Introduction

It is well established that individuals with intellectual disabilities (IDs) suffer from mood disorders. Individuals with IDs present with a similar set of depressive behaviors, including dysfunctional cognitive deficits similar to individuals without IDs such as having a low self-concept, attending to negative features of an event, and making negative causal attributions for stressful events (Benson & Ivins, 1992; Esbensen & Benson, 2006; Hartley & MacLean, 2009). Standardized criteria for major depression episodes, manic episodes, dysthymia, and bipolar disorder among individuals with IDs are now available, with limited modifications needed from the criteria for the general population (Fletcher et al., 2007). Although much is understood about the treatment of these disorders for the general population, less is known about their appropriateness among individuals with IDs. Cognitive–behavioral therapy (CBT) is one of the most common treatments, and one of the few established empirically supported treatments by the American Psychological Association (Chambless & Hollon, 1998) for depression in the general population. Preliminary studies suggest that CBT may also be beneficial for treating depression in individuals with IDs when training procedures and modifications are used (e.g., Lindsay et al., 1997; McCabe et al., 2006). This chapter will review the core features of CBT for treating depression, training procedures, and modifications to CBT appropriate for individuals with IDs, and the empirical support for these training procedures and modifications.

Review of CBT and Mood Disorders

The theoretical basis behind CBT is that depressive cognitive processes cause individuals to interpret experiences in such a way as to develop, maintain, or exacerbate
their depression. These dysfunctional cognitive processes are often acquired during childhood and adolescence and make the individual vulnerable to construing events in a negative way. Although there remains a debate about the development and nature of depressive cognitive processes (Esbensen & Rojahn, 2005), there is widespread agreement that therapies should be aimed at modifying these cognitive processes.

Depressed individuals are theorized to possess negative schemata for processing information as well as a negative view of themselves, the world, and their future. In the face of events the individual interprets as stressful, the negative schemata are activated and subsequent information is processed negatively, leading to the development of dysfunctional beliefs. The depressed individual automatically interprets situations in a negative manner and has limited ability to generate rational and obvious alternate explanations for the same event. For example, depressed individuals may consider themselves inadequate, believe that unpleasant experiences occur as a result of their own actions or characteristics, view the world as full of obstacles, interpret interactions with the environment in a negative manner, view the future as full of hardships, and view that current difficulties will continue endlessly. These dysfunctional beliefs predispose the individual to symptoms of depression. Thus, the focus of treatment is to identify negative thoughts that are associated with feelings of depression and encourage the individual to engage in more activities that are positive and rewarding in an effort to improve mood.

Current CBT packages for the general population focus on altering irrational and overly negative cognitions, identifying automatic thoughts and accurately labeling them as distorted or overly pessimistic, and challenging depressive thinking about the individual and his or her world. In addition, CBT packages educate the individual about depression, his or her depressive symptomatology, and the rationale behind CBT. Most CBT programs also include behavioral components of learning to monitor mood, identify feelings and emotions, and engage in effective problem-solving strategies.

There is a large body of research demonstrating the efficacy of CBT for depression in adults in the general population (e.g., Butler et al., 2006; Westen & Morrison, 2001). CBT has also been shown to be an efficacious intervention for treating depression in children and adolescents in the general population (Brent et al., 1997; Compton et al., 2004; Ryan, 2005), although there are some discrepant findings (March et al., 2004). When these CBT programs are implemented with children and adolescents, most programs share two core features. First, in addition to targeting affect regulation, social skills, and problem solving, these programs address the specific needs of the individual child or adolescent, such as any comorbid diagnoses, medical problems, and/or environmental stressors, in a more formal manner than is true of programs geared at adults. Second, parents and other family members often participate in sessions with the child/adolescent or attend separate sessions. The purpose of involving parents and other family members in the treatment is to educate them about depression, and teach them about CBT so that they can encourage and help the child/adolescent continue to monitor and modify his or her negative thoughts outside of the therapy sessions. In addition, by including parents or other family members in treatment, the therapist is able to better assess for and address any family environment (e.g., parent depression or recent change in the family) or
relationship (e.g., problems with the parent–child relationship) problems that might be exacerbating the depressive symptomatology.

CBT programs for children and adolescents have other modifications from the CBT programs geared toward adults. CBT programs with children and adolescents tend to be more present oriented and focused on building skills. This comes from the assumption that skill deficits in problem solving and engaging socially are preventing the child or adolescent from interacting effectively with his or her world and contributing to or maintaining his or her depressive symptoms. Within a collaborative working relationship, the therapist helps the child or adolescent to learn new ways of thinking and behaving, which in turn is assumed to reduce the severity of the symptoms of depression.

There is empirical evidence that CBT will work better for some children and adolescents than others. Successful reduction of depressive symptomatology is more likely when the individual in therapy has fewer comorbid diagnoses or presenting problems (Hughes et al., 1990). Having fewer comorbid diagnoses allows the therapy to focus more on the depressive symptoms and thoughts than on the other problems. Success is also more likely if the individual in therapy acknowledges that there is a problem and wants to get help, and more likely when family or important caregivers acknowledge that there is a problem and are willing to support the therapy. Finally, success is more likely for individuals with mild or moderate cases of depression as compared with individuals with severe depressive disorders (Brent et al., 1999; Clarke et al., 1992; Jayson et al., 1998).

Thus, the efficacy of CBT for mood disorders is not altered by modifications to the intervention that take into account the developmental level and cognitive ability of children and adolescents, although there are a variety of factors that influence the success of the intervention. The presumption then is that CBT would also be efficacious among other populations with similar developmental levels and cognitive abilities including individuals with IDs, although this remains to be empirically tested. Clinicians have reported on the suitability of and several modifications to CBT for individuals with IDs and comorbid mood disorders, with encouraging support for the use of CBT for this disorder in this population.

**Training and Modification of CBT for Individuals with IDs and Mood Disorders**

CBT requires that the individual receiving treatment possess certain requisite skills. These skills include (1) adequate receptive and expressive communication skills, (2) the ability to identify emotions, (3) a cognitive capacity for the requirements of CBT (self-monitoring of emotions, memory skills for homework, conceptualization of temporal events, ability to self-reflect and self-evaluate), and (4) the ability to understand the CBT model (Hatton, 2002). Only a few studies have investigated the extent to which individuals with IDs have these skills. These studies indicate that individuals with IDs who have a well-developed receptive vocabulary are better equipped with these skills than individuals with lower IQs (Sams et al., 2006). Thus, individuals with IDs who are higher functioning may be more suitable for CBT for depression.
than their lower-functioning peers. Researchers within the field of ID are beginning to design training procedures aimed at teaching these prerequisite skills to individuals with IDs as a precursor to conducting CBT (Dagnan et al., 2000; Dagnan et al., 2013, Chapter 4, of this book).

In addition to the individual with ID requiring certain skills, there are a variety of modifications that the therapist can implement to engage the individual in CBT for depression. Some modifications are global and apply to any form of CBT, and some are pertinent to the structure of CBT for depression. Within CBT for depression, there are several core components, including (1) psychoeducation of CBT and the relationship between thoughts, feelings, and behaviors; (2) setting an agenda; (3) identifying dysfunctional beliefs, maladaptive automatic thoughts, and their underlying assumptions; (4) reviewing the accuracy of these interpretations and testing alternate explanations; and (5) problem solving (Lindsay et al., 1993). This chapter will review some general modifications to CBT for depression for individuals with IDs, then review modifications to the core components, and end with some additional techniques that may be complementary to CBT for individuals with IDs.

**General modifications**

Language is very important in CBT. It is imperative to ensure that not only does the individual with ID have adequate receptive and expressive language skills, but also that he or she understands the content of what is discussed in therapy. It is important to use words and sentences appropriate for the individual’s cognitive level. It is also important to monitor the language of the individual with ID to ensure that the terms that he or she uses within therapy mean the same thing to him or her as to the therapist. “I feel bad” may have different meanings. It is helpful for the therapist to probe often to ensure that he or she is using the same language as the individual with ID. While these probes may need to be more direct, such as “are you feeling sick or sad?”, it is also recommended that prior to probing, the therapist use open-ended questions to avoid acquiescence.

It is also important to simplify concepts discussed in therapy. Using concrete examples relevant to his or her life experiences (e.g., referencing a specific conflict that the individual had with his or her roommate, staff person, or job coach) and engaging in role plays or other hands-on exercises (e.g., drawing pictures, reading a story, and playing games) are preferable to discussing abstract concepts. This modification will be elaborated on more within the discussion of how to modify the core components of CBT. Also, it is helpful to underscore key information by stating it multiple times and in multiple ways throughout the session, and to have the individual with ID repeat and rephrase key concepts to ensure that he or she understands what is being discussed.

The structure of therapy and each session may also need to be tailored to the individual. It is often important for therapy to proceed at a slower pace, so that each concept can be adequately understood. Some individuals may require longer sessions to fully understand the concepts. Others may have a limited attention span and require numerous shorter sessions to complete the therapy. A good guideline is to limit the length of each therapy session to what would best suit the individual (Haddock & Jones, 2006).
During therapy, the therapist and the individual identify the cognitive distortions that underlie depressive thinking. Throughout the therapy sessions, it is also useful for the therapist to identify any deficits in the client’s executive functioning (e.g., memory, attention, and motor skills), problem-solving, and reasoning skills, and to take these into account in the intervention. For instance, instructions for homework assignments could be audio recorded, and thus played back numerous times, for individuals with memory problems. Visual information, hands-on activities, and graphical rating scales (e.g., pictures of faces indicating various levels of sadness) could be used for individuals with poor verbal reasoning skills. Reminder cues may also be needed for individuals with short attention spans, such as giving them a watch that beeps every hour as a cue to record their thoughts or feelings or to engage in a pleasurable activity such as taking a walk or calling a friend.

For individuals with lower IQs and verbal skills, CBT may also need to be focused more on behavioral than cognitive components. The focus may need to be on teaching affective skills, coping skills for dealing with aversive events, activity scheduling, or problem-solving skills. The goal being that by changing behaviors, mood will improve.

The first sessions and psychoeducation

The goal of the first few sessions is to establish rapport with the individual with ID and to obtain a detailed description of the presenting problem. During this stage, it may be helpful to involve family or caregivers who work with the individual with ID, such as his or her day rehabilitation or group home staff, case manager, or job coach. Referrals often originate from family or caregivers, and thus, it may be valuable to include them in the information gathering stage to better understand the client’s mood and affect difficulties and associated problems. The complaints presented by the individual with ID in the first session may be vague, and it is the therapist’s role to use probes and simple language to generate a specific list of target problems for treatment. This process may be more difficult if the individual with ID did not self-refer and does not believe that he or she is depressed. If staff or family initiated the referral, more time may need to be spent in the first session to determine what the individual views as problematic and thus amenable to treatment.

The client’s broader environmental (e.g., are there any signs of mistreatment, is the individual provided with an appropriate level of privacy and autonomy) and social context (relationships with family, friends, and staff) also needs to be assessed in the first couple of sessions to determine how this context may exacerbate the depressive symptoms and/or how it could be modified or used to reduce these symptoms. For example, a mismatch between an individual’s functioning level and the degree of independence in his or her residential setting may be contributing to his or her depression, and moving the individual to a new residential setting may be an appropriate step in reducing his or her depressive symptoms. The therapist should also get an understanding of the nature of support for the individual, both social (e.g., do they have supportive people in their life) and functional (e.g., what services and assistance do they receive) and how this may contribute to depressive symptoms. For instance, an individual with ID may have many friends but not any transportation to visit these friends.
Prior to beginning the intervention, the individual with ID may benefit from knowing more about depression and CBT (McCabe et al., 2006). Depending on the level of cognitive ability of the individual, this information could be verbally communicated, or presented through story examples. Stories are useful aids to describe various situations that could have several alternate interpretations or several different outcomes on how the individual in that situation may feel or think. For example, the scenario could be presented of getting into an argument with a friend. Then, various interpretations of the scenario (e.g., the friend did not like the individual vs. the friend was just in a bad mood vs. the friend liked the individual but did not agree about a specific topic) and outcomes (e.g., the individual feels sad vs. the individual understands that the friend is just having a bad day) could be examined.

To measure change during the intervention, the therapist may choose to use standardized baseline measures of the individual’s behaviors and emotions during the first few sessions. However, little is known about how well some standardized instruments measure treatment change among individuals with IDs. In addition, the language and response options of instruments such as the Beck Depression Inventory (BDI) may be too complex for some individuals with IDs, and recalling events for a specific time period may be difficult (Lindsay & Lees, 2003). Still, standardized measures may be helpful in determining the presenting problems and symptoms, and providing tangible feedback to the individual with ID regarding how he or she has improved with therapy.

Setting an agenda

A set format for therapy is helpful to the individual with ID as it provides structure and predictability, which is often reassuring, and allows him or her to more quickly learn how therapy works and his or her role. It also allows the therapist to effectively manage time to ensure that target problems are adequately addressed within the allotted sessions. An example of the format for each session is (1) discuss current emotions and events, (2) review homework, (3) teach a specific skill, (4) assign homework, and (5) summarize the session. It is also beneficial to outline what topics will be addressed during each session so the individual has an understanding of what to expect. The format the therapist sets should also allow for flexibility. No format should be so rigid that it does not provide time to discuss new concerns that the individual with ID raises. This is particularly important for individuals with IDs who may contribute more during the course of therapy as they gradually become more comfortable with their treatment and aware of their thoughts and emotions.

Most importantly, the format, length, and frequency of therapy sessions should be tailored for the specific abilities and needs of the individual with ID. More sessions may be needed to account for the extra time spent repeating material within a session. The endurance, attention span, and motivation of the individual during each session will also dictate the length of each session. Additional sessions may be needed initially to establish rapport or to generate treatment targets. More support may be needed initially to guide the individual through the process of identifying the cognitive and behavioral factors that play a role in the initiating and maintaining of his or her problems and depressive symptoms. Additional sessions may also be needed to address topics or problems. Individuals with IDs often have comorbid diagnoses or
conditions, and additional sessions targeting topics such as relaxation for anxiety or anger management for aggression or irritability may be beneficial.

**Identifying dysfunctional beliefs**

The therapist should take the time to establish a common language or vocabulary for describing mood and feelings. A common language helps the individual to identify his or her dysfunctional beliefs and maladaptive automatic thoughts. These skills can be learned by teaching the names for various emotions through emotion labeling programs, through games, or through helping the individual to recognize and identify various emotions that he or she is experiencing within the therapy session.

Once a common language is established for discussing mood and feelings, the therapist can work with the individual with ID to monitor his or her thoughts. Reviewing upsetting events from the past week, or couple days, is one way to generate a discussion of the thoughts and feelings the individual was experiencing at that particular point in time. Some individuals with IDs will have difficulty remembering events from the past week, or have difficulty remembering what they were thinking at that time. For these individuals, it may be preferable to identify thoughts that occur within a session. The therapist is then responsible for commenting when he or she observes the individual with ID becoming upset, and moving the discussion toward identifying the thoughts and feelings that the individual is currently experiencing.

Other techniques can be used within the session to help the individual with ID to identify his or her thoughts. Role playing a past event or novel situations is a useful way to aid the individual with ID in identifying his or her negative thoughts. These situations need to be as concrete as possible. For example, a role play session related to a scenario at work should reference the specific coworkers and supervisors or job coach at the client’s job as well as the specific work-related issues that typically arise. Reverse role playing, where the individual with ID plays a role other than himself or herself, can also be effective. Reverse role playing may help the individual identify new thoughts to be probed during therapy. In any role play situation, it is important to focus on the situations that make the individual feel sad, and to have the individual with ID identify the emotions that accompany those thoughts. Pictures of social situations may serve as a useful prop to generate a discussion of what the individuals in the pictures are thinking and feeling. Pictorial diagrams may also be helpful to some for drawing the link between thoughts and emotions (Lindsay et al., 2005).

It is important for the therapist to be directive, in that he or she is leading the individual in identifying thoughts and emotions. But at the same time, the therapist needs to be aware of the cognitive abilities and deficits of the individual with ID. The techniques used to identify the dysfunctional beliefs need to match the ability and deficits of the individual with ID. For example, individuals with severe or moderate IDs may have particular difficulty understanding the thoughts or emotions of others, and require repeated practice on this skill using multiple formats such as pictures and role playing.

Once the individual with ID is able to identify emotions and negative thoughts within the therapy session, the therapist is encouraged to have the individual begin monitoring his or her mood and thoughts outside of the therapy session, generally
termed “homework.” However, it remains important for the therapist to continue to practice identifying mood and thoughts within therapy sessions as the validity and completion of homework cannot always be guaranteed. And depending on the individual with ID and his or her experiences with school, the therapist may choose to use a different term than “homework.”

Homework may include a graphical monitoring of the emotions the individual feels throughout the day. Histograms measuring the valence of the emotion or pictures may be useful to aid the individual with ID to document his or her feelings throughout the day, or to communicate to the individual how to do the monitoring. More support may be needed initially to help the individual with ID to understand how to complete a homework, and depending on the individual with ID, it may also be useful to recruit a support person to aid the individual with ID in completing his or her homework (see section on “External Informants”; Hurley, 1989).

Testing dysfunctional beliefs

A core component of CBT is helping the individual to review the accuracy of his or her interpretations of events, to test his or her negative thoughts, and to generate more adaptive thoughts and positive statements about himself or herself. In CBT, the therapist and the individual determine the evidence for and against a specific belief, generate alternative ways of interpreting a situation, de-catastrophize the situation, and learn problem-solving strategies.

Some of these cognitive components are complex, and extra supports may be needed for each of these steps. The therapist of an individual with ID should take the simplest dysfunctional belief that was generated and focus on testing the accuracy of its underlying assumptions. It is useful to select a behavior or belief that is likely to occur during the therapy session in order for the therapist to model cognitive restructuring. The therapist is thus able to immediately reinforce the individual for accurately identifying a negative thought and for evaluating the accuracy of that thought. It is also beneficial to focus on behaviors and thoughts that occur during the therapy session as, due to cognitive limitations of concrete thinking and temporal fixedness, it may be difficult for the individual to recall and test thoughts that occurred outside of therapy.

Once the problematic thought is identified, the therapist should help the individual with ID generate as many potential solutions to the problem, choose the best solution, determine the steps to carrying out the solution, and try out that solution. As problem solving is not specific to CBT or alleviating symptoms of depression, the individual may benefit from learning the concepts of problem solving on more concrete tasks (difficulty completing household task or job), and then building this skill into therapy and applying it to his or her negative thoughts and beliefs (problems at work, problems with peers). Again, role playing and concrete examples or vignettes are helpful aids for guiding the individual with ID through testing his or her dysfunctional beliefs.

For individuals with ID for whom these cognitive components are too complex, the therapist is encouraged to apply more behavioral measures, such as increasing positive statements, directing attention to positive events, and encouraging the individual with ID to engage in social activities outside of therapy. For example, the
individual with ID could be guided in identifying positive events that occurred throughout his or her day and developing a schedule of goal-directed and enjoyable activities. Breaking the cycle of negative thinking through engaging in positive statements and activities are helpful for reducing depressive symptoms. And engaging in social activities or projects can develop a sense of mastery and accomplishment for the individual with ID.

External informants

The involvement of parents, family members, and support staff within CBT may augment the therapy. Although individuals with IDs can reliably report on their depressive symptomatology (Esbensen & Benson, 2005), an external assessment of depressive symptoms can be useful when the individual with ID is initially less open about sharing his or her depressed thoughts with a clinician (Lagges & Dunn, 2003).

External informants can provide information about stressors or symptoms the individual with ID may be reluctant to talk about with a therapist. External informants can also serve as supports and be useful by (a) supporting treatment attendance, (b) supporting the individual to complete his or her homework (self-monitoring, engagement in social activities), (c) encouraging the use of problem-solving skills in the natural environment, and (d) changing environmental events that may exacerbate depressive thoughts and symptoms. In collaboration with the therapist, external informants can support the skills taught in therapy by coaching and modeling the skills throughout the day. They are also able to cue the individual with ID when they observe depressive behaviors, thus encouraging the individual to label thoughts and beliefs by himself or herself. External informants are a natural link between the acquisition of skills in therapy sessions and their application to the natural environment.

To enhance CBT, external informants can be brought in at the beginning and end of each therapy session to review progress and homework. Alternatively, they can be engaged in separate psychoeducation sessions about CBT and depression. Here, they are taught about the nature of the disorder, the components of CBT, and how to foster a more positive environment by using positive behavior management, praise, and reducing conflict. Key is flexibility, and making sure the involvement of the external informant maximally benefits the individual with ID. As part of the collaborative approach used in CBT, it is essential that the individual with ID dictates how involved the external informants are in his or her therapy.

It should be noted that although the use of external informants in CBT is theoretically enticing and supported by clinical practice, treatment outcome research has not been conducted for individuals with ID and mood disorders, nor has it been found to be efficacious for typically developing adolescents with depression (Birmaher et al., 2000; Lewinsohn et al., 1990).

Empirical Support for Modified CBT

To meet the criteria for an efficacious intervention, the selected treatment must be more effective than no treatment, a placebo, or an alternate treatment across multiple trials conducted by different investigative teams (Chambless & Hollon, 1998). A
“possibly efficacious” intervention would meet the same criteria but has not been replicated or been replicated by independent investigative teams. There exist very few empirical studies examining the effectiveness of CBT among individuals with IDs (Beail, 2003; Dagnan, 2007; Willner, 2005), and even fewer empirical studies using control groups or treatment follow-ups. As such, the efficacy of the modifications described earlier may have support from clinical experiences but lack empirical support.

Nonetheless, the existing preliminary reports are encouraging. Case reports using CBT or its components with individuals with ID and depression have favorable outcomes (Dagnan & Chadwick, 1997; Lindsay, 1999; Lindsay & Olley, 1998; Lindsay et al., 1993; Matson et al., 1981). There is some evidence supporting the behavioral components of CBT with mood disorders (Carr et al., 2003; Lindauer et al., 1999). And there is empirical support for the use of parental involvement in CBT for anxiety in children with autism spectrum disorders (reviewed in Reaven & Hepburn, 2006).

The most encouraging support for the efficacy of CBT for mood disorders comes from a group in Australia (McCabe et al., 2006). This group has examined the effectiveness of a group format of CBT for reducing depressive symptoms in adults with mild/moderate IDs. They targeted adults with sufficient language skills to participate in the intervention and with mild to severe depressive symptoms as reported on the BDI. The format of intervention was small groups of three to five individuals, for 2-hour sessions, over five weeks. Their group intervention contained the core components of CBT in that it identified negative cognitions, taught self-monitoring and adaptive behaviors, and reshaped cognitive distortions. Furthermore, the intervention used modeling, role play, and structured feedback to help apply CBT to adults with IDs. In addition, by adopting a group format, the intervention allowed for the practicing of skills with peers within a supportive social environment. This group intervention resulted in a significant improvement in depressive symptoms as compared with a wait-listed control group and the treatment effects were maintained three months posttreatment. The study of this application of CBT to individuals with depressive symptoms is not without its limitations. The study did not examine individuals suffering from clinical depression, individuals with limited language skills, nor did it examine relapse over longer periods of time. Nonetheless, this study is the most promising research to date examining CBT for individuals with IDs and depressive symptomatology.

Case Example

Jonathan is a 30-year-old white male of European decent. He has mild ID due to unknown etiology. Jonathan has lived in an apartment by himself for the past four years. Staff from Jon’s disability service provider check in on Jonathan several times a week and take him to get groceries and run other errands. Jonathan does not have his driver’s license and relies on transportation services through his disability service provider. Jonathan’s parents live in the same city and spend time with Jonathan every Sunday. Jonathan has worked part-time as a dishwasher at a fast-food restaurant for the past six years.
Jonathan has a history of recurrent major depressive disorder. His most recent episode began four weeks ago, following a disagreement with his boss at work. Since this time, Jonathan feels sad most of the day, sleeps most of the day, goes for days without showering, has been late to work on several occasions, and avoids leaving his apartment. Jonathan was referred for therapy by his disability service case manager, Noah.

Sessions 1 and 2

Goals

- Establish rapport.
- Define presenting problem.
- Understand client’s broader environment and social context.
- Identify ways of measuring change.

Prior to the first session, the therapist contacted Jonathan to ask if he would like to include a family member or staff person in some of the therapy sessions. Jonathan indicated that he would like to include his disability service case manager, Noah. Jonathan and Noah attended the first two sessions together. Jonathan initially stated that he was “depressed” and wanted therapy to “feel better.” The therapist used a series of probing questions to guide Jonathan in identifying behaviors, thoughts, and emotions related to being “depressed” (e.g., “what do you do when you feel depressed?”) and wanting to “feeling better” (e.g., “what would you be doing today if you felt better?”). Jonathan indicated that he felt “dark and stormy” when he is depressed and like “sunshine” when he feels good. These labels were then used by the therapist. Noah contributed to this discussion by commenting on changes in Jonathan’s behaviors that he has noticed. Limited transportation and opportunity to socialize with others and lack of a job coach at work were identified as important environmental and social context variables contributing to Jonathan’s depressed mood. The therapist created a picture of a ruler that went from “dark and stormy” to “sunshine,” and asked Jonathan to rate his mood. Jonathan and Noah were then given several copies of the ruler and Jonathan was instructed to rate his mood once a day. By the end of session 2, a list of specific problem behaviors and the following list of positive desirable behaviors were identified: shower every day, spend time with friends, exercise, be on time to work, and do artwork. These desirable behaviors were written on a large poster board and taped to Jonathan’s refrigerator. With the help of Noah, Jonathan was instructed to record if and how much time he spent engaged in each of these behaviors every day. For the remaining of the sessions, this homework was reviewed at the beginning of the session.

Sessions 3–5

Goals

- Learn to identify emotions and cognitions.
- Understand the connection between emotions and cognitions.
- Address social and environmental problems.
Several strategies were used to teach Jonathan about emotions and cognitions. Jonathan was told stories and guided in generating a list of what each character may be thinking and feeling. The therapist provided descriptions of emotions and Jonathan was asked to describe a time when he felt each emotion. Role playing was used to act out scenarios and Jonathan was guided in identifying his feelings and thoughts in each scenario. The therapist guided Jonathan in discussing how feelings and thoughts are connected. In all of these activities, the therapist highlighted how different interpretations of the same event are linked to different feelings. As a homework assignment during these weeks, Noah was asked to spontaneously ask Jonathan to identify his emotions and cognitions twice a day. This information was recorded. During these sessions, strategies for increasing access to transportation and opportunities for Jonathan to socialize with others were also identified. In addition, strategies for hiring a job coach to teach Jonathan ways to improve on his work and to help educate Jonathan’s boss about Jonathan’s disability were identified and implemented.

Session 6

Goal

• Learn muscle relaxation strategy.

Jonathan reported having difficulty dealing with feelings of frustration and anxiety. In order to help Jonathan learn how to manage these feelings, the therapist taught him a muscle relaxation strategy. This session was videotaped so that Jonathan could watch it at home and practice the strategy.

Sessions 7–10

Goal

• Identify and test dysfunctional beliefs.

Many of Jonathan’s negative emotions and thoughts were focused on his interactions at work with coworkers and his new boss. Jonathan believed that his coworkers made fun of him and did not like him. He was also upset because he believed that his boss was mad at him because he did not work as fast as the other dishwashers. Jonathan also believed that he did not have any friends and would never have a girlfriend. The therapist guided Jonathan in reviewing the accuracy of his beliefs and thoughts. Jonathan’s faulty logic was highlighted. Jonathan had a tendency to make issues “black and white” (i.e., he was either a good or a bad worker), to personalize situations (e.g., he was the cause of his boss’s bad mood), and to jump to conclusions (his neighbor did not say hi to him because she didn’t like him). Visual aids and role playing were used to challenging Jonathan to evaluate his beliefs. Noah attended two of these therapy sessions and continued to help Jonathan identify and evaluate his interpretations of events outside of therapy.
Sessions 11 and 12

**Goal**

- Learn problem-solving skills.

The therapist walked Jonathan through the steps of solving a problem: generate as many possible solutions as possible, choose the best solution, determine the steps to carry out that solution, and try the solution. A poster board with these steps and illustrative pictures was created, which Jonathan then took home. Jonathan was prompted to identify problems in his own life and the therapist guided him through the problem-solving steps. Noah was asked to attend one of these sessions so that he could also learn the problem-solving steps to use with Jonathan outside of therapy.

Session 13

**Goals**

- Review concepts and strategies learned.
- Identify obstacles to employing strategies once therapy is over.
- Create plan for booster sessions or additional support if needed.

The therapist reviewed the concepts learned in the therapy with Jonathan and Noah. The therapist also created a visual graph to show Jonathan how his mood had increasingly moved toward “sunshine” on the ruler scales and how Jonathan had increased the frequency and time spent engaging in his list of positive, desirable behaviors. A plan for a booster session in one month was created.

**Conclusions**

Individuals with IDs present with many of the same depressive behaviors as typical developing individuals, including dysfunctional cognitive processes. Preliminary research suggests that CBT may be a beneficial treatment for depression in individuals with IDs. In this chapter, we reviewed the core features of CBT and highlighted training procedures and modifications to CBT for use with individuals with IDs. The key to using CBT with individuals with IDs is to be flexible and tailor the intervention to match the cognitive and developmental abilities of the individual with ID. Recommended modifications include involving caregivers or supportive others in therapy, the use of games and activities to teach individuals how to label emotions and thoughts, careful consideration of language and checking in the individual with ID to ensure that words have a common meaning, using multiple learning formats including pictures and role playing and other active learning activities, and flexibility in terms of the length and number of sessions.

The development and maintenance of mood disorders is not solely cognitive, but rather is likely a combination of cognitive, behavioral, biological, social, and...
environmental factors interacting with each other (Stark et al., 1991). Thus, the presentation of CBT here is not an indication that this method of treatment is superior to other interventions. Rather, CBT should be viewed as a complement to behavioral and pharmacological interventions. There is encouraging evidence that CBT is an appropriate and efficacious treatment for depression in individuals with IDs (e.g., Dagnan & Chadwick, 1997; McCabe et al., 2006). However, additional research is needed to evaluate the effectiveness of CBT and better understand which components and modifications are best suited for individuals with IDs.

References


