Volume 6 Number 1 (2025) Pages 58 – 68

Coution: Journal of Counseling and Education

Email Journal : coution .bbc@gmail.com

Web Journal: http://journal.bungabangsacirebon.ac.id/index.php/ coution

Cognitive Application Behavioral Therapy in Overcoming Dysthymia in Adolescents with Borderline Disorder Intellectual Functioning

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Received: 2025-03-15 ; Accepted: 2025-04-17 ; Published: 2025-05-20

Abstract

Dysthymia, or *Persistent Depressive Disorder*, is a milder form of depression that lasts for years. This condition can cause problems in daily life and a decreased quality of life. *Cognitive Behavioral Therapy* (CBT) is an evidence-based approach proven effective in treating various *mood disorders,* including dysthymia. This study discusses the case of a 17-year-old female adolescent diagnosed with dysthymia and with an IQ of 70, thus categorized as *borderline intellectual functioning.* Symptoms that appeared were suicidal thoughts, hopelessness, low self-confidence, and fatigue. The client's condition was worsened by limited problem-solving abilities and inflexible thinking patterns. The assessments used were the Beck Depression Inventory (BDI), Millon Adolescent Clinical Inventory (MACI), SSCT (Sack's Sentence Completion Test), CFIT (Culture Fair Intelligence Test), and Graphic Tests (BAUM, DAP, HTP) which were used to determine the client's cognitive and emotional functioning. The intervention was structured, focusing on emotional regulation, cognitive restructuring, and improving *coping skills.* The intervention was repeated and simplified according to the client's understanding and interests. Results showed improvements in emotional regulation and social skills, improved self-perception, and reduced suicidal thoughts. These results indicate that CBT is effective and can be adapted for *borderline intellectual functioning clients* with dysthymia using simpler methods.

Keywords : *Borderline Intellectual Functioning; CBT; Dysthymia; Teenager; Slow-learner*

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INTRODUCTION

Dysthymia is a type of depressive disorder with milder symptoms but a longer-lasting intensity, sometimes lasting years (American Psychiatric Association , 2013). The global and national prevalence of dysthymia is not yet fully known, but the largest increase in dysthymia cases between 1990 and 2019 occurred in individuals aged 15 to 19 years (Luo et al., 2024). Meanwhile, depressive disorders are one of the most common mental health disorders experienced by adolescents in Indonesia (Wirawan, 2024). At least 10.7% of adolescents in Indonesia experience depressive disorders (Wirawan, 2024).

Dysthymia is characterized by at least 1-2 years of depressed *mood* accompanied by 2 or more of several other symptoms (American Psychiatric Association, 2013). These include decreased appetite or overeating, insomnia or hypersomnia, fatigue and decreased energy, low self-confidence, difficulty focusing and making decisions, and feelings of hopelessness. Individuals have never experienced a period without symptoms and without a depressed *mood* for more than 2 months (American Psychiatric Association, 2013). Dysthymia onset is divided into two types, namely *early* and *late. Early* onset begins under the age of 21 years, while *late onset* begins after the age of 21 years. *Early onset* is often associated with a worse prognosis because it can lead to self-harming behavior, addiction, and personality disorders (American Psychiatric Association, 2013).

Meanwhile, *Borderline Intellectual Functioning* (BIF) is a condition of cognitive dysfunction associated with an IQ of 70-80. This condition is called *borderline* because it is not included in the category of intellectual disorders, but also there are obstacles in academic fields and social adaptation compared to the average population (Peltopuro et al., 2014). BIF is not a disease or mental disorder, but rather a grouping of intelligence levels (Salvador-Carulla et al., 2013). This condition also limits the individual's functioning in daily life, for example in decision-making, understanding complex theoretical concepts, and thinking long-term (Salvador-Carulla et al., 2013).

Individuals with BIF are more susceptible to psychological disorders, including emotional, personality, adaptation, social relationship, and substance abuse problems compared to the general population (Salvador-Carulla et al., 2013). This is due to a lack of intellectual capacity to manage stress, take other perspectives, perceive a situation objectively, and solve problems effectively (Saraswati & Hildayani, 2019). Other risk factors such as having a single parent, mental disorders in the family, *stressful events* , and temperament also influence the increased likelihood of mental disorders in individuals with BIF (Salvador-Carulla et al., 2013).

The case in this study is about a 17-year-old female teenager, initials E, in grade IX of junior high school. E is the eldest of two siblings. E comes from a family with a lower-class background. E, her father and stepmother live in a cramped boarding house, where her father sells goods and her stepmother works as a domestic helper. E once committed *self-harm* by drinking Autan and cutting her own hands, which E did because she wanted to vent her emotions and believed that her death would benefit others. E felt insecure and *insecure* because she felt she was not beautiful and tall. She also felt disgusted with herself because she was sexually exploited by her ex-boyfriend. E and her ex-boyfriend were once caught kissing on the lips and neck. Her ex-boyfriend often groped E's body and invited her to have sex. E refused on the grounds that she was menstruating. E was called cheap by her ex-boyfriend and her friends, making E very angry with herself and the perpetrator.

E was not close to her family because her parents divorced, and her father remarried. Her father and stepmother often blamed and psychologically abused E. E felt sad, angry, and wanted revenge. E's father once said that E was dark-skinned, short, and useless. He also compared E to her younger sibling and said he regretted raising E. In fact, his father once said that he didn't care whether E would commit suicide or not. E actually loved her father because he was considered more caring towards him than her biological mother, but his father tended to blame E for many things, including when E asked for pocket money, her decision to continue school, and her liking for Korean boy bands. Her stepmother often said that E brought bad luck. E admitted that she hated her biological mother for abandoning her. E's relationship with her parents was greatly influenced by the family's economic conditions, where unstable income and poor economic conditions can increase the likelihood of domestic violence perpetrated by the father (Devakumar et al., 2021).

E is often offended by her friends' teasing. E easily feels *insecure,* when her friends spontaneously see a beautiful girl, E feels unnoticed and says " *Oh yeah, I'm ugly. No one pays attention to me* ." E's friends then think E tends to be *a drama queen.* E is also very *moody* and cries easily so her friends are confused about how to behave towards E. E feels sad almost every day and knows that other people are bored with her always sad condition. This complaint has been felt since 2 years ago. E had a relationship with her friend, but the relationship ended because E kept crying and focused on her own problems, even though her boyfriend had tried to comfort and listen to all of E's stories. E felt alone again, annoyed with herself and confirmed her parents' words that she brought bad luck. E felt that everyone was two-faced, only good in front but rotten behind. All advice from her teachers and friends was ignored, because she thought they were hard to trust. E's negative assessment of others is influenced by E's *insecurity* and low self-confidence. Both of these are influenced by E's belief that he always brings bad luck and is worthless, where this belief comes from his father's internalized words. A history of violence, especially psychological violence, can influence the formation of negative and *self-critical schemas,* thereby increasing vulnerability to depression, anxiety, and other mental disorders (Wright et al., 2009).

Medical treatment in the form of medication, combined with psychotherapy is effective in treating dysthymia, compared to medication alone or psychotherapy alone (Cuijpers et al., 2009). Various psychotherapy methods are effective in treating mood disorders, including dysthymia, for example CBT, IPT (Interpersonal Therapy), EFT (Emotion Focused Therapy), Behavioral Therapy and MBCT (Mindfulness Based Cognitive Therapy) (Hollon & Ponniah, 2010). CBT is the most effective intervention in treating *mood disorders* and can be used for clients with BIF conditions, of course with several adjustments such as repetition, providing interventions with visual media, and focusing on felt emotions (Saraswati & Hildayani, 2019). CBT is also effective in reducing complaints related to emotions, expressing emotions in a healthier way, and associating situations with a more adaptive perspective in groups of subjects with mild intellectual disabilities and depression (Hartley et al., 2015).

This study discusses the application of CBT to dysthymia in individuals with borderline intellectual functioning. This intervention is expected to reduce the intensity and frequency of *self-harm* and help clients manage negative emotions and thoughts about themselves.

RESEARCH METHOD

The method used was *a single case study,* which aims to determine the differences before and after treatment on a single individual. This method is in-depth and can bridge theory with practice, as well as provide an understanding of the application of a theory in daily activities (McDonald, 2015). The focus of this study was to implement a CBT intervention for dysthymia that was tailored to the intellectual capacity of the borderline individual and to evaluate the CBT delivery.

In the CBT approach, therapists work with clients to learn how their thoughts and perspectives on a situation influence their feelings and behavior. Once clients gain insight into how unrealistic, negative thoughts can affect them, they are trained to seek evidence that supports more rational responses (Corey, 2009).

Before beginning the intervention, a series of assessments were conducted on the client. The assessment procedures included interviews, interviews with teachers as *significant others*, and the administration of psychological scales. The interviews aimed to explore the client's history of complaints, family circumstances, social relationships, school adaptation, and educational history. The psychological scales administered included the Beck Depression Inventory (BDI), Millon Adolescent Clinical Inventory (MACI), SSCT (Sack's Sentence Completion Test), CFIT (Culture Fair Intelligence Test), and Graphic Tests (BAUM, DAP, HTP).

A series of interventions consisting of 10 sessions using CBT methods is then implemented. CBT is tailored to the client's intellectual capacity, making it simpler and more relevant to their daily lives and interests. Furthermore, there are multiple repetitions, so some sessions may cover the same topic.

Session 1: Contract and agree on counseling goals

Session 2: Recognizing automatic thinking and *reframing* (leading clients to recognize other points of view slowly), with the help of worksheets and visual media.

Session 3: *Reframing* and recognizing one's strengths, recognizing ways of *coping with stress,* with the help of worksheets and visual media.

Session 4: *Reframing,* recognizing ways of *coping with stress,* including relaxation methods, with the help of worksheets and audio-visual media.

Session 5: Creating rational thinking, strengthening the use of adaptive *coping* and relaxation, with the help of worksheets and audio-visual media.

Session 6: Creating rational thinking, strengthening the use of adaptive *coping* and relaxation, with the help of worksheets and audio-visual media.

Session 7: Creating positive *self-talk* with BTS song lyrics that the client likes, with the help of worksheets and audio-visual media.

Session 8: Creating rational thoughts aimed at other people, with the help of worksheets and visual media.

Session 9: Strengthening stress tolerance, with the help of worksheets and visual media.

Session 10: Strengthening expectations, setting goals, evaluation and termination.

RESULTS AND DISCUSSION

Based on results Based on the assessment , the client's emotions tend to be unstable. The client experiences mood dysphoria, where the client feels sad, empty, and worthless. The client is also easily offended and has difficulty accepting criticism. The client feels that the sadness he feels cannot be alleviated by others. The client tends to feel unable to feel happiness, even though he is actually still capable. The client is able to express his emotions despite having difficulty managing them, but there are times when the client's expressions tend to be excessive and *overreacting*.

The client has sufficient motivation to achieve his goals. This drive and energy are not sufficiently channeled, resulting in obstacles in achieving them. The client's ego function is also underdeveloped, although his superego is functioning well. Therefore, the client has difficulty regulating himself and balancing the id and superego in daily activities. The client tends to be childish, choosing to rely on others to solve problems. The client is a friendly individual, making it easy for him to build relationships. The client desires social acceptance, but will avoid it unless he is certain he will be liked. Feeling inferior and insecure, the client is highly sensitive to criticism from others, which he perceives as rejection. Then, the client will overreact and feel that others do not care about him.

Following is dysthymia diagnostic criteria with symptoms that exist in oneself client :

Table 1. Diagnostic Criteria For Dysthymia

Criteria	Information
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is depressed mood or loss of interest/pleasure.	There are 5 symptoms that are met.
1) Depressed mood most of the day, nearly every day, as indicated by client report (e.g., feeling sad or empty) or observation by others (e.g., appearing tearful). Note: In children and adolescents, the mood may be irritable.	The client often bursts into tears, confusing her friends. She feels sad almost every day and feels that others are tired of her constant sadness.
2) Reduced interest or pleasure in all, or almost all, activities most of the day (as indicated by the individual client or as observed by others).	The client continues to follow news about BTS (a Korean boy band) on social media, which is his favorite. The client is still able to perform daily activities such as bathing and attending school.
3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decreased or increased appetite nearly every day. Note: In children, consider failure to make expected weight gain.	The client's appetite decreased and she felt reluctant to eat. She reported a weight loss from 45 kg to 40 kg (currently). She felt she had lost weight since breaking up with her ex-boyfriend.

4) Insomnia or hypersomnia almost every day	The client tends to experience insomnia when thinking about her problems at night. The client also reports hypersomnia, where she feels tired even when there's nothing to do, leading her to go to bed early.
5) Psychomotor agitation or retardation nearly every day (observable by others, not just the client's feelings of restlessness or slowness).	The client can sit quietly in general and does not cause the client to be reprimanded by others.
6) Fatigue or loss of energy nearly every day.	Clients often feel tired and their whole body aches even though they haven't done any activity.
7) Feelings of worthlessness or excessive or inappropriate guilt (which may be imaginary) nearly every day (with only self-blame or guilt about being ill).	The client feels guilty for bringing bad luck to others. She also worries about being judged negatively by others. According to accounts from *significant others,* she even feels guilty when events occur around her that don't involve her.
8) Diminished ability to think or concentrate, or inattention, nearly every day (either by the client's judgment or as observed by others).	The client felt like he lost focus during the exam even though he thought he had remembered everything he had studied in his head.
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for suicide.	The client had injured himself with a razor and thought that his death would benefit others.
B. These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	The client had difficulty adapting to social relationships due to persistent irrational thoughts, such as feeling unlucky and guilty. The client became reluctant to attend school and felt sad almost constantly.
C. This episode is not due to the physiological effects of a substance or another medical condition.	The symptoms experienced by the client as a whole are caused by family and social relations.

The following are the results of each intervention session briefly described:

Session 1 : The client and counselor were able to jointly determine intervention goals, despite extensive guidance from the counselor. There were still feelings of *denial* and skepticism toward the counselor's guidance.

Session 2 : Clients are able to understand automatic thoughts using examples from their daily lives (e.g., feeling unlucky, unpopular, etc.). Clients also recognize the relationship between thoughts, emotions, and behavior.
Session 3 : The client is able to recognize that mistakes in group assignments aren't actually their fault, as are problems at home. The client is able to list another strength, namely caring about the feelings of others who are kind to them. The client will lightly tap themselves on the head when negative thoughts cross their mind and engage in *guided imagery* by imagining their favorite *boy band concert* .
Session 4 : The client realized she wasn't a burden to her friends, but she still harbored anger and felt like she couldn't think like an adult. She also realized that asking her parents for pocket money was normal. She also began practicing *progressive muscle relaxation* and playing *games* whenever she felt like hurting herself.
Session 5 : The client was able to develop a rational response to a fight with her younger sibling. She felt she had the strengths of being a good listener and having a sense of humor. Since the last session, she has begun writing short stories on her phone, which she plans to upload to Wattpad. She stated that writing short stories improves her mood. She was also able to write about positive experiences she experienced during the week.
Session 6 : The client was able to develop a rational response to a situation where her neighbor teased her for being afraid of chickens. She responded that her fear of chickens was normal and that it was none of her neighbor's business. She also realized that it was normal for her to want to see her mother, even though her father was scolding her.
Session 7 : The client is increasingly able to appreciate herself and has posted BTS song lyrics about mental health on her bedroom wall. The client feels that she is not a bringer of bad luck.
Session 8 : The client felt better, especially after her father defended her in the sexual harassment case. She felt she no longer brought bad luck to her friends, but she still considered her junior high school friends unpleasant. She chose to distance herself from her junior high friends and seek new friends at her new school.
Session 9 : The client now has a bicycle, allowing her to cycle when she feels tired and play games to reduce stress. She is able to vent her anger about family issues through WhatsApp status updates, whereas previously, if she had an argument with her father, she would remain silent and avoid using social media. The client still has difficulty adapting to her high school friends, despite realizing that they may have different perspectives.
Session 10 : Slowly, the client began to gain hope as she entered high school. She wanted to study cosmetology and find a side job, such as working as a shop assistant. She felt much better and expressed gratitude to the counselor for believing in her, which motivated her to change.

The following are the results of the evaluation of the client's dysthymia symptoms as measured using the BDI (*Beck Depression Inventory*).

Table 2. Pre -Test And Post-Test With BDI

	Score	Category
Pre-test	43	Severe depression
Post-test	22	Moderate depression

Results showed a decrease in depressive symptoms based on the BDI assessment. The client scored 22, indicating *moderate depression.* This was a decrease compared to the pre-counseling assessment, where the client scored 43. A score of 43 is considered *severe depression.* The client no longer *self-harmed,* and showed a decrease in the intensity of negative thoughts, such as feelings of failure and guilt. Behaviors such as crying also began to decrease after the intervention.

The client's disturbance stems from a negative self-schema, which consistently affects his self-concept across various situations. Self-schema is a generalization about oneself that can help individuals respond to and interpret stimuli from the social environment (Kim & Chen, 2016). Self-schema is formed primarily through parenting, where the stimuli and responses received by an individual are internalized into certain beliefs and cognitive systems. Neglectful and abusive parenting can cause children to develop maladaptive cognitive schemas, such as feelings of disconnection and rejection, which can interfere with their psychological development (Salari et al., 2022). Clients are accustomed to receiving derogatory remarks, such as being unlucky, physically unattractive, or even a father who doesn't care whether the client wants to commit suicide or not.

Negative schemas can lead to psychological inflexibility, which is the inability to adapt to changing situations, including changes in emotions, thought patterns, and bodily sensations, and difficulty adjusting cognitive processes to new or unexpected situations (Menéndez-Aller et al., 2023). This can be seen in the form of a tendency to avoid emotional situations or difficulty finding effective solutions to problems faced. One example is rumination, which is a form of emotional dysregulation where individuals tend to exaggerate emotional problems and think about them continuously (Ahmed et al., 2024). Clients have difficulty thinking of alternative solutions that are appropriate for the target and have difficulty managing their emotions, feeling that the sadness they experience is difficult for others to understand and somewhat *overreacting* in expressing their negative emotions.

The client's condition is exacerbated by the presence of borderline intellectual functioning disorders. Adolescents with BIF tend to have greater difficulty managing their emotions, as indicated by low stress tolerance and less adaptive emotional responses (Saraswati & Hildayani, 2019). Cognitive inflexibility is often found in individuals with BIF. This inflexibility causes them to tend to adhere to existing thought patterns and behaviors, making it difficult to consider alternative perspectives when assessing a problem (Contena & Taddei, 2017). The relationship between cognitive inflexibility and BIF suggests that interventions aimed at increasing cognitive flexibility may be beneficial in improving the well-being of individuals with BIF (Sätilä et al., 2022 ; Contena & Taddei, 2017).

One of how CBT improves flexibility cognitive is with challenge and restructure pattern maladaptive thinking. In therapy this, individual taught For recognize pattern think negative and replace it with more thinking balanced as well as adaptive. Restructuring process cognitive this no only help relieve symptom mental disorders, but also encourages pattern think more flexible, so that individual can see problem from various corner view (Oishi et al., 2018). Research show that improvement flexibility cognitive related with decline symptom depression . This is indicates that the more somebody capable think in a way flexible , welfare emotional also tends to be increase (Dennis & Van der Wal, 2010).

The client experienced increased cognitive flexibility, as evidenced by her ability to recognize that she wasn't necessarily at fault in various situations. She was able to accurately

identify all parties contributing to the problems she faced. She also realized that she wasn't a bad luck charm and was able to develop alternative responses to various situations. For example, she was able to respond to a neighbor who taunted her about bringing bad luck by replying that it wasn't her fault. Previously, she would have remained silent and cried, believing the remark was true. She also developed *stress-coping skills* through cycling and writing stories, preventing her from engaging in risky activities such as self-harm.

CONCLUSION

Client E is a 17-year-old female junior high school student. She complained of unstable moods and a tendency towards depression, feeling unlucky and worthless, and having self - *harmed* . Assessment results indicated that she had limited intellectual abilities and tended to feel helpless and exaggerate her emotional expressions. Based on the DSM-V, E met the diagnostic criteria for dysthymia . Intervention was carried out using CBT to help E increase cognitive flexibility, reduce self-harming behaviors, and train emotional regulation and stress management. The intervention method was tailored to the client's cognitive capacity and preferences/interests. The intervention results showed a decrease in depression scores, the client no longer *self-harmed* , and reported more stable emotions.

However, this study has limitations. It is a *single case study,* making it difficult to generalize to the entire population of individuals with dysthymia and BIF. Furthermore, this study was not longitudinal, so the intervention's effectiveness cannot be proven in the long term. Several suggestions for further research include increasing the number of subjects to improve the intervention's *generalizability* and validity, and conducting longitudinal research to enhance its validity. Longer-term *follow-up* , for example, at 3, 6, and 12 months after the intervention, could also be conducted to ensure its effectiveness. Other intervention methods, such as behavior modification with audiovisual aids, could also be implemented in future research.

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