitude, & inferiority complex,[8] anxiety,[9] physical health,[10] behavior issues,[11] and mental health issues.[12-14]

Despite this evidence in the literature, the professional services for siblings of the disabled are greatly lacking.[1] CBT remains one of the mainstays & evidenced-based psychotherapeutic interventions for many mental health issues, especially for children & adolescents.[15,16] Regardless of CBT's effectiveness, there is a dearth of literature on psychotherapeutic interventions for these siblings, especially in India. With this background, in the present article, we expected that after brief CBT the HD sibling will have better coping, attribution, and positive attitude towards their DD siblings.

MATERIAL & METHOD

A case series design involved 5 HD siblings of children with DD. After ethical clearance from the institute, the sociodemographic and clinical data sheet was filled. Pre & post assessments were carried out using Coping orientations to problems experienced – COPE,[17] Children's attributional style questionnaire: revised,[18] Brief semi-structured questionnaire; The parental and HD sibling attitude towards the DD sibling (5 statements assessing the attitude, specially prepared for the study). Techniques of brief CBT i.e., psychoeducation, identifying automatic negative thought (ANT), cognitive restructuring, and problem-solving skills were applied along with the parental sessions. Total of 12 sessions were taken for the period of 3 months. The sessions were given once a week. Each session lasted for 45-60 minutes.

Case Illustration

Demographic details of all participants are provided in the table 1.
Some perceptions towards the DD siblings;

- "It is so frustrating when he doesn't understand even a simple thing". (Case-5)
- "Sometimes when I am busy doing something and he destroys anything during that period, parents scold me badly, sometimes hit me and make me responsible for that. I often get punishment for his actions. (Case-3)
- "He doesn't know how to behave in front of others. He often removes his clothes in front of my friends when they come. It feels terrible and embarrassing. (Case-4)
- Whenever mom asks him to buy bread from the shops he doesn't go and then I have been asked to do that and that makes me angry. Why can't he go? (Case-2)
- We don't spend time together. Whenever my friends come to my home I feel embarrassed. Many a time I insist mother to make sure that he is not around. I even avoid going out with him. (Case-1)

The Procedure Of The CBT Sessions

A total of 12 CBT sessions were given over a period of 3 months (once-a-week session). Each session targeted cognitive restructuring & problem-solving techniques focusing on improving coping, and attribution. Each session lasted for 45-60 minutes. At the end of each session, participants parents joined for about 15 min and together summarized the session content. The essential component of the session for all the participants was as follows;

A. **Psycho-education:** The HD siblings were educated about their DD siblings' condition using the comprehensive psycho-education model. All the participants after psycho-education agreed by stating "they would like to know more about their DD sibling."

B. **Identifying The Automatic Negative Thought (ANT):** The goal was to identify the ANTs with the help of a thought record diary, and associated emotions related to their DD siblings. Some ANTs were: 'Social embarrassment, parents more attention towards DD children, and some HD siblings had the wish that their DD siblings were not present in their lives.

C. **Coping & Attribution:** The goal was to promote healthy coping and positive attribution with Cognitive restructuring & problem-solving techniques. In cognitive restructuring, verbal challenging, reattribution, and generating alternative thoughts were done. Some examples of cognitive restructuring were:

- **Automatic Negative Thought:** Whenever my friends are around he tries to get in, and that makes me angry and embarrassed. I wonder what they would be thinking.
- **Emotion (Sadness):**8/10 *(the higher the score, the more the emotion)
- **Challenge The Negative Thought:** how does it matter what they think? Important is what I think.
- **Generating Alternative Thoughts:** Ultimately, he is my brother. My genuine friends will accept him the way he is. Moreover, if I will take care of my sibling, my friends would do the same.
- **Emotion (Sadness):** 4/10

D. **Problem-solving Techniques:** The participants were taught to identify the problems, do brainstorming, generate alternative solutions, take one solution for action, and then review the consequences. Some examples were:

- **Problem Identified:** "He hit himself and destroys household articles when angry"
- **Brainstorming:** asked him to create ideas & solutions like why he does it, what to do to stop him etc instead of getting angry with him.
- **Generating Alternative Solutions:** I can hit him, lock him inside the room, and look for the cause. Weigh the pros & cons for each generated alternative solution.
- **Taking Action:** As I have tried the initial two solutions, this time I can try identifying the cause. He becomes angry when nobody pays attention or doesn't take him out for a ride.
- **Review The Consequence:** To my surprise, after fixing his time for outside play and riding his aggression reduced significantly.

E. **Summarization:** All the sessions were summarized at the end by siblings and parents followed by homework assignments focusing such as; doing a particular task together like playing a particular game, going out, or watching a movie together.

Data Analysis

The statistical analysis was done with the help of SPSS–16. The χ^2 test, Paired t-test, and Point biserial correlation coefficient were used wherever applicable.

RESULT

- Socio-demographic profile and clinical variables of HD siblings and their siblings with DD (Table-2).
- In coping style, significant improvement was seen in the domain of problem-focused coping (Table-3).
- In the attribution style, significant improvement was found in the negative attribution domain (Table-4).
- In the brief semi-structured interview, significant improvement was found in their attitude and perception towards the DD siblings. They became more positive towards them (Table-4).

DISCUSSION

The study focused on seeing the effectiveness of brief CBT on HD siblings of children with DD. In our study, on coping & attribution of HD siblings, significant improvement was seen. The change in the attitude was also seen not only in the HD siblings but also in the parental attitude and perception. Indeed brief CBT was effective in our case series. Remember while initiating therapies in this population, sibling relationships are the basis of cognitive and emotional development. The limitations of a child with a disability expose their HD siblings to internal and external tensions over a long time period,[19] and they have different roles and experiences than those in ordinary families.[20] Nevertheless, children in families with a disabled sibling not only provide emotional support that cannot be provided by their parents,[21]but they also act as a proxy for caretakers and play a special role in the family system.[22] Therefore, it is important that siblings of children with disabilities grow up with support, psychologically and socially, for healthy family development.[23,24] Similarly, in our study, sessions were targeted towards enhancing the HD siblings' strength, improving their coping mechanism and attribution style. Thus, they can be the best support to their DD siblings. Moreover, communication between the parents and non-affected siblings about the other child's "disability" needs to be established. This ensures healthy acceptance & positive development of both children. A similar positive change in the attitude of both parents and HD siblings was seen in our cases series.

The limitation of the study was a constriction of a time period, longer time and follow-ups with each child would have resulted in better maintenance effect and there was no control group to compare with.

CONCLUSION

Disability of any type can limit its' impact if the support can be strengthened. The HD siblings can be used as the best co-therapist for their disabled siblings.

Table1: Healthy Developing Siblings' Demographic Details

Participants/Age/ Sex	Diagnosis	Sibling/ Age/Sex	Parents' participation
Case-1/Mr. MS/11yrs/M	Severe ID With ASD	Mr. R/17yrs/M	Both Father & Mother
Case- 2/Mr. SC/17yrs/M	Mild ID	Mr. H/8yrs/M	Mother
Case- 3/Mr. AP/9yrs/M	ASD with Moderate ID with Hyperactivity	Mr. R/11yrs/M	Mother
Case- 4/Mr. MT/16yrs/M	Moderate ID with behavioral issues	Ms. J/12yrs/F	Both Father & Mother
Case- 5/Mr. SV/7yrs/M	ASD with Moderate ID	Ms.V/8yrs/ F	Mother
ID-Intellectual disability; ASD-autism spectrum disorder; M-Male; F-Female			

Table 2: Socio-demographic Profile And Clinical Variables Of HD Siblings And Their DDSiblings (n= 5)

Variables		Mean±S D/ N(%)
DD Siblings		
Age	12.20±4.60	
Sex (proband)	Male	05(100%)
	Female	0(0%)
Level of disability	Moderate	2(40%)
	Severe	3(60%)
Education (proband)	None	1(20%)
	Special school	4(80%)
Family type	Autocratic	3(60%)
	Democratic	2(40%)
Domicile	Rural	2(40%)
	Urban	3(60%)
Family income	Low	1(20%)
	Middle	4(80%)
HD Sibling		
Age	11.40±3.20	
Sex	Male	3(60%)
	Female	2(40%)
Education (Sibling)	Primary	4(80%)
	Secondary	1(20%)
Birth order	Older	3(60%)
	Younger	2(40%)
Primary school: Below 5th standard. Secondary school: Above 5th standard		

Table 3: Comparison Between Pre And Post Analysis Of Sub-domains Of Coping Orientation To Problem Response (COPE) Of HD Siblings Of DD Children.

Variables COPE			N=05 Mean±SD	t (df=4)	p
Problem Focused Coping	Active	Pre	9.60±1.14	-1.17	.305
		Post	10.20±1.30		
	Planning	Pre	10.00±.70	-1.63	.178
		Post	10.40±.54		
	Suppression to competitive activities	Pre	9.00±.70	-1.63	.178
		Post	9.40±.54		
	Restraint	Pre	8.00±.00	-1.00	.374
		Post	8.40±.89		
	Instrumental Social Support	Pre	12.00±1.58	-.27	.79
		Post	12.20±1.64		
	Total	Pre	48.40±2.07	3.31	.029*
		Post	50.60±3.05		
Adaptive Emotion Focused Coping	Emotional Social Support	Pre	12.20±.447	.000	1.00
		Post	12.20±.837		
	Positive Reinterpretation and Growth	Pre	10.00±1.41	-2.13	.099
		Post	10.80±.837		

	Acceptance	Pre	11.20±.83	2.44	.07
		Post	10.60±.54		
	Religion	Pre	10.80±2.38	1.00	.374
		Post	11.0±2.73		
	Humor	Pre	8.40±2.30	.00	1.00
		Post	8.40±2.07		
	Total	Pre	52.40±2.70	1.20	.294
		Post	53.20±3.76		
Maladaptive Emotion Focused	Denial	Pre	9.60±1.51	1.63	.178
		Post	10.00±1.41		
	Mental Disengagement	Pre	10.20±1.30	1.50	.208
		Post	9.60±1.14		
	Behavioural disengagement	Pre	10.20±1.92	.93	.405
		Post	9.40±1.51		
	Focus and Venting of Emotion	Pre	11.60±1.67	2.13	0.09
		Post	11.80±1.92		
	Substance use	Pre	5.00±2.23	.000	1.00
		Post	5.00±2.23		
	Total	Pre	47.60±4.50	2.16	.096
		Post	43.60±5.41		

*p<.05 (2-tailed)

Table 4: Comparison Between Pre And Post Analysis Of Children's Attributional Style Questionnaire-revised (CASQ-R) Of HD Siblings And Attitude Of Parents And HD Siblings Towards DD Children.

Variables		N=05 Mean±SD	t (df=4)	p
CASQ-R (HD Siblings)				
Positive Internality	Pre	2.60±.548	1.00	.374
	Post	2.80±.447		
Positive Stability	Pre	2.00±.707	1.63	.178
	Post	2.40±1.14		
Positive Globality	Pre	1.64±1.34	1.00	.374
	Post	1.40±1.14		
Composite Positive	Pre	6.20±2.16	1.63	.178
	Post	6.60±2.30		
Negative Internality	Pre	1.40±.548	2.44	.070
	Post	.80±.447		
Negative Stability	Pre	1.40±.894	1.63	.178
	Post	1.80±.837		
Negative Globality	Pre	2.60±.894	1.50	.208
	Post	2.00±.707		
Composite Negative	Pre	5.40±1.81	4.00	.016**
	Post	4.60±1.51		
Difference of Composite Positive and Composite Negative	Pre	3.20±1.78	.667	.541
	Post	2.80±3.03		
Attitude Towards DD Children				
Parents	Pre	20.80±5.63	6.51	.003*
	Post	24.60±5.12		
Siblings	Pre	22.20±6.14	7.25	.002*
	Post	28.00±5.43		

*p<.05(2-tailed) *p<.001 (2-tailed)

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