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A Preliminary Evaluation of Adapted Cognitive Behavior Therapy for Anxiety in Adolescents with Mild Intellectual Disability in Indonesia

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Abstract
Individuals with mild intellectual disability (MID) experience elevated rates of anxiety that adversely affect emotional well-being and social participation. Although Cognitive Behavioral Therapy (CBT) is well-established for anxiety in the general population, evidence for its use with individuals with MID remains limited. This case series explored the feasibility and preliminary clinical outcomes of an adapted CBT intervention for anxiety in adolescents with MID. Four adolescents (aged 14 years) with clinically significant anxiety received seven sessions of CBT adapted through simplified language, visual supports, repetition, role-play, and caregiver involvement. Anxiety was assessed at pre-intervention, post-intervention, and follow-up using the Glasgow Anxiety Scale for People with an Intellectual Disability (GAS-ID). Individual change was evaluated using the Reliable Change Index (RCI). Qualitative data from participant worksheets and supporter interviews were analyzed thematically. All participants demonstrated reliable reductions in anxiety symptoms that were maintained at follow-up. Qualitative findings suggested improvements in emotional awareness, social participation, and coping skills. These findings indicate that adapted CBT may be feasible and potentially beneficial for adolescents with MID, warranting further evaluation in controlled studies.

INTRODUCTION

Mental health difficulties are disproportionately common among individuals with intellectual disability (ID), with anxiety disorders representing one of the most frequently reported conditions (Cooper et al., 2015; Emerson & Hatton, 2007). Individuals with mild intellectual disability (MID), in particular, appear especially vulnerable to anxiety due to the interaction between cognitive limitations and increasing environmental demands. Anxiety in this population often presents as excessive worry, heightened fear responses in specific situations, and difficulties regulating emotional reactions. Elevated anxiety may restrict participation in educational and social contexts, disrupt interpersonal relationships, and reduce overall quality of life.

Mild intellectual disability is characterized by limitations in intellectual functioning and adaptive behavior, including challenges in abstract reasoning, problem-solving, and emotional regulation. Although individuals with MID typically retain functional verbal communication skills and can navigate familiar daily routines, they may experience difficulty interpreting social cues, anticipating consequences, and adapting to change. Such challenges can increase exposure to stressful experiences, including social rejection, repeated academic failure, and uncertainty in unfamiliar environments, thereby heightening vulnerability to anxiety. When

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persistent, anxiety may further impede the development of independence and adaptive functioning (Dagnan & Chadwick, 2006).

Cognitive Behavioral Therapy (CBT) is a well-established psychological intervention for anxiety disorders in the general population (Beck, 2011). CBT is based on the reciprocal relationship between cognitions, emotions, and behaviors, and aims to reduce anxiety by helping individuals identify and modify maladaptive thought patterns and avoidance behaviors. However, standard CBT protocols rely heavily on abstract reasoning, metacognitive reflection, and verbal insight, skills that may be relatively less developed in individuals with MID. Consequently, direct application of conventional CBT without modification may limit accessibility and effectiveness.

Emerging evidence suggests that CBT can be adapted to meet the cognitive and learning profiles of individuals with MID. Modifications commonly include the use of simplified language, visual supports, repetition, structured session formats, role-play, and increased caregiver involvement. Preliminary studies and meta-analytic reviews indicate that such adaptations may enhance engagement and are associated with reductions in emotional distress, including anxiety symptoms (Hassiotis et al., 2011; Vereenooghe & Langdon, 2013). Nevertheless, the evidence base remains limited, particularly with respect to anxiety-specific outcomes and adolescent populations. Much of the existing literature combines multiple diagnostic groups, focuses primarily on depression, anger management or other disorder rather than anxiety (e.g., Ardi et al., 2023; Siste et al., 2024).

In the Indonesian context, research examining adapted CBT for anxiety in individuals with mild intellectual disability is scarce (e.g., Arjadi, 2018; Sari & Assyari, 2019). Limited local evidence may constrain clinicians and special education practitioners in selecting empirically informed interventions tailored to this population. Further evaluation of adapted CBT within diverse cultural and service contexts is therefore warranted to inform the development of accessible psychological interventions.

The present study addresses this gap by examining clinical change in anxiety symptoms following an adapted CBT intervention delivered to adolescents with mild intellectual disability. Using a case series design and both quantitative and qualitative indicators of change, this study explores whether adapted CBT is associated with reductions in anxiety and improvements in coping-related functioning. By documenting individual-level outcomes and adaptation strategies, the study aims to contribute preliminary evidence to support further controlled investigation of CBT for anxiety in adolescents with MID.

METHODS

Design

This study employed a prospective multiple-case series design to examine individual trajectories of anxiety symptoms following an adapted Cognitive Behavioral Therapy (CBT) intervention. Repeated measures were collected at three time points: pre-intervention (T1), post-intervention (T2), and 4-week follow-up (T3). The case series design was selected to provide preliminary evaluation of clinical change in a population for whom controlled trials remain limited, particularly within the Indonesian context. The study was approved by the institutional ethics review committee of Universitas Medan Area (Approval No. 3653/FPSI/02.5/VI/2025). Written informed consent was obtained from supporters (parent, teacher, or peer), and assent was obtained from all participants. Confidentiality was maintained through the use of pseudonyms.

Participants

Four adolescents (all aged 14 years) with mild intellectual disability (MID) and clinically significant anxiety symptoms participated in the study. Each participant was accompanied by a

designated supporter (parent, teacher, or peer) who assisted with session reinforcement and between-session practice. Inclusion criteria were diagnosis of mild intellectual disability, presence of clinically significant anxiety symptoms, and ability to engage in structured therapeutic sessions with support. Diagnostic status for mild intellectual disability was confirmed through review of prior psychological reports, which included standardized cognitive testing and assessment of adaptive functioning consistent with DSM-5 criteria. Full-scale IQ scores ranged from 66 to 74 (Binet Intelligence Test; Roid, 2003). Although one participant obtained a score within the borderline range (IQ = 74), adaptive functioning impairments documented in prior assessments supported classification within the mild intellectual disability range. Non-verbal reasoning was additionally assessed using the Standard Progressive Matrices (SPM; Raven et al., 2000) to supplement cognitive profiling. All participants presented primarily with anxiety related to social evaluation and peer interaction, including avoidance of social engagement, anticipatory worry, and negative self-beliefs. Anxiety symptoms were associated with functional difficulties in academic participation and social communication. Each participant was accompanied by a designated supporter (parent, teacher, or peer) who assisted with between-session practice and skill generalization.

Table 1. Demographic Data

Participants	Gender	Binet IQ Score	Category	SPM Test Score	Supporter and relationship
Asa	Male	74	Borderline	Grade V	Wedari (Mother)
Senja	Female	68	Borderline	Grade V	Sri (Teacher)
Rania	Female	66	Borderline	Grade V	Sonia (Friend)
Hanif	Male	67	Borderline	Grade V	Purbani (Teacher)

Note. All participants were identified as having mild intellectual disability and anxiety; SPM = Standard Progressive Matrices.

Measures

Anxiety Symptoms

Anxiety was measured using the Glasgow Anxiety Scale for People with an Intellectual Disability (GAS-ID; Mindham & Espie, 2003). The GAS-ID is a 27-item self-report instrument specifically developed for individuals with mild intellectual disability. Items are rated on a three-point scale (never, sometimes, always), with total scores ranging from 0 to 54. A cut-off score ≥ 13 indicates probable clinical anxiety. In the present study, the Indonesian version was developed using forward–back translation procedures and reviewed by bilingual clinical psychologists to ensure semantic and conceptual equivalence (Muñiz et al., 2013). Items were administered verbally when necessary to support comprehension.

Reliable Change Index (RCI)

Given the small sample size and absence of a control group, clinical significance was evaluated using the Reliable Change Index (RCI; Jacobson & Truax, 1991). The RCI was calculated using established reliability coefficients from prior validation studies of the GAS-ID. Change scores exceeding ±1.96 were interpreted as statistically reliable improvement or deterioration beyond measurement error.

Mini Formulations Baseline

At baseline, each participant completed a simplified cognitive-behavioral "mini-formulation." According to Charlesworth and Reichelt (2004), such focused formulations are particularly valuable in the early stages of therapy, when establishing engagement, shared understanding, and collaboration is essential. This formulation focused on two to three interacting components (e.g., thoughts–feelings–behaviors) to enhance accessibility and reduce cognitive load. The formulation guided individualized treatment targets and session planning.

Intervention

Theoretical Framework

The intervention was grounded in cognitive–behavioral theory, which conceptualizes anxiety as arising from reciprocal interactions among cognitions, emotions, physiological responses, and behaviors. Treatment was informed primarily by Stallard's (2005) manualized cognitive CBT program developed for individuals with learning disabilities and common mental health difficulties. Given the cognitive and developmental characteristics associated with MID, the protocol was adapted to enhance accessibility while maintaining core CBT components.

Adaptations for Mild Intellectual Disability

Adaptations were implemented to accommodate reduced abstract reasoning, limited metacognitive capacity, and variable attention and memory skills. Language was simplified and delivered using concrete examples relevant to participants' daily experiences. Visual aids and pictorial materials were incorporated to support comprehension and retention. Core concepts were repeated across sessions to reinforce learning. Behavioral rehearsal and role-play were emphasized to promote experiential learning, and structured activities were kept brief to maintain engagement. A designated supporter (parent, teacher, or peer) was involved to facilitate practice and generalization of coping strategies between sessions.

Structure and Content

The intervention consisted of seven individual sessions delivered weekly, each lasting approximately 60 minutes. The first session focused on psychoeducation, introducing the relationship among thoughts, feelings, and behaviors. The second session explored anxiety triggers and associated physiological responses, alongside initial coping strategies. Sessions three through five emphasized cognitive and behavioral skill development, including identification of negative thoughts, generation of alternative interpretations, behavioral rehearsal, and relaxation strategies. The sixth session targeted social interaction skills through perspective-taking exercises and structured behavioral practice. The final session focused on consolidation of learning, relapse prevention, and planning for generalization of coping strategies across settings. Supporters received brief guidance at the end of each session regarding strategies practiced and methods for reinforcing these skills in daily contexts.

Therapist Qualifications and Treatment Fidelity

The intervention was delivered by a clinical psychologist with master's degree clinical psychology and over eight years of experience in delivering psychological interventions especially cognitive behavior therapy. To promote consistency, sessions followed a structured outline aligned with the adapted protocol. Treatment fidelity was monitored using session checklists documenting completion of core components. Periodic supervision was conducted to ensure adherence to CBT principles and appropriate adaptation to participants' cognitive profiles.

Procedure

The study was conducted in three sequential phases. During the T1, cognitive assessment records were reviewed to confirm diagnostic status, and the GAS-ID was administered. A simplified cognitive–behavioral mini-formulation was collaboratively developed to guide individualized treatment targets. The intervention phase comprised seven weekly CBT sessions delivered individually. Supporters participated in selected portions of sessions and were instructed on strategies to reinforce therapeutic skills between meetings. Immediately following the T2, anxiety was reassessed using the GAS-ID. A T3 was conducted four weeks post-

treatment to examine maintenance of change. Therapy worksheets and structured supporter feedback were collected to contextualize observed outcomes.

Data Analysis

Quantitative analysis focused on individual-level change across assessment points. The RCI was calculated to determine whether changes in GAS-ID scores exceeded measurement error, with values less than −1.96 interpreted as reliable improvement. Qualitative materials, including therapy worksheets and supporter feedback, were analyzed descriptively to identify changes in emotional awareness, cognitive restructuring, coping behaviors, and social engagement. Qualitative findings were used to complement and contextualize quantitative results rather than to establish causal inference.

RESULTS

Treatment Completion and Adherence

All four participants completed the seven-session intervention and attended all assessment time points (T1–T3). No adverse events or premature withdrawals were reported. Supporters participated consistently in reinforcement activities across sessions.

Quantitative Outcomes

Table 4 presents individual GAS-ID scores across assessment points and Reliable Change Index (RCI) values for pre–post change. At T1, all participants scored above the clinical cut-off (≥13), indicating probable clinical anxiety. From T1 to T2, all four participants demonstrated reductions exceeding the RCI threshold for reliable improvement (RCI < −1.96). Post-intervention scores for Asa fell below the clinical cut-off, while Senja, Rania, and Hanif showed substantial symptom reduction but remained above the cut-off. At T3, anxiety scores further decreased for all participants. All four participants scored below the clinical cut-off at follow-up, indicating maintenance and additional reduction of anxiety symptoms. No participant demonstrated reliable deterioration at any time point.

Table 2. Participants' GAS-ID anxiety scores across time

Participant	T1	T2	T3	RCI (T1–T2)
Asa	26	12	10	−3.52
Senja	30	20	12	−2.51
Rania	27	18	9	−2.26
Hanif	28	19	10	−2.26

Note. RCI values less than −1.96 indicate reliable improvement.

Qualitative Findings: Participant Perspectives

Theme 1: Anxiety Experiences Prior to Intervention

Prior to intervention, participants described anxiety as pervasive and closely tied to social situations. Their accounts reflected anticipatory worry, heightened physiological arousal, and behavioral avoidance. Anxiety was experienced not only as an emotional state but as a physical and behavioral response that disrupted daily functioning. These descriptions were consistent with elevated baseline GAS-ID scores and illustrate the embodied and socially situated nature of their anxiety.

Asa described,
"When I meet other people, I feel anxious and want to urinate." (P, 3)

Hanif reported,
"My heart pounded, and my hands sweated as my friend called out to me. I avoided the crowds and chose a quieter path." (P, 5)

Senja and Rania both noted recurrent headaches:
"I get headaches. Bad headaches sometimes." (P, 12)

Participants also described coping strategies used prior to intervention. These strategies were often solitary or avoidance-based and did not consistently address the underlying anxiety. Some strategies provided temporary relief but did not appear to reduce social fears or negative self-beliefs.

Hanif stated,
"Cycling makes the feeling of anxiety that I feel lessen." (P, 26)

Asa reported,
"When I feel frustrated, I prefer to paint on the walls." (P, 32)

Senja and Rania acknowledged using medication without medical consultation:
"When I have a headache, I often take medicine without a doctor's prescription." (P, 17)

Theme 2: Positive Engagement with Therapy

Participants consistently described the sessions as structured, interactive, and meaningful. Engagement appeared to be supported by concrete activities, repetition, and role-play exercises. Rather than describing therapy as abstract or confusing, participants reported feeling motivated and emotionally supported during sessions. This positive engagement may have contributed to sustained participation and skill acquisition across sessions.

Senja stated,
"I always enjoy the activities provided during the sessions. I can't wait for the next session. I'm happier." (P, 33)

Asa reflected on the impact of role-play exercises:
"I enjoy role-playing and meeting new people. I become a different person than I was before." (P, 41)

Theme 3: Changes in Social Interaction and Confidence

Participants described increased willingness to approach social situations that had previously been avoided. These changes included initiating conversations, expressing opinions in class, and participating in shared activities. Such behaviors represent behavioral activation and reduced avoidance, which are central targets of CBT for anxiety. The narratives suggest gradual shifts in perceived social threat and self-efficacy.

Hanif reported,
"I asked the teacher about the material that I didn't understand." (P, 35)

Senja described sharing food with classmates:
"I feel happy when I bring food to my friends. They respond very happily and accept

me." (P, 56)

Rania stated,
"When I invited my classmates to the canteen, they accepted my invitation, and this made me happy." (P, 45)

Asa recounted a positive social interaction in an elevator:
"While I was in the elevator, I met someone new, and we greeted each other. It was really fun meeting and getting to know new people." (P, 67)

Theme 4: Impact of Specific CBT Activities

Participants frequently identified particular exercises as helpful in managing anxiety. Activities involving emotional labeling, visual tools, and behavioral practice were recalled as concrete and understandable. These exercises appeared to enhance emotional awareness and promote cognitive reappraisal in developmentally accessible ways.

Asa described an activity involving body mapping of anxiety symptoms:
"I like it when I'm given a picture of the human body, and I write down which part of the body the symptoms are felt on." (P, 10)

Senja and Rania commented on an exercise using contrasting emotional expressions:
"I didn't expect that when I smile, my face looks more attractive." (P, 90)

Hanif reflected on classroom participation:
"It turns out that my teachers and friends appreciate my courage." (P, 87)

Supporter Perspectives

Theme 1: Pre-Therapy Difficulties

Supporters described participants as socially withdrawn, hesitant to speak in class, and highly sensitive to evaluation prior to intervention. Their observations aligned closely with participants' self-reports of avoidance and fear of negative judgment. Supporters noted that anxiety often interfered with classroom participation and peer interaction.

Purbani noted regarding Hanif:
"Hanif was very quiet in class. When asked questions, he always looked down and was afraid to answer." (S, 7)

Sonia described Rania's withdrawal:
"Rania always sits alone, and when she is anxious, she hurts herself." (S, 4)

Sri reported:
"Senja always sits alone in class, sometimes following the teacher wherever he goes." (S, 6)

Theme 2: Observable Changes During Intervention

Supporters reported gradual increases in social participation and assertiveness. Behavioral changes were described as noticeable but developing over time. Supporters also

highlighted the practicality of session materials and homework tasks in supporting skill generalization.

Purbani stated:

"Earlier in class, Hanif dared to raise his hand and express his opinion. This was a remarkable change." (S, 12)

Wedari described Asa's practice at home:

"Asa practiced in front of the mirror. She changed her gloomy expression into a smile." (S, 15)

Theme 3: Hopes for Maintenance

Supporters expressed optimism regarding continued improvement while acknowledging the need for sustained reinforcement. Their comments reflected both recognition of progress and concern about long-term maintenance. Continued social initiative and emotional regulation were identified as key goals.

Sri stated,

"I hope Senja will be a person who has the initiative to make friends." (S, 25)

Sonia commented,

"I hope Rania won't hurt herself again when she's anxious." (S, 17)

Convergence of Findings

Reductions in GAS-ID scores were consistent with participant and supporter reports of improved emotional awareness, reduced avoidance, and increased social engagement. While causal inference cannot be established in the absence of a control condition, the convergence of quantitative and qualitative data provides complementary evidence of meaningful within-case change during the intervention period.

DISCUSSION

The present multiple-case series examined anxiety trajectories following an adapted Cognitive Behavioral Therapy (CBT) intervention for adolescents with mild intellectual disability (MID). Across all four participants, reliable reductions in anxiety were observed from pre-intervention to post-intervention, with further improvement and maintenance at 4-week follow-up. Convergence between GAS-ID scores, participant narratives, and supporter observations suggests meaningful within-case change during the intervention period. However, given the uncontrolled design, findings should be interpreted as preliminary rather than confirmatory evidence of treatment efficacy.

All participants demonstrated Reliable Change Index (RCI) values exceeding the threshold for statistically meaningful improvement. By follow-up, all participants scored below the clinical cut-off for probable anxiety. These findings are consistent with emerging literature indicating that CBT can be beneficial for individuals with intellectual disability when appropriately adapted (Hassiotis et al., 2011; Vereenooghe & Langdon, 2013). They also align with NICE (2016) guidance recommending CBT for anxiety in individuals with mild learning disabilities, while emphasizing the need for further empirical evaluation.

Importantly, the observed reductions occurred in a population characterized by cognitive limitations in abstract reasoning and metacognitive reflection (Hronis et al., 2017). Standard CBT protocols rely heavily on these capacities (Beck, 2011), which may partially explain the historical underrepresentation of individuals with ID in anxiety treatment trials. The present

findings suggest that structured adaptation may mitigate these barriers.

Qualitative accounts indicated increased social initiation and classroom participation following intervention. Participants described asking questions, initiating conversations, and joining peer activities, behaviors previously avoided. Within CBT models of anxiety, avoidance maintains fear through negative reinforcement and prevention of corrective learning (Beck, 2011). The behavioral shifts reported here are consistent with exposure-based processes and behavioral experimentation, central mechanisms in CBT for social anxiety.

These behavioral changes are particularly relevant for individuals with MID, for whom repeated social failure or rejection may contribute to heightened vulnerability to anxiety (Dagnan & Chadwick, 2006). The data suggest that structured behavioral rehearsal may support disconfirmation of maladaptive beliefs regarding rejection and inadequacy.

Participants demonstrated increased ability to identify physiological symptoms and distinguish thoughts from feelings. Exercises such as body mapping and visual emotion identification appear to have supported emotional literacy. Emotional awareness is foundational to CBT and may be especially important in MID populations, where difficulties in emotion labeling can impede cognitive restructuring. Participants' statements reflecting alternative interpretations of social situations suggest emerging cognitive reappraisal. For example, recognizing that peers or teachers responded positively may represent shifts in negative automatic thoughts. According to Beck's cognitive model (2011), modification of maladaptive appraisals reduces emotional distress and avoidance behavior. Although cognitive change was not directly measured, qualitative data are consistent with this theoretical pathway.

A central contribution of this study lies in its emphasis on developmentally appropriate adaptation. Consistent with prior research (Hronis et al., 2017; Hassiotis et al., 2011), modifications included simplified language, repetition, visual supports, and experiential learning. Participants explicitly identified these elements as helpful. Such adaptations likely reduced cognitive load and supported comprehension of abstract CBT constructs. Given that individuals with MID often retain functional verbal communication but experience difficulty with abstraction and complex reasoning, tailoring intervention delivery may be critical for therapeutic engagement. The present findings support the argument that accessibility, not theoretical limitation, is a key determinant of CBT applicability in this population.

Supporter observations corroborated participant-reported changes, including increased classroom participation and social initiative. Involving supporters may facilitate generalization of skills beyond the therapy context and provide ongoing reinforcement. This is particularly important given that anxiety in individuals with MID often manifests across social and educational settings (Emerson & Hatton, 2007). The triangulation of self-report and supporter data strengthens confidence in observed behavioral changes.

Implications, Limitations, and Future Directions

Within the Indonesian context, empirical evaluation of CBT for individuals with intellectual disability remains limited. The present study contributes preliminary evidence supporting the feasibility of structured psychological intervention in school-based settings. While cultural generalization cannot be assumed, findings align with international literature suggesting that CBT principles retain relevance when appropriately adapted.

Several limitations warrant consideration. The small sample size and absence of a control condition preclude causal inference and limit generalizability. Improvements may reflect nonspecific therapeutic factors or maturation effects. Anxiety classification relied on symptom severity rather than structured diagnostic interview. Outcomes were based primarily on self-report and supporter report without blinded assessment. Follow-up was limited to four weeks, preventing conclusions regarding long-term maintenance. Finally, treatment fidelity was monitored through session checklists rather than independent adherence ratings. These

limitations underscore the need for randomized controlled trials with larger samples, longer follow-up, and formal diagnostic procedures.

Future research should examine adapted CBT using controlled designs and multi-informant assessment and explore mediating mechanisms such as cognitive reappraisal and reduction in avoidance behavior. Investigation of culturally responsive adaptation within diverse educational contexts would further strengthen the evidence base.

CONCLUSION

This multiple-case series provides preliminary evidence that developmentally adapted CBT may be associated with reliable reductions in anxiety among adolescents with mild intellectual disability. Convergent quantitative and qualitative findings suggest improvements in emotional awareness, cognitive appraisal, and social engagement. While replication under more rigorous conditions is required, the findings contribute to the growing literature supporting accessible psychological interventions for individuals with intellectual disability.

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AUTHOR CONTRIBUTION STATEMENT

The authors contributed equally to the completion of this research.

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