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Review

A Scoping Literature Review on Compassion-Focused Therapy for Individuals with Intellectual Disability

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Abstract

Individuals with intellectual disabilities (ID) are at a higher risk of shame and self-criticism and tend to make downward social comparisons. Compassion-focused therapy (CFT) is commonly used to address these issues in the general population, however, information on the adaptability and effectiveness of CFT for individuals with ID is limited. Thus, we conducted a scoping review of studies on CFT for individuals with ID, to accumulate and consolidate the information and provide a basis for future studies to further develop, alter, and implement CFT for individuals with ID. To conduct this review, we searched eight databases and included descriptive studies, reviews, and empirical peer-reviewed English and Dutch studies. We focused on ID and also included concurrent visual and intellectual disabilities, compassion-focused therapy, compassion, shame, self-criticism, and social comparison. Seven articles were included in the review. We found that CFT can be adapted for individuals with ID and can effectively reduce self-criticism and downwards social comparison. Thus, CFT can promote

the well-being of individuals with ID. However, the methodologies of these studies had several limitations, for example, the lack of standardized instruments or protocols for individual or group therapy. While CFT is adaptable and clinically relevant for individuals with ID, its limitations need to be addressed in future studies. In this review, we highlighted and elaborated on the limitations of the research conducted and provided suggestions for the next steps in the field. We provided an overview of the current studies on CFT and ID and highlighted their positive therapeutic effects. Future studies should design robust protocols through collaborations between clinicians and researchers to provide clients with appropriate support and determine the clinical and statistical significance of CFT.

Keywords
Compassion-focused therapy; intellectual disability; compassion; well-being; scoping review; treatment

1. Introduction

1.1 Intellectual Disabilities

Growing up and living with an intellectual disability (ID) has significant socioemotional challenges for individuals and their families. About 1% of individuals worldwide suffer from ID [1]. From a young age, individuals with ID are at a high risk of developing psychopathology, possibly due to stigmatization and prejudices [2], and high chances of encountering traumatic or adverse life events [3]. Together, these aspects make individuals with ID highly vulnerable, which not only is a burden to the individual but also holds significant societal implications [4]. Particularly, social and healthcare policies promote programs for integrating and including individuals with ID in the workforce [5], education system [6], and community [7]. Although these programs often rely on the ability of individuals with ID to acquire skills and strategies for adapting to the environment and, in turn, the ability of the environment to cater to the needs of these individuals, greater attention must be paid to the emotional profile and experiences of individuals with ID [8].

The integration of individuals with ID might be hindered by their self-perception (e.g., self-concept) [9]. Shame, for instance, is a commonly reported experience, which is characterized by feeling inferior, worthless, devalued, or undesirable [10, 11]. However, studies on the reports of the first-person experiences of shame in individuals with ID are limited [12]. Shame is a limiting factor for self-to-other relations and increases downward social comparisons. A compassionate approach might help to reduce negative thoughts and feelings. While traditional therapeutic approaches, such as cognitive behavioral therapy [13], promote new ways of thinking about oneself, the thoughts often remain at a rational level, while the individuals might still deeply feel shame and anger [14]. Thus, different therapeutic approaches need to be considered depending on the individual being treated.

1.2 Compassion-Focused Therapy

Compassion-focused therapy (CFT) is based on social psychology and attachment theory and is a therapeutic approach that helps individuals develop compassion toward themselves [15, 16]. Gilbert [15] postulated that CFT is a multimodal approach that integrates empathy, sensitivity, non-judgmental views, sympathy, care for tolerance, and well-being, among others. CFT aims to train the reasoning, sensations, attention, and behaviors of individuals and create feelings of warmth. The attachment system plays a fundamental role in developing these skills of compassion [17]. Complex and life-long schemas of acceptance and soothing practices are established within the earliest experiences of an individual with ID and their primary attachment figure [18]. Soothing behaviors affect stress biology and influence the regulation and production of hormones, such as the stress hormone cortisol (e.g., de-stressing may lead to a decrease in cortisol release) and the so-called love hormone oxytocin (e.g., physical affective touch can lead to increased oxytocin release) [19], which in turn affect physical and psychological well-being. From an early age, sensitive care promotes the physiological balance between several biological systems leading to optimal behaviors of self-care or other-care [20]. Thus, signals received from others can activate the attachment system and facilitate different care behaviors in an individual, based on what they have learned from the earliest relationships [21]. A threatening signal, for example, a shameful experience, can trigger a cascade of negative thoughts, behaviors, and distress. However, the same experience can also be interpreted positively, for example, by eliciting soothing thoughts and being compassionate toward oneself [22]. This is the goal of CFT interventions.

Correlational evidence has shown that CFT can improve self-compassion and self-esteem in clients without ID [23-25]. Moreover, in CFT, the well-being of individuals with chronic psychological problems can be promoted by teaching them to soothe themselves with kindness and to view themselves in a non-judgmental manner [26]. CFT is a third-generation therapeutic strategy [27] and can be adapted to the needs of the individual. In the past, efforts were made to also adapt CFT for individuals with ID [28]. Compassionate approaches were applied by practitioners in clinical settings; however, CFT for ID (henceforth CFT-ID) was empirically investigated only recently. Cooper and Frearson [29] pioneered the field by publishing a case study on CFT-ID, which besides highlighting the usefulness of the intervention and providing an example of how CFT can be adapted for individuals with ID, also elucidated numerous issues to be addressed in future studies, such as the lack of standardized outcome measures. Further adaptations were made for group CFT-ID [12, 30], showing the clinical relevance, feasibility, and acceptance of the therapeutic intervention. While these studies provide strong clinical evidence for the feasibility of CFT-ID, statistical evidence on the effectiveness of CFT-ID is lacking. Only in one study, a group without ID was compared to individuals with ID after implementing CFT-ID, and their ability to generate and use a compassionate image after a single therapy session was assessed; the results showed that there were no differences between the groups [31]. The abovementioned studies have different conclusions regarding the adaptations and use of CFT-ID, which makes it difficult to extrapolate and formulate evidence-based guidelines.

1.3 The Current Study

To advance our understanding of CFT for individuals with ID, in this study, we collected information on the current state of CFT by performing a qualitative scoping review. We identified

the adaptations, effects, and social validity of CFT-ID. We also discussed the limitations and suggested some strategies to address certain issues in this field. Scoping reviews of research fields summarize the scope of studies to identify problems and future directions [32]. Accordingly, we provided a substantive overview of the recurrent themes in the literature and formulated a working framework for future studies by addressing the following questions: 1) How was CFT adapted for individuals with ID? 2) What were the effects on behavioral and cognitive outcomes in individuals with ID? 3) How suitable was CFT deemed by individuals with ID?

2. Materials and Methods

2.1 Design

A structured approach proposed by Kable and Pich [33] was used to document the search strategy for this scoping review on CFT for individuals with ID. Additionally, the Preferred Reporting Items for Systemic reviews and Meta-Analyses extension for Scoping Reviews Checklist (PRISMA-ScR) was used for high-quality reporting [34].

This review did not involve the participation of humans, animals, plants, or subjects, and thus, no ethical approval was required.

2.2 Inclusion and Exclusion Criteria

Three steps were used to screen the published studies and identify relevant papers: 1) title screening, 2) abstract screening, and 3) full-text review. The inclusion and exclusion criteria are presented in Table 1.

Table 1 The inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
- Clients with an intellectual disability or visual-and-intellectual disability - Compassion Focused Therapy (CFT) Intervention - Descriptive-, review-and experimental studies - English & Dutch peer-reviewed articles - No time limit for published articles*	- No clients with an intellectual disability or visual-and-intellectual disability - Intervention not based on Compassion Focused Therapy (e.g., Mindfulness) - Papers about compassion, shame, self-criticism or social comparison that do not describe an intervention - Non-peer reviewed articles, conference abstracts, and papers

Notes. *The literature search was conducted until May 10th, 2021.

2.3 Search Strategy

Several databases were searched till May 10th, 2021, including CINAHL, APA PsychInfo, APA PsychArticle, ERIC via EBSCO host, PubMed, Web of Science, Cochrane, and Embase. The search terms included “intellectual disabilities”, “learning disabilities”, “compassion-focused therapy”, and their variations combined with Boolean search operators AND and OR. The complete list of the

search strategy, including the number of papers found in each database, is provided in Appendix 1. Based on this search, 141 papers were found. After removing 39 duplicate papers, 102 papers were identified for step 1, i.e., title screening. Through this screening process, 55 papers were excluded. In step 2, the remaining 47 papers were screened by abstract; another 35 papers were excluded, and 12 papers remained. In step 3, the 12 full-text papers were thoroughly read and assessed; six papers were excluded, and six remained. Finally, one Dutch pilot study was added to the final selection, which did not appear in the database search. This paper was jointly written by the third and the final authors of this review and matched the inclusion criteria. Finally, seven papers were selected for the analysis (for an illustration of this process, see the flowchart in Figure 1).

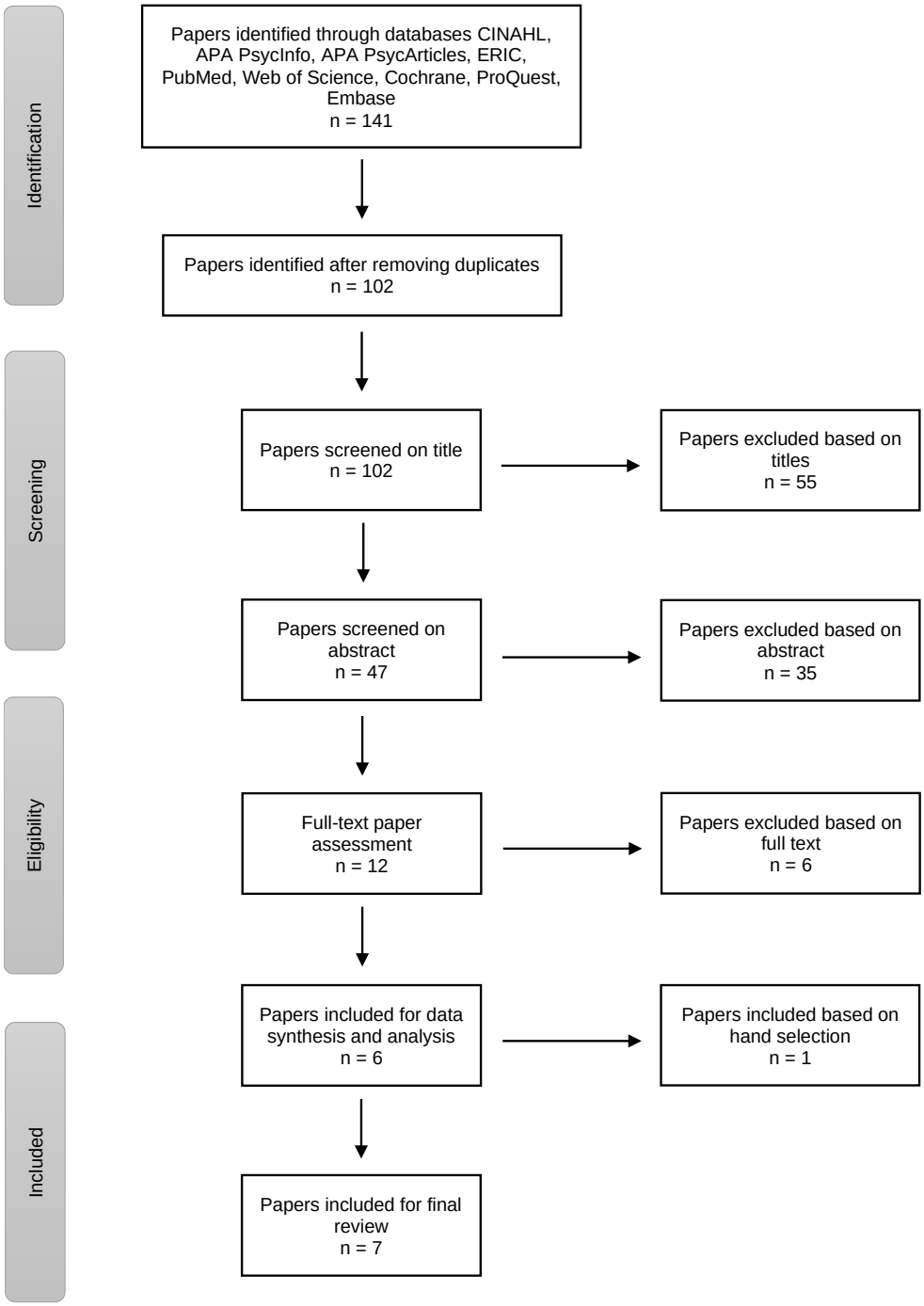

Figure 1 The flowchart of the identification and the selection processes.

2.4 Characteristics of the Studies

A summary of the studies included in this scoping review is provided in Table 2. The reference numbers in the running text are denoted as superscripts and correspond to papers in Table 2. Of the seven studies included, one was conducted in the Netherlands[7,] and the remaining six were conducted in the UK[1–6]. Two studies described group CFT interventions[2, 5], four described individual interventions[1, 3, 6, 7], and one was a conceptual review with case studies[4]. The duration of the therapy ranged from one session[1] to 12–15 weeks of therapy[6]. The target population included individuals with mild to moderate ID in all the studies, except for one study, which included individuals with ID and concurrent visual impairments[7]. Only one study compared two groups of samples, one with ID and one without ID[1]. Sample sizes ranged from one client[3] to 39 clients[1], with ages ranging from 16 to 65 years. The primary outcome measures included self-compassion, self-criticism, self-esteem, coping strategies, and self-soothing. The secondary outcome measures included psychological problems and well-being. Four studies[2, 5–7] used either the Self-Compassion Scale [35] or the Self-Compassion Scale-Short Form [36]. All studies, except one, used a mixed approach, including quantitative and qualitative data[1–3, 5–7]. Five studies reported pre-intervention and post-intervention effects[2, 3, 5–7], and two of these also reported follow-up measurements at one or three months post-intervention[6, 7].

Table 2 Summary of the studies included.

Reference	Country	Type of article	Target population	N	IQ	Age	Sessions (Duration in min)	Outcome	Scales used
1. Brougham et al., 2020 [31]	Scotland (UK)	CFT intervention; comparison of non-ID and ID group	ID	39 (19 ID)	WASI-II: 59 (4.70)	16–65	1	generate and use a compassionate image	GAS-ID | anxiety LSI | coping strategies CIT | compassion WASI-II | IQ CFT-ID Session Feasibility & Acceptability Measure SCS-SF | self-compassion & self-criticism SCS-ID | social comparison PTOS-ID | psychological distress & wellbeing Interview | CFT experiences
2. Clapton et al., 2018 [12]	Wales (UK)	Group CFT intervention; longitudinal (pre-, 2 to 4-weeks post intervention)	ID	3; 3	51–69	38.5 (15.6)	6 (90 min)	self-compassion, psychological wellbeing, social comparison	
3. Cooper & Frearson, 2017 [29]	Bath (UK)	Case study; longitudinal (pre-, 1-week post intervention)	ID	1	Mode rate	Mid 40s	13	mood and self-compassion	CORE-LD | mood FSCRS | self-criticism, self-reassurance Mood monitoring thermometer

4. Cowles et al., 2020 [28]	Bath (UK)	Conceptual review; CFT intervention (no information on methods)	ID	3	Mild-mode rate	40s, 50s, 70s	na	staff-reports of general positive mood, trauma flashbacks, aggression	-
5. Goad & Parker, 2021 [30]	UK	Group CFT intervention; longitudinal (pre-, 2 to 4-weeks post intervention)	ID	3; 3	Mild	25–40; 19–32	10	social comparison, mood and self-compassion	CORE-LD | mood SCS-ID | social comparisons SCS-SF | self-compassion & self-criticism Mini PAS-ADD | mental health
6. Hardiman et al., 2018 [37]	UK	CFT intervention; longitudinal (pre-, within 2-weeks post intervention, 3-month follow-up)	ID	3	Mild-mode rate	31–48	12–15 weeks	self-compassion and anxiety	SCS | self-compassion & self-criticism GAS-ID | anxiety Interview | compassion, anxiety, therapeutic relationship
7. Zoutenbier et al., 2020 [38]	NL	CFT intervention; longitudinal (4-weeks pre-, start-, post-intervention, 4-week follow-up)	ID	4	Mild-mode rate	23–30	10	self-criticism and shame	YCORS | wellbeing SCS | self-compassion & self-criticism SERS-SF | self-esteem UCL | coping Interview | CFT experiences

Notes. CFT = Compassion Focused Therapy; ID = intellectual disability; WASI-II = Weschler Abbreviated Scale of Intelligence Second Edition; GAS-ID = Glasgow Anxiety Scale for people with Intellectual disability; LSI = Lifestress Inventory; CIT = Compassionate Image Task; SCS/SCS-SF = Self-Compassion Scale-Short Form; SCS-ID = The adapted Social Comparison Scale-Intellectual Disability; PTOS-ID = Psychological Therapy Outcome for people with intellectual disability; CORE-LD = Clinical Outcomes in Routine Evaluation-Outcome Measure, Learning Disability version; FSCRS = Forms of Self-criticizing/attacking and Self-reassuring Scale; Mini PAS-ADD = Mini Psychiatric Assessment Schedule for Adults with Developmental Disabilities; YCORS = Young Child Outcome Rating Scale; SERS-SF = Self-Esteem Rating Scale-Short Form; UCL = Utrechtse Coping Lijst ; na = not applicable.

2.5 Coding Procedure

The third author and another researcher read all the selected papers until they had a good overview of the topics mentioned in the papers. Then, they made notes indicating the themes of the papers. The themes and sub-themes were extracted independently and discussed. The last author went through all the papers, after which, the themes and sub-themes were discussed until a consensus was reached. The first author then imported all the papers to Atlas.ti, version 22.1.4.0 [37], and coded all the relevant quotes to the three core themes that were investigated in this study, which included "adaptations", "effects", and "social validity of CFT". A list of topics was obtained belonging to each of the three themes, which were further categorized into additional sub-themes, forming a hierarchical coding frame. The first, second, and final authors discussed and reached a consensus on the final coding frame. Thus, the core themes and the sub-themes were obtained using an inductive approach during the coding process, based on the quotes coded. The Atlas.ti-coding frame, including all the codes of the quotes, is provided in Appendix 2.

3. Results

The sub-themes identified from the reviewed papers were structured under the three core themes of 1) adaptations made to CFT, 2) effects on clients, and 3) social validity of CFT (Table 3). The reference numbers in Table 3 correspond to the numbered papers in Table 2.

Table 3 The identified themes and sub-themes of CFT-ID.

A. Adaptations made to CFT	*A1. Language & understanding* • [a1.1] concrete and simple language. [1, 2, 3(D), 4, 6, D7] • [a1.2] inclusion of a supporting workbook. [2(D)] • [a1.3] verbal summaries. [3] • [a1.4] review materials between sessions. [2, D3, 4, 5, 6, 7] *A2. Modality* • [a2.1] use of visual materials. [2(D), 3(D), 4, 5, 6] • [a2.2] use of visualisations. [1, 2, 3, 4, 6, 7] • [a2.3] use of sensory materials (touch) and auditory materials (sounds, music). [4, 7] *A3. Guidance* • [a3.1] scaffolding and prompting. [1] • [a3.2] caregiver involvement. [4] • [a3.3] reassuring clients there are no right or wrong answers. [1, D3] *A4. Implementation* • [a4.1] increasing experiential and practical exercises. [(D)3, 4, 5] • [a4.2] more breaks during the sessions. [5] • [a4.3] reduced speed and content of sessions. [1, 3, D5] • [a4.4] techniques, materials and activities adapted for the client. [4, D7]

B. Effects on clients

B1. Primary outcome measures

- [b1.1] self-compassion. 1(D), 2(D), D3, D4, 5(D), 6(D), 7(D)
  - [b1.1.1] common humanity. 2, 6
  - [b1.1.2] social comparison. 2, 5(D)
  - [b1.1.3] coping strategies.
    - [b1.1.3.1] self-soothing images and thoughts. 1, 6, 7
    - [b1.1.3.2] searching for support. 1(D), D7
  - [b1.1.4] Flow of compassion
    - [b1.1.4.1] showing compassion to others. D2, 5, 6
    - [b1.1.4.2] receiving compassion from others. D2, 6
- [b1.2] self-criticism. 2, 3, 6(D), D7
- [b1.3] self-esteem. 7(D)
- [b1.4] psychological problems. 2, D3, 4, 6(D)
- [b1.5] wellbeing. 2, 3, 4, 5(D), 7(D)
- [b1.6] problematic behavior. 3, 4

B2. Secondary outcome measures

- [b2.1] fear, blocks and resistance to compassion. 2(D), D4
- [b2.2] managing emotions. 5
- [b2.3] developing confidence. 4, 5
- [b2.4] developing connections. 5(D)
- [b2.5] understanding change. 6

C. Social validity of CFT

C1. Understanding CFT

- [c1.1] understanding CFT exercises. 1, 2(D), 3, 4, 5(D), 6, 7(D)
- [c1.2] understanding CFT concepts. D1, 2(D), 3, 4(D), D5, D6, 7
- [c1.3] retaining/remembering concepts discussed. 3(D), 4, 5, 6

C2. Clients' experiences

- [c2.1] (qualitative) feedback clients. 3, 5(D), 6(D), 7(D)
- [c2.2] experiencing CFT as enjoyable and helpful. 2(D), 3, 5, 6, 7(D)

C3. Suitability CFT for individuals with ID

- [c3.1] behavioural and skills based. D2, 4, 5, D6
- [c3.2] more prompts for ID. 1
- [c3.3] contingent upon regular practice. 4
- [c3.4] importance of carers and staff members. D3, 4, D5, D7

Notes. D in the references stands for discussion, e.g., D1 = mentioned in discussion of paper 1; 1(D) = mentioned in results and discussion of paper 1. Reference numbers refer to Table 2.

3.1 Adaptations Made to CFT

3.1.1 Language and Understanding

The use of concrete and simplified language was the most prominent aspect of the adaptations of CFT for ID. The treatment included concrete psychoeducational materials and exercises[2, 7], based on which the depth and complexity of the concepts of CFT were reduced[1, 3, 4, 6]. To enhance understanding and memory, the clients were suggested to review materials in-between sessions[2–7]

and use a supportive workbook[2]. Additionally, the clients were often asked to summarize and repeat the materials[3].

3.1.2 Modality

The adaptations of CFT included the use of visual materials for psychoeducation, such as colorful diagrams, visual prompts, and images, to facilitate the understanding of verbal material[2–6]. Likewise, most studies incorporated imagination, where the clients were asked to visualize either a compassionate image or a safe place[1–4, 6, 7], sometimes also stimulating other senses like hearing, touch, and smell (for example by imagining the sense of objects, fabrics, and listening to sounds and music)[4, 7].

3.1.3 Guidance

The adaptations regarding guidance during therapy included scaffolding and prompting during the compassionate image exercise with reassurance that there was no right or wrong answer[1]. Another important aspect that was highlighted in some studies was the involvement of caregivers or the lack thereof. In one study, caregivers were invited to engage more when the clients needed to practice exercises in-between sessions[4].

3.1.4 Implementation

Compassion-focused therapy increases experiential and practical exercises instead of relying solely on verbal explanations[3–5]. One technique involves the simple but effective practice of smiling in the mirror[4]. In a study, clients were asked to smile at their reflection for about 30 s, either alone or with a caregiver, to enhance positive feelings. The clients reported feeling happier during and after the exercise. Other adaptations regarding the implementation of CFT involved more breaks during sessions[5] and a reduction in the speed and content of the sessions[1, 3]. This entailed slowing the pace and asking the client only one question at a time to provide them with adequate processing time. Additionally, the implementation of CFT was changed based on the requirements of the client[4], and materials and activities that suited the interests and personal environment of the clients were selected. For example, choosing the senses to focus on during the compassionate image task depended on the interests of the client[7]. These sub-themes are illustrated in Figure 2.

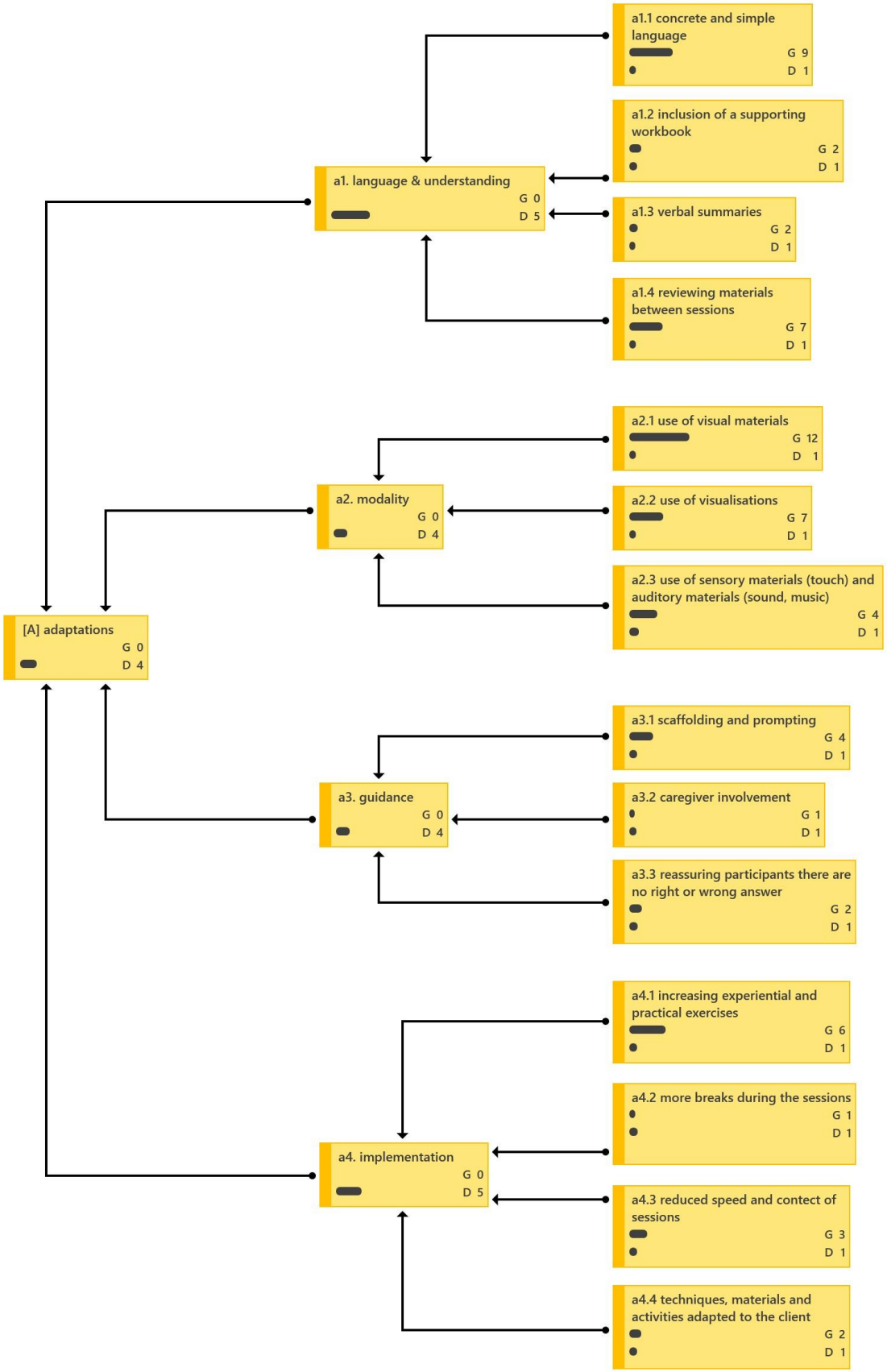

Figure 2 The network of theme A: Adaptations. Legend: G = grounded (the number of quotations the label is linked to); D = density (the number of other labels the label is linked to).

3.2 Effects on Clients

3.2.1 Primary Outcome Measures

Self-Compassion. Self-compassion was the primary focus of the reviewed studies. Generally, the intervention successfully increased self-compassion[5, 7], although some studies reported no significant changes from pre-intervention to post-intervention[2, 3]. However, in one study, self-compassion was not significantly higher immediately after the intervention but increased considerably after a four-week follow-up[7]. This finding highlighted the potential long-term effects of CFT. A qualitative study found that clients with ID were as able as the participants in the control group to generate a compassionate image and use it as a form of soothing[1]. Similarly, one client enjoyed the compassionate exercises and repeated them continuously, while another client stopped self-verbal aggression, which suggested a more compassionate approach of the client toward themselves[4]. The clients also reported improvements in self-understanding, self-acceptance, the regulation of negative emotions, and a reduction of shame and self-criticism[2]. Self-compassion was further subdivided into *common humanity, social comparison, coping strategies,* and *the flow of compassion*.

Common humanity refers to the awareness that others share similar positive and negative experiences and feelings, and therefore, experiencing these emotions is not shameful. In a study that implemented group therapy, the clients reported the experience of de-shaming by sharing their experiences with one another[2]. Interestingly, before implementing CFT, some clients were afraid of sharing their experiences with others, while post-intervention, they reported feeling "normal"[6].

Social comparison involves comparing oneself to others. In this study, we focused on downward or negative social comparisons, which emerge from feeling shame [10]. The clients reported less negative social comparison with others post-intervention than at the start[2, 5].

C*oping strategies* entail 1) self-soothing images and thoughts and 2) searching for social support. For self-soothing images, the clients were asked to perform visualization exercises, such as producing a compassionate image or safe-place imagery. The clients reported a decrease in distress[6] and an increase in the frequency of performing these exercises post-CFT[7]. Furthermore, the clients with ID could generate a compassionate image and compassionate words like the clients without ID, although they required more prompts[1]. However, not all studies using visualization exercises reported positive results following the exercises[4]. The clients with ID searched for social support more often than those without ID to solve a problem[1], and the use of this coping strategy for solving a problem was more frequent post-CFT[7].

Flow of compassion is the ability to provide compassion to oneself and others and to receive compassion from others. From the reviewed studies, we found that the clients who underwent CFT were not only more compassionate toward themselves but also others and reported feeling more confident in receiving compassion from others[2, 5]. In another study, although the flow of compassion was not explicitly described, the clients reported the calmness of the therapist, which might suggest their acceptance of compassion from the therapist[6].

Self-Criticism & Self-Esteem. Self-criticism refers to being judgmental and harsh toward oneself, probably because the individual feels inferior or inept. Two studies found a significant decrease in self-criticism before and after CFT[2], but not for all clients[6]. Additionally, feelings of self-hatred

decreased, but feelings of self-inadequacy increased[3]. Finally, one study found an increase in self-esteem following CFT[7].

Psychological Problems, Well-being, and Problematic Behavior. Studies on the changes in mental well-being showed mixed results. In a CFT group intervention, psychological well-being did not change significantly[2]. In a case study, the level of distress increased[3], which led to doubts regarding the effectiveness of CFT in all clients. Some clients might benefit from other approaches or a combination of therapies. In contrast, other studies reported mood improvements[5] and a reduction in anxiety post-CFT[6]; however, these findings could not be replicated elsewhere[4]. Along with standard instruments, some authors used a self-report pictorial mood monitoring scale[3, 7], with which mood improvements were reported. Additionally, several mental and behavioral changes occurred post-CFT, such as a lower number of flashbacks and fewer sadness-related and trauma-related symptoms. Moreover, one client cleared hoarded objects in her room with the help of a therapist and stopped self-verbal aggression[4].

3.2.2 Secondary Outcome Measures

Regarding secondary outcomes, some clients reported initial fear, blocks, and resistance toward compassion (e.g., finding the compassion exercises strange or stupid, or having difficulty being kind to oneself when one is used to being critical)[2]. However, these clients overcame these challenges by trusting the therapist, modeling their behavior, and practicing repeatedly. Other secondary outcomes included improvements in managing emotions and developing confidence and connections[5]. Another secondary effect involved a better understanding of situations[6]. The clients reported a positive change in emotions, bodily sensations, and perception of themselves after undergoing CFT. These sub-themes are illustrated in Figure 3.

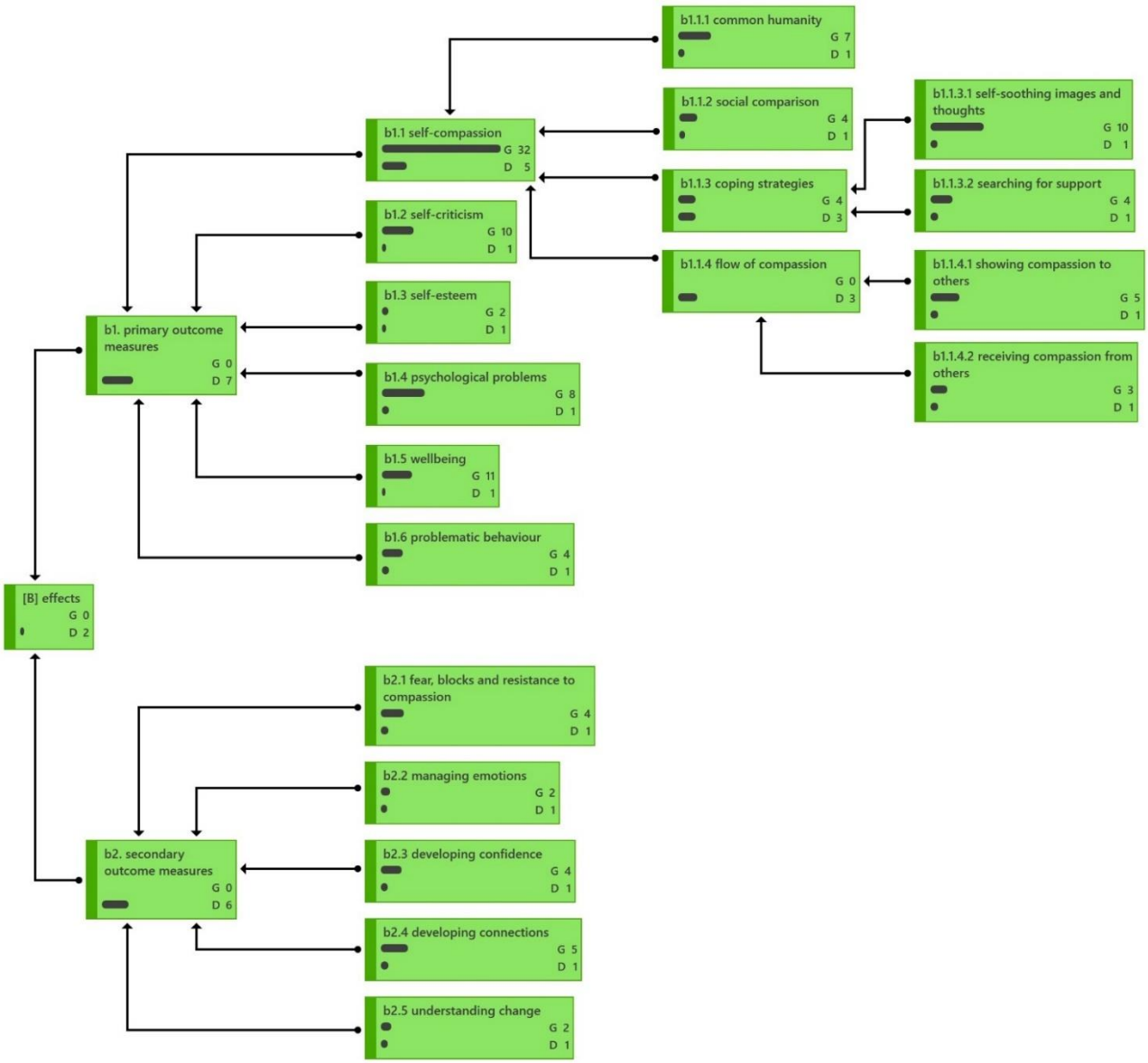

Figure 3 The network of theme B: Effects. Legend: G = grounded (the number of quotations the label is linked to); D = density (the number of other labels the label is linked to).

3.3 Social Validity of CFT

3.3.1 Understanding CFT

Although clients with ID required additional prompting, and their descriptions were less elaborate compared to those of individuals without ID, they clearly understood the compassionate image exercise[1]. Based on the information obtained from the semi-structured interviews and focus groups held with the clients after the CFT intervention, the studies found that other successful exercises were the safe-place imagination exercise, the smiling-in-the mirror exercise, and various calm breathing exercises[3, 4, 6]. The experiential and visualization exercises were recalled more often than the cognitive exercises[3–6]. Moreover, clients preferred performing the experiential exercises and reported feeling positive during these exercises, which indicated additional physiological

effects[5]. The concepts of CFT were generally less understood. For example, clients reported understanding the rationale behind the *tricky brain,* but this concept might still have been abstract[2]. Although clients understood that the circular representations of their feelings of sadness and happiness could increase or decrease, it remained unclear whether they understood that the circles represented their feelings[4]. Visual aids were crucial for understanding and recollecting the concepts of CFT[5].

3.3.2 Experiences of the Clients

The clients were asked about their opinions and experiences during CFT. Generally, clients enjoyed the therapy session and found it useful, particularly, the visual elements and the experiential exercises[2, 3, 5–7]. Some clients also enjoyed the group CFT interventions because of the opportunity to meet new people and learn that others might share similar feelings and experiences[5]. Moreover, they found the group to be safe and accessible[2]. Some clients also provided constructive feedback[5] by requesting the company of another client of the same gender for group intervention and to discuss the examples of the clients more extensively during the sessions.

3.3.3 Suitability of CFT for Individuals with ID

Compassion-focused therapy is particularly suitable for individuals with ID, as CFT is primarily behavior- and skill-based, which makes it easier for clients with ID to understand CFT[2, 4–6]. However, even with the experiential exercises, repetition and regular practice were key to effective recollection[4]. The involvement of the caregiver outside the CFT sessions was particularly interesting. The lack of involvement of a caregiver might be the reason for the lack of improvements in clients[3]. Caregiver support was found to be important to integrate compassion into the daily lives of the clients[4]. Thus, friends and caregivers should engage more in CFT interventions[5, 7]. These sub-themes are illustrated in Figure 4.

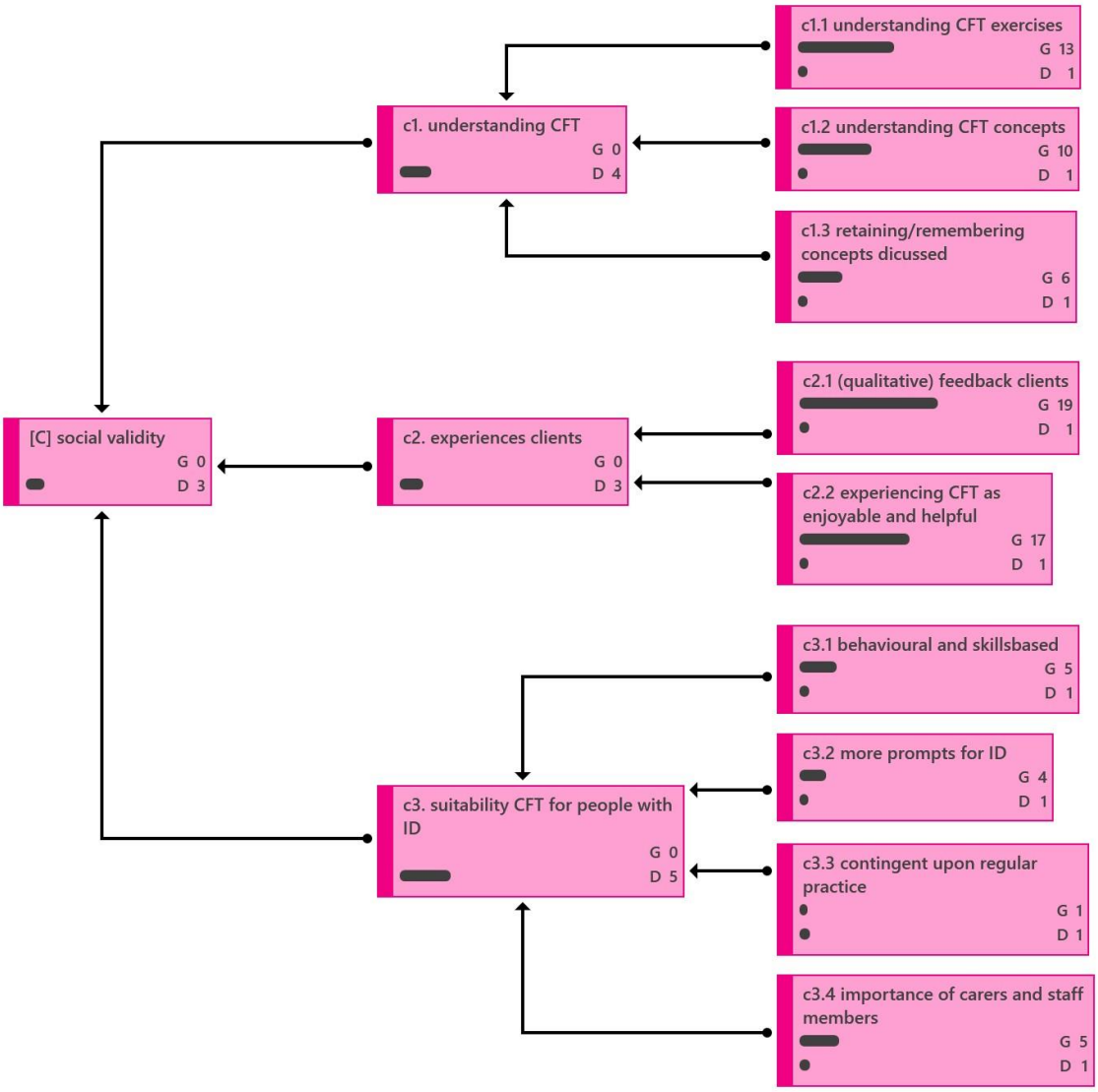

Figure 4 The network of theme C: Social Validity. Legend: G = grounded (the number of quotations the label is linked to); D = density (the number of other labels the label is linked to).

4. Discussion

In this review, we summarized the key themes from studies on CFT concerning adaptations of CFT for individuals with ID, its effects on behavioral and cognitive outcomes, and the suitability and social validity of CFT. We included seven studies after searching eight databases and handpicking one article. Six of these studies were on CFT interventions for individuals with mild-to-moderate ID, and one sample also presented concurrent visual impairments. One study was a conceptual review that reported cases of individuals with ID. Our study showed that CFT intervention can be successfully adapted for individuals with ID.

Most adaptations involved changing the language, the modality of delivery, providing guidance, and implementing the intervention. To make CFT suitable for individuals with ID it is necessary to adopt easy and concrete language, and this observation matched the findings of some studies that language encoding and comprehension skills of individuals with ID are often limited [39, 40]. To help recall the materials, therapists often asked clients to review the materials between sessions, used

workbooks, and also asked the clients to verbally summarize the contents. Memory domains were often impaired in individuals with ID [41, 42]. However, overcoming these challenges is possible by adapting the *modality* of delivery with the use of visuals and providing a multimodal sensory experience to the clients (i.e., touch, smell, etc.), as performed by some of the reviewed studies. Similarly, an integrative literature review indicated that memory performance in individuals with ID depends not only on the cognitive abilities of individuals but also on the type of tasks and modality of presentation, with visual modalities showing higher memory performance preservation compared to other sensory modalities [43]. Additionally, besides linguistic and modality adaptations, our theme analysis showed that clients with ID might require additional guidance through prompting and scaffolding. Scaffolding is important to engage and promote understanding of the task [44] and can improve problem-solving abilities and performance, as found in a study on students with ID [45]. As a part of the *guidance*, the involvement of caregivers contributed positively to the outcome of the intervention. However, one study showed that the absence of some expected therapeutic effects was due to the lack of involvement of the caregivers[3]. Idusohan-Moizer et al. [46] described the importance of the involvement of caregivers to foster motivation in clients to engage in therapy. It is also important to be aware of a general lack of confidence in one's skills and the fears of making mistakes in individuals with ID [47] and to reassure clients that no answer is right or wrong. Some studies have also focused on the *implementation* of CFT for ID. These studies found that it is necessary not only to adapt the materials in language, modality and guidance but also in how the therapy is carried out, for example by offering more practical and experiential exercises instead of cognitive exercises. Additionally, CFT adaptations involved providing more breaks to clients within each session and reducing the speed and the content of therapy. Anecdotal evidence from two studies suggested[2, 5] that clients might also benefit more from group therapy, which allows them to share their feelings and experiences with others. This practice is key to developing compassion toward oneself and others. This corroborates previous findings indicating that group therapy for individuals with ID provides a sense of alliance in overcoming the needs of the clients [48]. Finally, we found that at least 10 sessions are required to allow for enough repetition for clients to deeply engage and remember the skills learned.

The effects of CFT-ID were subdivided into primary and secondary outcomes. For primary outcomes, the adapted CFT-ID led to substantial improvements in self-compassion, self-esteem, self-criticism, psychological well-being, and problematic behaviors. These results mirror those of a large systematic review of third-wave therapies (to which CFT belongs) for individuals with ID, which showed positive effects on psychological and behavioral problems [49]. However, the results for the effects of CFT-ID were mixed, probably due to the use of non-validated instruments for individuals with ID and/or the lack of norm scores for clinical ranges. Additional effects observed included positive secondary outcomes, such as an increase in confidence and the development of meaningful connections, reduction of fear toward compassion, better management of emotions, and understanding changes. Although the management of emotion emerged as a secondary outcome, this topic needs to be empirically investigated in the context of ID, given that the regulation of emotion is a core deficit for individuals with ID [50] and remains largely understudied [51].

Overall, the adapted CFT-ID resulted in a generally well-accepted intervention with positive outcomes and good social validity. This was achieved by making the intervention easily understandable and the exercises enjoyable, better recollection of the material through visual cues, providing feedback to the clients, and involving caregivers. Although these adaptations were useful

to clients with ID, the theoretical foundations of the CFT treatment must be incorporated (for a detailed discussion see Patterson et al. [52]). Rigorous randomized controlled trials (RCTs) need to be conducted with large sample sizes and good instruments.

4.1 Limitations of the Reviewed Studies

Several limitations need to be acknowledged in this study, and thus, our findings should be interpreted with caution. Some of the reviewed studies lacked rigorous designs, and thus, discerning the effects of CFT might not be possible. For example, only one study included a control group[1], whereas, others used case-studies[3] or within-participants designs[2, 5, 6, 7] and often performed only one post-CFT assessment[2, 3, 5]. One study included individuals with ID and visual impairments, potentially adding a confounding factor when investigating the effectiveness of CFT-ID[7]. Future studies should conduct rigorous RCTs to establish causal inferences and determine the efficacy of CFT for individuals with ID, thus making CFT-ID an evidence-based treatment [53]. Sample sizes were very small (1–39 and most often 3)[1, 2, 5, 7], which might have contributed to the mixed findings. One limitation of longitudinal studies is the restricted time period between assessments, which might affect the strength and the validity of the findings[3]. Thus, future studies should perform repeated assessments with longer gaps between them, as suggested by a study on CFT meta-analysis [54]. Cowles et al.[4] concluded that group therapy might be more effective than individual therapy, given the positive effects on common humanity and the flow of compassion. We found that all types of CFT can have positive effects on the clients, depending on the goals of the therapy. Individual therapy might focus more on the strengths and challenges of the individual, whereas, group therapy might focus more on social dynamics and the flow of compassion. One limitation regarding the intervention is the number of sessions, which varied greatly in the studies reviewed. For example, in a study by Goad and Parker[5], which is an extension of a study by Clapton et al.[2], the authors increased the number of sessions from six to ten and concluded that this might have improved the abilities of the clients to apply the learned skills to their daily lives. The measures used might also be unsuitable since they were often not validated for individuals with ID. Therefore, better instruments need to be developed that can perform more accurate measurements and provide good psychometric validity for individuals with ID to obtain reliable results[1, 2, 3, 5, 6]. For example, there was neither a validated instrument to measure shame in individuals with ID[2] nor to measure self-criticism[3], although they were sometimes assessed through the subscale of larger instruments[2, 5, 6, 7]. Even when measures were validated for individuals with ID, psychometric data on the validity and reliability of the scale were lacking, and no cut-off point was determined for a clinical range[5]. Other limitations included 1) the lack of testing the instruments for individuals with ID[1], 2) the lack of long-term assessments[2], 3) the limited range of answers for the mood thermometer[3], 4) self-report bias[6], 5) the difficulty for individuals with ID to understand the statements despite adaptations[5], and 6) the lack of outcome measures in the conceptual review[4]. Thus, the external validity of CFT-ID remains unknown. It is unclear if and for how long clients benefit from the exercises and the skills learned in therapy. Moreover, in some studies, clients were also provided other interventions (i.e., mindfulness) before undergoing CFT. This increased the uncertainty regarding whether the effects reported in the study were due to CFT alone, a mix of the two interventions, or mindfulness only[7]. Future studies need to address these limitations by comparing

CFT to other therapies, such as Mindfulness, Cognitive Behavioral Therapy, or Eye Movement Desensitization and Reprocessing[4, 7].

Finally, some general aspects that might improve the therapeutic effects include the openness of the clients to therapy, the involvement of caregivers[7], and therapeutic alliance[4]. Along with providing CFT interventions to clients, therapists also need to be well-trained to apply the techniques and exercise self-reflection [55-57].

4.2 Strengths & Limitations of the Study

This was the first study to review and summarize the studies published on CFT-ID and discuss the limitations and future considerations. Some limitations of this study need to be considered. We searched for studies published till May 10th, 2021; thus, newer studies might have been omitted. Only one study fitted our inclusion criteria, which investigated gender/masculinity conceptualization in individuals with ID following CFT intervention [58]. The findings of that study were similar to our findings concerning improvements in the psychological outcomes following CFT intervention and had some of the limitations mentioned above. Also, our search terms might not have been fully exhaustive, especially considering that the search was performed in English and Dutch only.

4.3 Recommendations and Future Directions

The field of CFT-ID is still in its infancy, presenting scarce and heterogeneous evidence. Although the efforts of the reviewed studies are commendable, they represent a preliminary but strong basis to advance the development of the field by creating and publishing standardized protocols. Our findings might encourage studies on CFT-ID based on RCTs across countries and generations. We found that studies on CFT intervention for children and adolescents are lacking. Considering that nurturing compassion from an early age has long-lasting benefits, adaptations of CFT should also address activities for young clients. More attention should be paid to which treatment strategy works for whom and why to indicate how standardized protocols might be tailored to specific individuals. Additionally, future RCTs should control for non-specific effects, such as breaks from regular day-to-day programs, by including active (treatment-as-usual) control groups or should consider this as a limitation when using wait-list controls [59]. Moreover, for achieving good therapeutic alliance and compliance, and also to address challenging behaviors of individuals with ID, the need for a client to attach to a secure base needs to be considered [60, 61]. Similarly, by giving importance to emotion regulation skills for coping strategies and challenging behaviors in individuals with ID, future studies should investigate the mechanisms through which CFT might act on these.

We proposed that the domains, including *attentional deployment* and *cognitive change* of the Modal Model, provide a strong framework to address the topics of shame and compassion [62]. While a full description of this is beyond the scope of our review, we would like to highlight this relationship for future studies to adopt while investigating compassion in individuals with ID. The Modal Model is a model of regulation of emotion and highlights the person-situation interaction that involves attentional systems depending on the person's goals and the attributed meaning to the situation. This model suggests that focusing on threatening information is imperative for maintaining symptoms or negative schemas. Cognitive change refers to the mechanism by which

the same situation might be appraised in a different way than the one that was learned earlier. For example, when encountering a threatening signal, negative thoughts, behaviors, and distress might arise and lead to the experience of shame. However, the same situation might also be interpreted positively through re-appraisal, for example, by eliciting soothing thoughts and being compassionate toward oneself. These processes need to be further examined empirically in individuals with ID and should be considered in the adaptations of CFT-ID. Although executive functions were investigated in individuals with ID, the focus was mostly on 'cold' tasks (involving cognitive information processing only), while 'hot' tasks (involving information related to emotion, reward, and motivational processes) were ignored [63, 64]. Thus, these need to be integrated into the fields of ID and compassion-related research.

5. Conclusions

This study provided a framework for designing future studies to investigate the effectiveness of CFT for individuals with ID. Our findings might have important implications for clinicians and researchers. Based on the adaptations of the CFT intervention, the effects on the cognitive and behavioral outcomes of the clients, and the suitability of CFT for clients with ID, CFT can be considered to be a promising intervention for individuals with ID. However, the published studies have considerable methodological limitations, which might be addressed by conducting large, rigorous RCTs, using validated instruments for individuals with ID, and testing the impact of individual and group CFT interventions in future studies.

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Author Contributions

HH contributed to the study conceptualization, conducted the literature search, selection of papers and preliminary theme analyses. LDW ran all the theme analysis. LDW and SVV wrote the first draft of the manuscript and revised the manuscript based on feedback from PSS. PSS contributed to the study conceptualization, coordinated the study and provided feedback for the writing of the manuscript.

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Competing Interests

The authors declare that no competing interests exist.

Additional Materials

The following additional materials are uploaded with this paper.

1. Appendix 1: Search Strategy.
2. Appendix 2: Atlas.ti CFT-ID coding frame.

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