Cognitive-Behavior Therapy and Intellectual Disabilities
[Summary White Paper Developed by Louisiana OCDD Clinical Services Team]

Overview of CBT

Cognitive-behavior therapy (CBT) has become one of the most **frequently utilized treatments** by mental health providers worldwide because of its proven efficacy and widespread applicability. Tens of millions of copies of CBT books and self-help guides have been sold, and there are many accessible materials available to the general public. CBT was initially developed, and still maintains widespread use, as a treatment for **depression**. It is also frequently employed as a component of treatment of **anxiety** disorders, **addictions**, and many other **mental health disorders**.

CBT is extensively used to treat depression in persons with **Mild and Moderate Intellectual Disabilities** (IDs). A simple internet search of CBT and IDs or CBT and developmental disabilities (DDs) will disclose dozens of published studies reporting positive results. A few of these studies are discussed below and others are listed in the reference section of this document. **Outcomes** included significant **improvements** in **mood** and **social engagement** and **decreases** in **sad** mood, **isolation**, and **suicidality**. CBT as a component of treatment for other disorders, for example -- anxiety disorders, often used along with exposure and desensitization, is also beginning to see more widespread use in persons with IDs[1]. **Outcomes** across over a dozen studies have included results such as **decreases** in **anxiety**, **panic attacks**, and **avoidance behavior**. Use of Trauma-focused CBT (addressed elsewhere) in DDs is increasing. And as a further example of growing use, a recent review of CBT for persons with IDs spanning 75 pages also included examples of CBT applied to assist with problems related to **chronic pain**, **hoarding**, **fire-setting**, **sexually abusive behavior**, and **psychosis**[2].

CBT Components and Adaptations for Persons with IDs

Standard CBT steps and how these might be adapted when working with someone with an ID are discussed below. **Adaptations** are fairly **simple** and **straightforward**. Conducting CBT with persons with IDs is not any more difficult than treating persons without IDs. Many clinicians consider it even less complicated. CBT teaches participants to:

STANDARD STEPS	ADAPTATIONS
1) Understand the **basic model**. That is, the person is helped to understand how **negative thinking** can impact mood and behavior and how **thinking a different way** can improve mood.	**SIMPLIFY CONCEPTS**: Some of the concepts and components of CBT can be simplified to facilitate understanding. Some components are perhaps less essential and may not need to be included at all. For example, the complex explanations that often accompany helping someone to understand how one's negative thinking style alter how an event is interpreted, and the idea that negative thinking can impact mood and depression, can be boiled down

	to **simpler language** such as, "**Thoughts change feelings**."
2) Identify one's own **patterns of negative thinking**. The person is helped to become aware of when he/she is engaging in negative thinking and then notice how this is accompanied by sad, hopeless, depressed mood and depressed behavior.	**CONCRETE DEMONSTRATION**: This can be easily concretely demonstrated by having someone think about something negative and describe feelings and then having them think about positive experiences and describe feelings. Using **simple concrete examples** to illustrate points and allowing the person to immediately experience the impact of thoughts on feelings may be more meaningful to some persons with IDs vs. discussing things in the abstract. **EASY TO REMEMBER PHRASES:** The benefits of cognitive reframing can be reduced to easily memorable phrases such as "**Think positive, feel positive**," and "**Think Negative, Feel Negative**," which capture the essential concepts with minimal language.
3) Persons are taught to **label** the type of **distorted thinking** he or she is engaging in. Distorted thoughts can be categorized. So for example, the person is taught to recognize when they are "**disqualifying the positive**," or insisting that a positive event that has happened "**doesn't count**" for some reason or other. Or the person may be taught to recognize and label another common distorted thinking pattern, "**fortunetelling**", which involves predicting that some future event is going to turn out badly and feeling convinced the prediction is already established as a real fact.	**OMISSION:** For some persons with IDs, the labelling and categorization of the negative thought Is not taught. Instead, the **person** is just **taught** to identify he or she is **having a "negative thought**" or "sad thought."
4) Persons are then taught **to counter negative thinking**, and this is the principal active treatment component of CBT. So for example, when a person thinks, "I fail	**MODIFIED TEACHING**: Learning to say and think positive things when starting to think negatively, probably the most essential active treatment component in CBT, is a

at everything," he/she is then taught to challenge this thought and list out things that he/she has historically succeeded at and to continue listing these out until the thoughts about failure shrink and are displaced. Positive thinking about accomplishments are associated with positive mood- feelings of power, hope, confidence, etc. **Positive thinking** approaches are practiced over and over again in response to negative thinking until the person is able to quickly shift to positive thinking whenever negative automatic thoughts occur.

concrete skill. **Adaptations** often considered when teaching other skills to persons with IDs, can be incorporated into teaching positive thinking skills. For example:

-- **simplifying language**
-- having a therapist or caregiver **model skills** before asking for participants to demonstrate them
-- increasing **repetition of skills**, extra practice
-- utilizing **massed practice** (practicing a few times in a row)
-- **shaping approximations** to the terminal target skill – teaching in steps
-- using **positive reinforcement**

These simple, common teaching approaches used to maximize learning in persons with IDs can be incorporated into CBT if needed. As in persons without IDs, teaching positive thinking is often initially done by having people verbalize out loud the negative thought and then the positive replacement thought.

CAREGIVER SUPPORT: With some persons, therapists may **rely more on caregivers** to prompt and remind and reinforce skill usage over the course of the week. That is, in the same way that some persons with ID rely on caregivers for additional reminders, coaching, and assistance in using daily living skills like self-care, some persons with IDs may need this type of assistance **to use CBT skills**.

EXTRA REINFORCEMENT: For many people, using positive thinking skills is self-reinforcing. A person uses positive thinking and immediately feels better and these positive feelings are enough to reinforce

	and maintain the skill. For others, especially **at the beginning of treatment**, praise/social reinforcement for positive thinking may help jump start skill use. **BOOSTER SESSIONS FOR RETENTION**: For some persons with IDs, even after skills are mastered, it may be necessary to **schedule regular skills practic**e or provide booster sessions to maintain skill mastery and usage.
5) Persons are taught to keep a **thought log** where negative thinking is documented, the category or type of distorted thinking is labelled, the person numerically rates mood associated with the thought, the person then documents positive thoughts used to counter negative thoughts, and then finally the person rates numerically the new mood rating which documents the degree to which mood shifted from sad to happy. Documentation illustrates the link between negative thinking and negative mood, positive thinking and positive mood, and how negative mood can be countered with positive thinking.	**SKIP UNNECESSARY STEPS**: As noted, some of the steps in the standard multi-step processes in CBT, such as **labelling a distorted thought** per category (e.g., "I am catastrophizing", "I am using 'should' statements," etc.) and numerically rating mood, **may not be important as long as** the person can **recognize** a **negative thought**, **counter** it with positive thinking, and **feel better**. **GIVE EXTRA HELP**: **Mood logs** are employed, some persons with IDs may keep their own Mood Logs. For some persons, the person may dictate what goes in the mood log but a **family member or staff can write it down and read** it for the person. In some cases where writing and reading skills are limited, **symbols or pictures** can be substituted for words or written mood logs can be eliminated altogether and the practice of changing negative thinking to positive thinking can be done all verbally. Examples of standard and modified mood logs are included below.

CBT has been successfully utilized to **treat depression** in persons with **Mild to Moderate IDs**, who make up most persons with IDs. Some persons with Mild IDs may not require any accommodations at all. Others may require adaptations to **accommodate deficits in language** functioning and **cognitive abilities**. Given the wide diversity in people with IDs, clinicians are encouraged to not pre-judge a person as being unable to benefit from CBT or aspects of CBT

while also being flexible to make adaptations when it becomes apparent in therapy that adaptations are needed to promote understanding and success.

While some types of negative thinking represent distorted, overly-negative views of reality and a person's actual experiences, **negative thinking is not always necessarily distorted**. Sometimes depressed mood and behavior are impacted by a combination of distorted thinking and legitimate sources of dissatisfaction in a person's life. Therefore, in designing CBT treatment for a person, an appraisal of her/his **actual life circumstances** and attention to **quality of life** factors and wellness supports is often beneficial. In some cases, changes in the environment, a person's support structure, his or her opportunities for choice and acceptance should accompany psychotherapeutic approaches such as CBT.

Efficacy of CBT in Persons with IDs

There are many studies that have reported on and evaluated the successful use of CBT in persons with DDs with the following outcomes:

- **Improved** levels of **depression**, positive **feelings about self**, and **lower** levels of **automatic thoughts** after treatment with 2 hours of CBT a week for 5 weeks[3]
- **Improved** symptoms of **depression** with 1.5 hours of group therapy a week for 10 weeks[4]
- **Improved** symptoms of **depression** for persons with mild to moderate ID[5]
- **Improved** symptoms of **anxiety**[1]

STANDARD MOOD LOG

Negative Thoughts	Cognitive Distortion	Mood Rating	Positive Thoughts	Mood Rating
No one likes me. No one cares about me. I am alone, ignored, and discounted.	All or None Thinking	20* *0 = Severely Depressed Mood	**My friend** Alice cares about me. My **sister** cares about me. I am still lucky to have her. The other day **Mary** called to check on me and we had a nice talk. Some of my **office mates** are kind and I should give them credit for this. I guess when I stop and think about it, there are people who care about me.	80* *100 = Happy Mood

ADAPTED MOOD LOG

Sad Thoughts	Mood Rating	Happy Thoughts	Mood Rating
Nobody likes me	☹	**Momma**, **grandma**, **Alice**, and **Mary** love me. A lot. Alice is coming to see me tomorrow.	☺ I feel a lot better now.

The above example represents an actual excerpt from CBT work with a young woman with a **moderate ID** and shows how the active treatment component of changing negative to positive thoughts can be adapted and **can be effective** even in persons **with IQs of 50** or even lower. But it is again worth emphasizing, **some** persons with **Mild ID require no or almost no modifications** of CBT approaches. Some master positive thinking without difficulty or modifications. Some persons with writing skills can complete their own mood logs and use numeric ratings and practices, and outcomes fully resemble work in persons without IDs.

ADAPTED ANXIETY LOG

Worry Thoughts	Worry Rating	Calming Thoughts	Worry Rating
If I get in the car, we're going to get in another accident and I'll get **hurt again**. (written and read by caregiver)	☹ 9	My dad is a **good driver**. We drove places last week and it was fine. I can do this. I'm gonna breathe and listen to music. (written and read by caregiver)	☺ 3

The above example is an excerpt from CBT work with a young woman who developed a **phobia** related to driving in a car after being involved in an accident.

REFS

(References include studies and publications cited in this document along with other studies that have evaluated CBT in persons with Intellectual or Developmental Disabilities and may be of interest to the reader.)

[1] Dagnan, D., Jackson, I., & Eastlake, L. (2018). A systematic review of cognitive behavioural therapy for anxiety in adults with intellectual disabilities. *Journal of Intellectual Disability Research, 62,* 974-991.

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