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Conceptualizing the Use of Cognitive Interventions Among Persons with Intellectual Disabilities Who Experience Depression

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Abstract -- Depression can affect the lives of all persons and can have especially profound implications on those with cognitive limitations; however, depression need not be an insurmountable roadblock to employment for persons with intellectual disabilities. Cognitive interventions – such as life story approach, socio-cognitive, and rational emotive behavior therapy – can be effective for litigating problems with depression among those with cognitive limitation including employment-related barriers due to depression. This article reviews how counselors can use cognitive interventions' behavioral and cognitive components to assist those with intellectual disabilities with depression.
Keywords: Intellectual disabilities, depression, modified cognitive interventions

The most recent statistics from the Centers for Disease Control and Prevention indicate between 2006 and 2008, nearly one in six children in the United States had a developmental disability (Centers for Disease Control, 2010). Developmental disabilities (DD) are a group of conditions with onset between birth and 22 years of age, usually lasting through a person's lifespan and includes autism spectrum disorders, attention-deficit disorders, cerebral palsy, intellectual disabilities (ID), and other developmental delays. Persons with DD generally have problems with learning, language, mobility, and independent living. Over the past 12 years, the prevalence of DD increased 289.5%. This is in part due to the Metropolitan Atlanta Developmental Disabilities Surveillance Program adding autism to its scope in 1996 (Autism Society of America, 2006; Boyle et al., 2011). Since these increased rates of prevalence indicate a serious health problem, Boyle, et al. (2011) advocate for future research to examine the influences of DD on risk-factor shifts, changes in acceptance, awareness of conditions, and benefits of early intervention.

Depression affects about 19 million adults in the United States (Lee, 2010; Stice & Moore, 2005). The prevalence rate is higher among those with DD compared to those without disabilities. Among those with DD, 1-9% of individuals with ID report high levels of depression (Cooper, 1997; McDermott, Moran, Platt, Issac, & Hope, 2005; Stewart, Barnard, Pearson, Hasan, & O'Brien, 2006). Prevalence rates for depressive disorder are 6–30% among persons with ID, compared to 5–9% for women and 2–3% for men in the general population (Morin, Cobigo, Rivard, & Lepine, 2010). The high rate of depression among those with ID has recently spurred research interest on those with ID with depression (Lindsay, Howells, & Pitcaithly, 1993). However, it is worth noting research on depression and persons with ID is scant; also, depression rates for persons with ID appear to be underreported (Jahoda et al., 2005) resulting in underrepresentation in the population.

Experts define depression as an organic or reactive psychological state, which is a realistic response to frustrating and adverse life circumstances (Ledley, Marx, & Heimberg, 2010). According to the *Diagnostic and Statistical Manual of Mental Disorder-Fourth Edition-Text Revision* (American Psychological Association [APA], 2000), depressive symptoms include decreased energy; changes in appetite, weight, sleep, and psychomotor activity; feelings

of worthlessness or guilt; and difficulty thinking, concentrating and making decisions. More severe symptoms include recurrent suicidal ideation. People experiencing major depressive episodes may demonstrate the inability to be interested in or experience pleasure in activities they once found pleasurable. Due to the obstacles many persons with ID may face including lack of education, social skills, and support, low income, negative attitudes of society, and stress; they are likely to experience depression (Jahoda et al., 2005; Meertens, Scheepers, & Tax, 2003; Stice & Moore, 2005). Therefore, those with ID can become trapped in a cyclical process, that is, depression leads to lack of employment and lack of employment leads to depression (Catherine, Seekins, & Ravesloot, (2009). The corollaries are poverty and poor quality of life (Esbensen & Benson, 2005).

Modified cognitive therapy (CT) interventions and rational emotive behavior therapy (REBT) have shown promise in treating depression among those with ID because these are less complex and require less time. The purpose of this work is to discuss these psychotherapeutic interventions and to demonstrate how they can be effectively utilized for those with ID.

Cognitive Interventions and Depression

Those with intellectual disabilities experiencing depression may have shorter life spans and be more prone to other medical illnesses than the general population (Enns & Cox, 2005). To be diagnosed with major depressive symptoms (MDD), an individual must have one or more major depressive episodes at least two weeks in duration, accompanied by at least four additional symptoms of depression; symptoms must persist for two or more years in order for a person to meet the full criteria for a major depressive episode (American Psychiatric Association, 2000; Hensley, Nadiga & Uhlenhuth, 2004). Medication and psychotherapy are used for this mental illness. Notwithstanding their positive effects in reducing depressive symptoms, medications do not cure depression (Jackson & Hollon, 1996). Instead, they suppress the reemergence of symptoms. Many clients respond adversely to medication and relapse within 12 months (Fava et al., 1999; Friedman & al., 2004). According to Hirschfeld (2001), discontinuing medications increases clients' risk for relapsing. Moreover, medications may cause undesirable side effects, such as insomnia, fatigue, tremors (Kikuchi, Suzuki, Uchida, Watanabe, & Mimura, 2012) resulting in the individual discontinuing the medication

Due to these limitations, it is no surprise psychotherapy, such as cognitive- related interventions (e.g., such as cognitive therapy (CT), cognitive behavior therapy (CBT), rational emotive behavior therapy (REBT), cognitive interventions and medication, and behavioral therapy), has emerged as the alternative to medication. Research in the general (Garske & Bishop, 2004; Hollon & Beck, 2004; Ledley, Marx, & Heimberg, 2010; Morin, Cobigo, Rivard, & Lepine, 2010; Satre, Knight, & David, 2006) has demonstrated the effectiveness of these interventions in combating depression; compared to no treatment or placebos, meta-analysis studies suggest cognitive interventions are more effective (Bobson, 1989). Beyond the general population, CT interventions have shown promise with individual with disabilities; in rehabilitation contexts, CBT is successful in reducing unipolar and mood disorders' symptoms and the risk of relapse (Miranda, Gross, Persons, & Hahn, 1998; Swett & Kaplan, 2004) and REBT is efficacious in aiding PWDs with depression returning to work (Garske & Bishop, 2004). The behavioral components of CBT and REBT that focus on reducing the frequency of behaviors associated with depressive disorders and increasing the frequency of appropriate behaviors (i.e., improving social skills) are paramount in decreasing depressive symptoms (Morin, Cobigo, Rivard, & Lepine, 2010).

However, when distorted thoughts of self and/or other persist, these behavioral components remain insufficient in overcoming this illness– many with ID encounter such false thoughts, especially about their abilities due to past failures. CT (along with CBT and REBT's cognitive components) shows success in treating depression due to false beliefs about self and others. Furthermore, Dobson's (1989) meta-analysis showed CT was superior to behavior therapy in treating depression. Unlike CBT and REBT's behavioral components, CT (along with CBT and REBT's cognitive components) focus on changing negative thought patterns and attitudes, which is facilitated by these therapies' cognitive components. Yet, it is worth noting those with ID may respond poorly to CT because of the low cognitive abilities many with ID face (Lindsay, Howells, & Pitcaithly, 1993).While CT interventions are effective treatments for depression, its deficiency among those with ID is the high cognitive ability one needs to benefit from its cognitive component. As such, there is a crucial need to use refined CT interventions that enable those with low cognition to benefit from its cognitive components (Jahoda, et. al., 2005).

Research shows modified CT interventions, such as life story strategies work effectively with those with low cognitive or intellectual abilities (Lindsay, Howells, & Pitcaithly, 1993; Lindsay & Kasprowicz, 1987; Stenfern-Kroese, Dagnan, Loumides, & Loumidis, 1997 in Sturmey, 2004; Willner, 2006). At first glance, CT interventions that rely on verbal skills, including abstract verbal skills, the ability to report thoughts and feelings, and weigh evidences, seem inappropriate for those with ID. However, life story approach enables those with limited cognitive abilities to convey their thoughts (Jahoda, et al., 2005).

However, it is worth noting, CT may not be a panacea, curing all levels of depression. According to Lubin and Whitlock (1995), cognitive related interventions, including life story approaches, may depend on the depression level, which, according to the Beck Model of Depression, are: 1) depressed/normal, 2) mild depression, 3) moderate depression, and 4) severe depression (Lubin, & Whitlock,1995). Research in general supports CT effectiveness in treating

the first three levels of depression. For example, in a control study, Hollon and Beck (2004) found CT was superior to no treatment in reducing and treating acute distress. Satre, Knight, and David (2006) found cognitive techniques may be appropriate for clients with milder degrees of depression. However, in regards to the effectiveness of CT in treating severe depression, research findings are mixed (Brent, 2006; Hollon & Beck, 2004).

On the one hand, in a quantitative review comparing CT and medications, Hollon and Beck (2004) concluded CT is more effective with less severe depression and medication with more severe depression. Along this vein, Elkin et al.'s (1995) yielded conclusions consistent with those from Beck. On the other hand, DeRubeis et al.'s (1999) mega-analysis found cognitive intervention was at least as effective as antidepressants in treating more severe depression; such claims have not gone unquestioned. Bobson (as cited in Lambert and Ogles 2004, p.162) and Lambert and Ogles (2004) noted the possibility of bias conclusions, favoring cognitive therapy – for example, only one medication is chosen for a study and the medication is not altered when clients do not respond. While generally research conclusions fall short in unequivocally endorsing CT effectiveness for those with severe depression, research suggests medication combined with CT is more effective than medication alone (Brent, 2006; Friedman et al, 2004; Hirschfeld, 2001; Hollon & Beck, 2004).Table 1 provides a comparison of these CT interventions, including the modified cognition intervention (Life story).

Table 1
Comparison of Interventions

Cognitive Therapy	Life Story (within SPPRD frame)	Social-Cognitive Interventions	Rational Emotive Behavioral Therapy's Behavioral Intervention
Clients should have capability for abstract thinking and insight.	Clients do not need capability for abstract thinking and insight.	Clients do not need capability for abstract thinking and insight.	Clients do not necessarily need capability for abstract thinking and insight.
See the client as the problem and "fixes" client.	While it can see the client as the problem and "fixes" client, it also ascribes the problem to external circumstances (e.g., stigmatization) and distancing the client from the problem.	Ascribes the problem to external circumstances (e.g., stigmatization) and tries to change the circumstances.	While it can see the client as the problem and "fixes" client, it also ascribes the problem to external circumstances (e.g., stigmatization, complex tasks, feared objects, etc.).
Collaborative	Collaborative	Not necessarily collaborative	Collaborative
Complex; requires time and might not be appropriate for counselors who are not also trained therapists.	Less complex and requires less time; are appropriate for counselors who are not necessarily a trained therapist.	Less complex and may require time; are appropriate for counselors who are not necessarily a trained therapist.	Less complex and require less time; are appropriate for counselors who are not necessarily a trained therapist.
Focus on identifying and changing negative thought.	Focus on identifying and changing negative thought.	Focus on changing negative environment (e.g., discrimination and stigma).	Focus on changing behavior.

Life Story: Modified Cognitive Interventions for Those with Intellectual Disabilities

Life story approach - a modified cognitive intervention within a cognitive framework - shows promise in alleviating depression for those with ID (Jahoda, et al., 2005; Scior & Lynggaard, 2006). It may be difficult for counselors to elicit beliefs and attitudes in order to change false beliefs of many with ID, but with life story approach, this may be possible. This approach utilizes clients' stories to correct their false beliefs. For example, for persons with negative false beliefs regarding their work ability or performance, the therapist aids the person in recalling positive memory or forgotten successful accomplishment (e.g. graduating from a program) and narrating them. Accordingly, the person may come to realize positive aspects of their lives or an accurate assessment of themselves (White, 1993). That is, the story the client narrates dis-empowers the client's false sense of self due to false beliefs and empowers a vision of real self (Lambie & Milsom, 2010).

SPPRD. In SPPRD, the (S) stands for "separate false from real thoughts", the (PP) for "put these thoughts in perspectives", the (R) for "retain healthy thinking" and the (D) for "discard faulty thinking". McFarlane and Lynggaar's (2009) model of conversation that mirrors the SPPRD frame can help counselors who use life story to assist individuals with ID and depression change their false beliefs and potentially their depression. Specifically, counselors aid clients separate false from real thoughts (S), put

these thoughts in perspectives (PP), and ultimately help clients retain healthy thinking (R) and discard faulty thinking (D). In conjunction with life story approach, the McFarlane and Lynggaar's (2009) frame is an appropriate tool for CT intervention for those with ID and depression., McFarlane and Lynggaar have successfully utilized life story with an individual with ID. They assisted a couple, one of whom had ID, separate false beliefs about themselves and their real self and maintain appropriate thinking styles, resulting in a better quality of life for the couple. Table 2 provides a scenario example of SPPRD frame.

The S: Separate false from real thoughts. Narrative therapy's life storytelling approach encourages people to view themselves as separate from their problems and empowers them to construct preferred stories about themselves and the future (Scior & Lynggaard, 2006). As a profession that values empowering individuals, rehabilitation counseling meshes well with life story approach. In other words, life story strategy is relevant in rehabilitation counseling. This approach not only directs the clients' focus on themselves as positive, but, within McFarlane and Lynggaar's (2009) frame, also motivates them to characterize the problem (e.g., seeing selves as stupid for not succeeding in a task) or define it as external origin (e.g., ineffective training program). This way, clients can differentiate or separate themselves from the problem, thereby distancing themselves from it, and forming real pictures of selves.

The PP: Put these thoughts in perspectives. With psycho-educational strategy (a CT strategy), clients (as they narrate their stories) understand the problem and put it in perspective. This allows them to correct distorted thinking, thereby helping to retain positive views or discard negative ones (Willner, 2006). Psycho-educational strategy shows potential for many with ID who tend to explain failure in terms of stable, global causes and success in terms of unstable and specific causes (Abramson, Seligman, & Teasdale, 1978; Peterson, & Seligman, 1984), which, according to Nolen-Hoeksema, Girgus, & Martin (1986), correlate with depressive symptoms such as decreased persistence and initiation of tasks, poor problem-solving strategies, and lowered expectations for success. Using this strategy, a counselor can explain failing in one task at a particular time does not portend failure in future tasks, be it the same or a different task - in other words, failure is unstable or not universal. Conversely, the counselor can equate client's successes as stable and universal. For example, as the client narrates his/her success stories, the counselor can let the client picture him/herself as intelligent (stable) and efficacious in present and future tasks (universal). Through this psych-educational strategy, clients can better understand the problem and use their success to overshadow past failures and highlight a positive self, rather than a negative self that can lead to depression.

The RD: Retain healthy thinking and discard faulty ones. In addition to fostering thought patterns that dissociate clients from their problems, it also aids clients in discarding false beliefs and retaining new, appropriate ones. Persons with limited cognitive abilities recall positive memories and espouse real, positive conclusions about selves, rather than negative failures, as they convey positive stories about themselves, (Jahoda et al, 2005). By connecting the past and future, life story strategy redirects persons who dwell on past, negative situations to positive ones and as a result makes it possible for the persons to abandon or discard negative thought and retain or acquire new, appropriate thinking styles (Bryntwick, 2009; Dagnan & Waring, 2004). Ultimately, instead of viewing oneself as a failure, a person may start recognizing he/she is a success (Kondrat & Teater, 2009). Such strategy empowers a positive sense of self (White, 1993).

It is worth noting, to better assist those with limited cognitive and communication abilities with conveying their stories, effective communication strategies, such as life story's strategy of mapping/scaffolding - by asking ques-

Table 2

Life Story Scenario Examples

Scenario 1 Separate the Client from the Problem	Scenario 2 Ascribing the Problem to External Circumstances
Counselor: You say you cannot do the job because you believe you are not smart. Client: I think I am stupid Counselor: (based on client's story) From what I have been hearing, you assembled 40 vacuum cleaners and packaged them without any help. That does not mean stupidity to me. A person who can do that is smart. You are not stupid.	Counselor: You cannot do the task; it may be because of the lack of your supervisors' training to help you learn the task, or because s/he gives you too many tasks at one time.
Scenario 3 Putting Things into Perspective	**Scenario 4 Contrary View and Accounting for Unforgotten Memories**
Counselor: Not doing A or B job does not mean you cannot do similar jobs or that you will not be able to do them in the near future. Perhaps you cannot do C (a very difficult task), but I see you did D. There is not much difference between the two jobs. How did that feel? Was it difficult? Client: Not too difficult.	Counselor: You said you are lazy and not as smart as others. However, (based on client's story) you come to work every day and you teach others how to play bingo; you are learning how to use the computer without problems, etc. (contrary to clients negative thought about self). Why do you think this is the case? Client: Perhaps, I am smart. Counselor: Why perhaps? You are smart. Counselor: Remember when you fixed the dryer at home? Do you recall how you do most of the chores at home (unforgotten memories)? Client: Yes; thank you.
Scenario 5 Retaining and Discarding	
Counselor: Let us write a list of your negative (false) and positive (real) thoughts about yourself. Let us keep the real ones that truly represent you and throw out the false ones. Do you want me to do it or do you want to do it? How does that feel? Client: Good. Counselor: I would like to hear your story again, but this time use the list of thoughts that we kept to tell me your story.	

tions and further breaking the questions into smaller steps – is essential. Using mapping/scaffolding to aid persons with limited cognition and communication skills communicate and understand their problems, the therapist "maps" the effect of the problem by asking questions and the person responds to main and follow-up questions. Questions therapists might ask, include, "How do you think about yourself now as a result of this problem? How does this problem affect you at work and with others?" To facilitate answers to these questions, a counselor further asks mini questions as the clients respond to the previous questions. Accordingly, clients can pin point their distorted view of themselves and understand them as contrary to their real selves (A. Samuel, personal communication, May 8, 2012).

Dennis (2002) cautioned the communication be mutual and the relationship nurturing. Fullager and Owler (1998) added a trusting relationship over time is critical in piecing together clients' stories. Pictures and appropriate language expression (facial expressions, nodding, basic signs) complement verbal communication. As the counselor communicates with clients and assists them in telling their stories, he/she can show pictures or clips of the clients' successes (e.g., pictures of a victory in a sport, or pictures of work accomplishments).

In addition to utilizing CT and medication to defeat depression among those with ID, changing negative situations (e.g., discrimination) linked to depression is paramount, because those with ID face discrimination and marginalization in society in general and work in particular (Smart, 2004). These situations, coupled with depressive symptoms, can lead to barriers in employment, further increasing negative moods rather than dimming them. However, socio-cognitive intervention shows promise in preventing or reducing depression caused by these negative social conditions (Rosbrook & Whittingham, 2010). REB, which utilizes behavior components such as assertiveness training, systematic desensitization, modification of the environment, and activity schedules (Garske & Bishop, 2004), can also be effective for those with ID who encounter distinct circumstances (e.g., fear of performing new tasks, boredom due to repetitive tasks or unfamiliarity and complex tasks) that are related to depression.

Social-Cognitive and REBT and Depression at Work

Unlike cognitive models of depression, the social-cognition approach postulates that negative social conditions such as social stigma, labeling, segregation, victimization, rejection, and restricted opportunity trigger depression (Sullivan et al., 2006). Changing these adverse situations can prevent or reduce depression caused by these situations (Rosbrook & Whittingham, 2010). In work settings, counselors can empower those with ID to advocate for safe psychological environments (Rosbrook & Whittingham, 2010), and those with ID can meet with supervisors to discuss and find solutions to the issues they face. Through such diplomatic advocacy, those with ID and counselors can inveigle even indifferent supervisors regarding bullying and humiliation in the work place to their cause. Seminal authors such as LaPointe and Rimm (1980), Wlope and Lararus (1976), and Watson and Herder (1980) have demonstrated assertiveness training's effectiveness in treating depression. In particular, in LaPointe and Rimm's study, compared to both insight-oriented group therapies and cognitive intervention, assertiveness training was more efficacious in treating depression among women. Assertiveness training has the potential of thwarting depression due to denigrating comments, discrimination, and other negative attitudes toward individuals with ID (Sanchez, Lewinsohn, & Larson, 1980). Other REBT's approaches (e.g., systematic desensitization and activity schedules) have the potential of reduce the frequency of maladaptive behaviors linked to depression and increasing adaptive behaviors (Ledley et. al., 2010; McCabe, McGillivray, & Newton, 2006 in Morin et. al., 2010).

Counselors can use systematic desensitization to reduce or eliminate the fear or anxiety of performing some tasks (e.g., tasks person was once unsuccessful with). For example, first the counselor and the person approach the task together and then the person alone. After that, the counselor performs the task with the person, and finally the person tackles the task alone. Breaking tasks into small tasks is even more important for those with ID since complex tasks can be difficult for them. By using this REBT's strategy of modifying the environment by breaking down complex tasks into simple, small ones, those with ID can perform seemingly cumbersome and unmanageable task with less difficulties. This strategy can reduce or eradicate ID's fear of performing seemingly difficult tasks.

Activity scheduling has the potential of assisting those with ID to cope with their depression by identifying tasks the client enjoys performing and engaging him/her in these tasks (Wolpe & Lazarus, 1976). In employment settings, working in tandem with site supervisors, the counselor and client can identify particular job tasks the client appreciates and improves his/her mood. The effectiveness of activity scheduling in treating depression is well documented; it may be as effective as antidepressants and cognitive therapy (Cuijpers, Straten & Warmerdam, 2007). REBT's use of assertiveness training, systematic desensitization, and active scheduling definitely has the potential of assisting those with ID to overcome roadblocks to employment due to depression. Table 1 provides a comparison of these interventions.

While these interventions have the potential to assist those with intellectual disabilities in overcoming their depression, more research is needed to demonstrate these interventions do indeed work for individuals with ID. Researchers can focus on each of the above-mentioned interventions, and the combinations of these interventions, in aiding those with ID to overcome their depression. Research can also consider the level of depression when investigating the effect of these interventions.

Given an employment obstacle for those with ID is depression and several studies report negative relationships

between employment and depression (Crisp, 2005; Samkange-Zeeb, Altenhoner, Berg, & Schott, 2006), there is a need for effective strategies such as life story, social-cognitive method, and REBT approaches to assist persons with intellectual disabilities to overcome their depression. By changing adverse situations (e.g. poverty) which may cause depression, social-cognitive interventions have the potential of assisting persons with IDs, many of whom face daily negative situations, to overcome depression caused by social situations. REBT's strategy of breaking down complex tasks to simple ones is likely to reduce or eliminate the frustrations caused by difficult tasks and the depression caused by frustrations. Furthermore, REBT's strategy of empowering persons is valuable for a person with intellectual disabilities, who through empowerment, is strengthened and motivated to take action and initiative for their lives (Mahon, Yarcheski, Yarcheski, & Hanks, 2007). By assisting persons with intellectual disabilities to narrate their positive life stories, they can utilize their cognition and therefore benefit from CT. As such, they can concentrate less on negative situations and more focused on positive and current events, thereby shifting negative images and encouraging new, appropriate thinking styles. This in turn can avert depression caused by faulty beliefs (Bryntwick, 2009). These modified cognitive interventions and REBT's behavioral components, which are less complex and require less time, are appropriate tools for counselors to use with those who have intellectual disabilities.

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