Therapeutic Relationships with Individuals with Learning Disabilities: A Qualitative Study of the Counselling Psychologists' Experience.

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ABSTRACT

Individuals with learning disabilities are at a significantly greater risk of developing mental health problems than the general population. Historically, treatment has been dominated by psychopharmacology and applied behavioural models; however, an evidence base is growing, which advocates the use psychological therapy with these individuals.

In the non-learning disabled population, the therapeutic relationship, between client and therapist, is seen as a fundamental aspect in the outcome of therapy. It is suggested by Moss (1998) that the issues that are important in psychological therapy with the non-learning disabled population should not lose significance with individuals with learning disabilities. Despite this, there exists a poor empirical and theoretical understanding of the complexities of the therapeutic relationship, when the individual has a learning disability. As a discipline, Counselling Psychology has a particular interest and skill base in understanding the therapeutic relationship and is therefore in a position to offer a valuable contribution to understanding the therapeutic relationship when an individual has a learning disability.

Through eight semi-structured interviews, counselling psychologists currently working with individuals with learning disabilities were asked to share their experiences and understanding of the nature and role of the therapeutic relationship. A qualitative methodology guided by interpretative phenomenological analysis (IPA) enabled detailed exploration of the counselling psychologists' perspective. Themes emerged identifying the therapeutic relationship as fundamental yet difficult due to variables such as the client's experience in relationships, the need for multiple relationships, the experience of needing to facilitate reassurance and the necessary skills for therapeutic approaches. Themes also emerged relating to therapist's motivations, values and needs when working with this client group and conflicts concerning individualisation and the setting culture. The themes identified are discussed in relation to the existing literature. Implications for theory and practice are explored, together with suggestions for future research.

INTRODUCTION

Overview

The following literature review intends to outline theoretical and contextual issues concerning individuals with learning disabilities and their additional mental health needs. Traditional approaches to treatment will be reviewed, particularly the developments in the use of psychological therapy. The literature review will focus upon one core feature of psychological therapy, the therapeutic relationship. The role of counselling psychology within service provision for individuals with learning disabilities will be reviewed and followed by the presentation of the research question.

1. Individuals with a Learning Disability

1.1 Definition

The term 'learning disability' was introduced by the Department of Health in 1991 and has become widely used throughout the UK (Emerson et al 2001). Historically terminology adopted in the UK has included terms such as mentally handicapped, maladjusted, spastic and subnormal (Sinason 1992). Internationally, a variety of terms and definitions continue to be used throughout publications; learning disabilities are also referred to as developmental disabilities, intellectual disabilities or mental retardation (Emerson et al 2001; Forsyth & Winterbottom 2004).

Irrespective of the precise terminology and wording of definitions, there exist three core criteria for 'learning disabilities' emphasised by the British Psychological Society (BPS), in perhaps the most widely accepted and comprehensive definition. The BPS (2001) defines learning disabilities as:

- *Significant impairment of intellectual functioning;*
- *Significant impairment of adaptive / social functioning;*
- *Age of onset before adulthood.*

1.2. Diagnosis

Diagnosis is a contentious issue and research suggests that families are often dissatisfied with the manner in which this is done (Bromley 1998). The principal method for determining levels of 'intellectual functioning' is through psychometric assessment; primarily intelligence quotient scores (BPS 2001). Individuals with a score two standard deviations below the population mean, i.e. below 70 on most recognised IQ tests, will be diagnosed as having a learning disability. Individuals with learning disabilities are also often sub-categorised by their IQ scores. Traditionally in the UK two to three sub-categories have been utilised; mild to moderate disability (50-69), or severe disability (below 50).

'Adaptive/social functioning' is assessed through direct observational work and more formal measures such as the Vineland Adaptive Behaviour Scales[1] and the Hampshire Assessment for Living with Others[2] which assess the person's abilities in areas such as communication, daily living skills including dressing, personal care, travel and finance, and social/interpersonal skills (Emerson et al 2001). 'Age of onset' criterion is below 18 years and is assessed through historical evidence and information from an individual who knows the person well (BPS 2001).

It is noted that the term 'learning difficulties' is used in literature often in an interchangeable fashion with 'learning disabilities'. Learning difficulties is a broader term encapsulating people with educational related difficulties such as dyslexia and dyscalculia, but with an IQ of 70 or above (Emerson et al 2001).

1.3. Epidemiology

Determining the epidemiology of learning disabilities has been described as "*an inexact science*" (Hatton 1998 p.20) primarily because of differences in classification criteria, assessment methods and variations in the sub-classification of learning disability (Emerson et al 2001). Recent estimates suggest that within England alone

[1] Sparrow, S.S., Balla, D.A. & Cicchetti, D.V. (1984). *Vineland Adaptive Behaviour Scales.* Circle Pines, Minnesota: American Guidance Service.
[2] Shackleton Bailey, M., Pidock, B. & Hampshire Social Services (1982). *Hampshire Assessment for Living with Others. Users Manual.* Winchester: Hampshire Social Services.

about 1.2 million people have a mild to moderate learning disability and 210,000 have a severe learning disability (Department of Health 2001); representing approximately 2.3% of the population of England (Forsyth & Winterbottom 2004).

Prevalence and incidence vary according to gender, age, ethnicity and socio-economic circumstances. Most studies report that males are more likely than females to have learning disabilities (Emerson et al 2001). Ethnicity has been linked with severe learning disabilities, with higher prevalence rates in South Asian communities in the UK; whilst poor socio-economic status has been linked to mild learning disabilities (Emerson et al 2001).

These figures are expected to increase by approximately 1% per annum for the next fifteen years (Department of Health 2001), due to a number of reasons, including:

- Improved life expectancy for people with learning disabilities, although it remains lower than for the general population.
- Growing numbers of infants and young people with complex and multiple disabilities who now survive into adulthood.
- An increase in birth rates in ethnic groups who experience higher prevalence of learning disabilities.
- Increases in maternal age.

(Hatton 1998; Department of Health 2001; Emerson et al 2001).

However, there are additional factors that are likely to lead to a decrease in the incidence of learning disabilities, including:

- The use of prenatal screening.
- Amendments to the abortion law resulting in no time limit for terminations where there is substantial risk of a child being 'seriously handicapped'.
- The use of gene therapy is likely to reduce the disorders that cause severe learning disabilities, however it is unlikely to impact the treatment of mild learning disabilities.

(Emerson et al 2001; Moser 1995).

1.4 Causes

A complex interaction between biological, environmental and social factors are all involved in causing learning disabilities. Research has suggested that biological factors influence the development of severe learning disabilities whilst social and environmental factors contribute towards the development of mild learning disabilities (Emerson et al 2001). During the early stages of life, prenatal factors such as chromosomal disorders, for example Down's Syndrome, perinatal factors such birth trauma and asphyxia and postnatal factors such as meningitis and head injury have all been identified as causing learning disabilities (Hatton 1998). Social and environmental factors include psychosocial adversity and deprivation, maternal malnutrition or drug and alcohol dependency as well as abuse and neglect (Hatton 1998).

1.5 Key Characteristics

As detailed in the above definition, significant impairments in intellectual and social functioning are the key characteristics of learning disabilities. As a socially constructed concept, it has emerged to include a large number of syndromes and many different underlying disorders. It is therefore important to note that a great deal of heterogeneity exists within the learning disabled population (Hodges 2003; Rapley 2004).

Clements (1998) describes how individuals with learning disabilities display slow but normal functioning in addition to a variety of domain specific impairments. These may present themselves as difficulties in executive functioning, such as problem solving, working memory and selection of task relevant information. Language/communication systems are often impaired, impacting upon comprehension and expression. Other characteristics include impairments in social cognition, such as theory of mind, which is the ability to recognise that others have knowledge and beliefs that are different from their own. In addition, Clements (1998) emphasises how key characteristics of individuals with learning disabilities are also influenced by the role of affective characteristics such as personality, motivation and behavioural

style. For example, high levels of anxiety, low mood and social avoidance may all inhibit learning.

The developmental trajectory for an individual with learning disabilities will be influenced by environmental, individual and biological factors (Clements 1998). Environmental factors identified as enhancing development may include structured approaches to teaching and skill development. Individual factors such as temperament and biological factors such as diet have also been identified as influential in facilitating change and developing skills.

1.6 The Historical Position of Individuals with Learning Disability

There exists a particular historical and cultural context out of which individuals with learning disabilities have grown (Bungener & McCormack 1994). Throughout the first half of the twentieth century individuals with learning disabilities were considered a threat to society and were subsequently detained under the Mental Deficiency Act (1913) in large institutions. Two ideological movements, normalisation and empowerment, significantly changed the lives of individuals with learning disabilities. With the establishment of the National Health Service (NHS) in 1948, the abolishment of the Mental Deficiency Act in 1959 and a government White Paper in 1971 'Better Services for the Mentally Handicapped', a massive increase in community services was advocated (Caine et al 1998).

The need for improvements to services continues to be highlighted. The White Paper 'Valuing People' (Department of Health 2001) emphasises how people with learning disabilities are one of the most socially excluded and vulnerable groups in Britain. The paper, based upon four key principles; rights, independence, choice and inclusion, sets out proposals to improve education, social services, health, employment, housing and support for people with learning disabilities and their families.

Individuals with learning disabilities receive assistance from a variety of services and professionals throughout their lives, including multidisciplinary community teams, day services and residential or supported living projects. Staff turnover is a major

problem within services which, in turn, has serious consequences for service quality (Hatton et al 2001). A number of empirical studies have researched factors influencing staff turnover in learning disability services, including Blumenthal et al (1998), Hatton et al (2001) and Mascha (2007). Factors include high job stress, low job satisfaction and inexperience and a lack of training. Professionals involved may include community nurses, psychologists, speech & language therapists, occupational therapists, psychiatrists, creative therapists (art & music), care managers, and residential support staff (Caine et al 1998). The array of professionals involved in the lives of individuals with learning disabilities reflects an awareness of their complex and diverse needs.

1.7 Additional Needs Associated with Learning Disabilities

1.7.1 Health Needs

People with learning disabilities are more likely to experience health inequalities when compared to the non-learning disabled population such as shorter life expectancy and higher level of comorbid complex health needs, such as sensory impairments, physical disabilities, early onset dementia and epilepsy (Emerson et al 2001; Cooper et al 2007). McLaren & Bryson (1987) estimate that 10-33% of individuals with learning disabilities are likely to possess sensory impairments, 20-30% experience motor-impairments such as cerebral palsy and between 15-30% are reported to have epilepsy.

1.7.2 Adverse Life Events

Individuals with learning disabilities are more likely to experience adverse life events (Caine & Hatton 1998). The majority of individuals with mild learning disabilities live in relative poverty; they are likely to be unemployed and are more likely to have limited social networks and fewer opportunities for intimate relationship (Caine & Hatton 1998; Hollins & Sinason 2000; Emerson et al 2001).

Due to the vulnerabilities and dependency associated with having a learning disability, it is perhaps unsurprising that as a population they are significantly at risk

of abuse. People with learning disabilities are the victims of a range of abuse including physical, verbal, sexual, emotional and financial as well as discrimination and neglect (Hodges 2003; Emerson et al 2001). One study suggests that 1,400 new cases of sexual abuse occur each year in the UK (Brown et al 1995); whilst physical and psychological abuse appears even more common (Emerson et al 2001).

Literature has also considered the psychological consequences of having a learning disability. Hollins & Sinason (2000) argue that the existence of a learning disability itself is a traumatic experience which inevitably impacts upon early psychological processes and emotional development. They suggest that existing emotional disturbance is subsequently exacerbated by the presence of coexisting physical disabilities such as sensory losses. In addition, parents and families of individuals with learning disabilities are likely to have their own psychological problems, such as feelings of guilt, loss and stress, which will impact upon the individual (Royal College of Psychiatrists 2003). Sinason (1992 p.319) also highlights how individuals with learning disabilities have to come to terms with persistent stigmatisation and "*familial and societal death-wishes*" as they may bear witness to casual mentions of genetic advances and abortions.

These adverse life experiences are believed to lead to greater emotional disturbance than in the general population, as individuals with learning disabilities are less likely to have the skills to cope with such experiences adaptively, due to the adjustment problems associated with limited cognitive functioning and limited access to social support (Reiss et al 1982; Hollins & Sinason 2000). The higher incidence rates of adverse life events combined with limitations in managing such experiences predispose individuals with learning disabilities to a further vulnerability; developing mental health problems.

1.7.3 Mental Health Needs

Individuals with learning disabilities are at a significantly greater risk of developing mental health problems than the non-learning disabled population (Cooper & Bailey 2001). Prevalence studies have shown almost without exception much higher rates of mental health problems when an individual has a learning disability (Borthwick-Duffy

1994). However, Whitaker & Read (2006) recently completed a review of all epistemological studies concerning these prevalence studies. They identify a number of limitations within existing research, such as sampling methods, diagnostic criteria and the use of appropriate control groups, and suggest that the current results should be considered cautiously and call for further comprehensive research.

Whilst some studies report rates between 10% and 80% the majority of studies have produced life time prevalence rates between 25% and 40% (Borthwick-Duffy 1994; Hatton 2002). More recently Cooper et al (2007) completed a population based study to determine prevalence rates which attempted to overcome some of methodological limitations of previous studies. A cohort of 1023 underwent comprehensive individual assessment using a variety of different assessment tools and diagnoses criteria. Results indicated that the prevalence of mental health problems among adults with learning disabilities was more than a third, 40.9% (clinical diagnoses) and 35.2% (DC-LD[3]). It also concluded that the ICD-10-DCR[4] & DSM-IV-TR[5] undercount mental health problems in people with learning disabilities. This is in comparison to the non-learning disabled population where estimates are approximately one in six at any one time (The Office for National Statistics 2001).

Incidence of particular mental health problems has also been the subject of research. There are no major classifications of psychopathology that cannot co-exist with learning disabilities (Prout & Strohmer 1998). Distribution is believed to be different to the non-learning disabled population with reduced rates reported for substance misuse and affective disorders, whilst increased rates reported for psychoses (Caine & Hatton 1998). A further element to take into consideration is challenging behaviour. Between 5-15% of people with learning disabilities show behaviour which presents a significant challenge for those caring for them and may include verbal and physical aggression, destructive behaviours and self-injury (Emerson et al 2001). An argument exists within the literature as to whether this should be considered a mental health

[3] Diagnostic Criteria for Psychiatric Disorder with Learning Disabilities (Royal College of Psychiatrists 2001).
[4] International Classification of Diseases 10 (Worlds Health Organization 1993).
[5] Diagnostic and Statistical Manual of Mental Disorders, 4th edn (American Psychiatric Association (2000).

problem; however it is noted that it has been included in the majority of prevalence studies (Whitaker & Read 2005).

Historically, it has not been recognised that people with learning disabilities could suffer from the same mental health problems as the non-learning disabled population (Gravestock 1999). A lack of appropriate assessment tools and a tendency towards diagnostic overshadowing[6] combined with the long-standing separation of mental health and learning disability services are some of the challenges facing practitioners (Esbensen et al 2003; Mason & Scior 1994; Nezu 1994). As recently as 2001 the DC-LD (Diagnostic Criteria for Psychiatric Disorder with Learning Disabilities) was published by the Royal College of Psychiatrists, the first classification system for psychiatric disorders and learning disabilities. In 2007, the first edition of Advances in Mental Health and Learning Disabilities was published; the first UK journal dedicated to the mental health needs of people with learning disabilities.

2. Treatment of Mental Health Needs in Individuals with Learning Disabilities

2.1 Psychopharmacology

The primary method of treatment of mental health problems in individuals with learning disabilities is psychopharmacology (Chapman et al 2006). Psychotropic drugs tend to be prescribed for their general sedative qualities to control challenging behaviour as opposed to addressing specific psychiatric symptoms (Caine & Hatton 1998; Ahmed et al 2000). The use of psychotropic medication with individuals with learning disabilities has been increasingly criticised and a number of empirical studies have investigated its usage, including Deb & Fraser (1994), Ahmed et al (2000) and Chapman et al (2006). Evidence from these studies suggests that psychopharmacology is over prescribed and used with a significant lack of monitoring, evaluation of treatment, or matching of drugs to diagnosis. Studies conclude that a substantial proportion of people with learning disabilities prescribed antipsychotic medication could have their drugs reduced or withdrawn.

[6] The tendency to ignore symptoms of mental health problems in people with learning disability, considering them to be part of their disability.

2.2 Behavioural Analysis

Psychological interventions for people with learning disabilities have been dominated by the applied behavioural analysis models, synonymous with the practice of clinical psychology (Caine & Hatton 1998; Jones et al 1997). The behavioural model enables analysis of specific problem behaviours, with the aim of reducing these behaviours through environmental manipulations, such as positive and negative reinforcement (Emerson et al 1998). The nature of behavioural models makes them easy to examine empirically and there is considerable evidence that it is a successful approach when individuals present with mental health needs or challenging behaviours and in cases when they co-exist (Jones et al 1997; Hodges 2003).

2.3 Critical Appraisal of Approaches

Both psychopharmacology and applied behavioural analysis have however been criticised heavily in more recent publications. They have been described as overly concerned with social control of individuals with learning disabilities (Kroese 1997). In addition, they have been criticised as lacking awareness of the subjective experience of the individual with a learning disability (Bender 1993), offering them "*nothing*" in respect of their emotional problems (Willner 2005 p.82). Behavioural models have allowed distance between the individual and the practitioner with no need to develop relationships or interact, the individual is a "*passive recipient*" of environmental changes (Hodges 2003; Williams & Jones 1997 p.67). It has been suggested that the influence of a strong behavioural background has resulted in clinicians overlooking the individual, resulting in collaborative or reciprocal relationships with an individual with learning disabilities rarely existing (Jones et al 1997).

It has been argued that the historical position of people with learning disabilities and their additional mental health needs, combined with success of psychopharmacology and behavioural models, is reflected within the limitations of current treatment options and a general lack of interest and research (Emerson et al 1998). For example, despite their increased vulnerabilities and predisposition to adverse life events and

mental health problems traditional approaches to individuals with learning disabilities have not included psychological therapy (Willner 2005).

3. Psychological Therapy for Individuals with a Learning Disability

3.1 Historical & Current Perspectives

Psychological therapies are concerned with the treatment of mental health and emotional needs through the use of a wide range of psychological models and techniques (Department of Health 2004). Psychological services have been slow to respond to the needs of people with learning disabilities (Baum 2006). A number of reasons for this have been postulated within literature.

The diagnosis of learning disability itself has been used as exclusion criteria (Royal College of Psychiatrists 2003). A number of authors cite the long-lasting implications of Freud describing the need for a reasonable degree of natural intelligence (Kroese 1997; Hodges 2003). Other psychoanalysts have also labelled individuals with learning disabilities as "*therapeutically hopeless*" (Sinason 1992 p.63). The debate concerning the level of functioning required for psychological therapy remains current[7].

Social attitudes towards learning disabilities are also believed to have had an impact upon the way in which this group have been considered for psychological therapy (Bungener & McCormack 1994). Bender's (1993) "*The Unoffered Chair: The history of therapeutic disdain towards people with a learning difficulty*" highlighted institutionalised therapeutic disdain amongst mental health professionals. He described how within the worlds of leading professionals such as Rogers and Beck, people with learning disabilities do not appear to exist. Kroese (1997 p.5) suggested that there is "*a common ethos of pessimism and rejection*" within the field.

As such, interest in the delivery of psychological therapy to individuals with learning disabilities has been described as sporadic until the end of the twentieth century

[7] Explored further in 3.2 "Factors Affecting the use of Psychological Therapy".

(Royal College of Psychiatrists 2003). The publication of *"Psychotherapy and Mental Handicap"* [8] in 1992 recording the experiences of a number of therapists unwilling to accept the incompatibility between psychological therapy and learning disabilities prioritised interest in this area (Willner 2005). The same year Sinason, a psychoanalytic psychotherapist, published her seminal book *"Mental Handicap and The Human Condition"* providing further inspiration for clinicians (Royal College of Psychiatrists 2003). Cognitive-behavioural therapists have been described as taking longer to welcome to individuals with learning disabilities into their clinical practice (Kroese 1997). In 1997, Kroese et al published *"Cognitive-Behavioural Therapy for Individuals with Learning Disabilities"* which was described as marking an important new development in the care of people with learning disabilities (Novaco 1997).

The use of psychological therapy as a treatment option for individuals with learning disabilities has received increasing recognition and over the past decade particularly, there have been developments in both interest and provision of psychological therapy to individuals with learning disabilities (Beail et al 2005; Willner 2005).

There is believed to be significant demand for therapy and a range of models are now being adopted (Royal College of Psychiatrists 2003). In 1999, Nagel & Leiper circulated a questionnaire to all clinical psychologists working in community learning disability teams and concluded that psychological therapy is now widespread. Whilst behavioural approaches remained the most popular, with 81% using it frequently or very frequently, cognitive-behavioural therapy received a rating of 35%, humanistic/person-centred approaches 31%, and psychodynamic approaches 17%. However, there do remain significant boundaries in the access and delivery of psychological therapy for individuals with learning disabilities, including attitudes of others and appropriate training and supervision (Royal College of Psychiatrists 2003). The specialist nature of delivering psychological therapy to individuals with learning disabilities raises questions about clinicians' competencies, which Mason (2007) believes has influenced the low number of clinicians choosing a career in the field. As a result access to clinicians "*who are skilled, interested and motivated to offer CBT for this group of patients, remains limited*" (Brown & Marshall 2006 p.240). Current

[8] Edited by Waitman & Conboy-Hill.

training has been described as unlikely to equip therapists with the necessary skills (Hollins & Sinason 2000).

3.2 Factors Affecting the use of Psychological Therapy with Individuals with a Learning Disability

It has been suggested that *"Rigid adherence to established models [...] can effectively exclude people with learning disabilities..."* as a result psychological therapies have had to be modified for their application to this client group (Royal College of Psychiatrists 2003 p.7). There exists limited evidence concerning specific adaptations for particular theoretical models of psychological therapy. Whilst psychodynamic therapists have argued that facets such as verbal skills are not necessary and communication is possible in many other forms (Sinason 1992), cognitive-behavioural therapies have explored the necessary criteria for an individual to engage in therapy in articles such as Othamshaw & Haddock (2006).

At a generic level the development of psychological therapy tools have been based on evidence that suggests adjustments to, or more simplified versions of what is currently used in the typical population have validity and work successfully with individuals with learning disabilities (Kroese et al 1997; MacDonald et al 2003). For example, using simple language, visual aids, working at a slower pace and seeking assistance from carers with the rehearsal of work have been identified as useful.

Mason suggests that despite little direct research "*...it is arguably implicit in much of the research in this area [...] is aimed at people with mild to borderline levels of intellectual functioning.*" (2007 p.245). Literature from cognitive-behavioural therapists have considered *"potential barriers"* in the delivery of psychological therapy, due to the clients' diagnosis and key characteristics associated with this, such as impairment in intellectual and social functioning (Kroese 1997 p.1). They have emphasised the importance of assessing an individual's ability to actually utilise therapy (Kroese et al 1997).

One of the challenges in the delivery of psychological therapy for people with learning disabilities is that these individuals are usually slower functioning, the

parameters of time focused/time limited work need to be adjusted to be flexible to the abilities of the client (Smith 2005). Other characteristics of a learning disability that may influence approaches to psychological therapy may include:

- The ability to self report
- Comprehension and expression
- Motivation to engage
- Locus of control
- The influence of social desirability presented as acquiescence[9] and dependency
- Memory problems
- Recency effects
- Anxiety

(Clements 1997; Kroese 1997; Willner 2005)

Techniques such as cognitive restructuring may require too great a level of complexity and abstraction for people with learning disabilities (Clements 1997). Acquiescence is well documented in learning disabilities, evidence suggests that it is less likely to occur when questions are concrete and accessible (Reed 1997). Role play and role reversal have also been found to be effective for eliciting thought patterns (Lindsay et al 1993).

Other factors that have been identified within literature as important to consider include gaining consent for treatment and explaining confidentiality and its limitations (Royal College of Psychiatrists 2003). The role of the individual's system is also a consideration given the dependency associated with learning disabilities. Carers may not only need to be involved with practical arrangements, but also at stages throughout interventions to ensure that any therapeutic gains are sustained (Bungener & McCormack 1994). It is also necessary to consider how carers may respond to change and how adaptable an individual's systems are (Willner 2005).

3.3 Empirical Evidence

[9] The tendency to answer in the affirmative regardless of question content, Reed (1997).

3.3.1 Considerations

Despite the increased recognition of the mental health and emotional needs of people with learning disabilities and developments in the use of psychological therapy as a treatment option there exists limited evidence of the effectiveness of its usage (Willner 2005). A considerable number of articles cite the need for more research on the efficacy and effectiveness of psychological therapy with individuals with learning disabilities, including Nezu & Nezu (1994), Beail et al (2005) and Willner (2005). However the absence of evidence is not in itself evidence of ineffectiveness and is perhaps a reflection of the recency of developments in the field which has greater emphasis upon exploratory studies (Beail et al 2005).

Literature has cited a variety of reasons that have hampered empirical exploration of psychological therapy provided to individuals with learning disabilities. These have included the lack of suitable measures and standardised assessment tools, the available number of participants and the reliance of retrospective accounts from individuals with learning disabilities. In addition to this there is a degree of complexity in obtaining consent to participate from individuals with learning disabilities, especially with randomised control trials in light of the necessary explanations of randomisation and implications of participating (Royal College of Psychiatrist 2003; Hodges 2003).

It is observed that some recent publications have questioned the current usage of psychological therapy in light of the limited evidence within a debate that took place in the American Mental Retardation Journal (2005). Sturmey (2005) provided his critical account in an article entitled "*Against Psychotherapy With People Who Have Mental Retardation*"; he advocated the continued use of behavioural approaches. However, Sturmey's paper appears more concerned with the application of traditional psychotherapy as opposed to adapted models. He also uses a broad definition of behavioural approaches, which included, for example, relaxation and assertiveness training, points identified in a response to Sturmey's paper by King (2005). King (p.448) emphasised the need for "*Proceeding With Compassion While Awaiting The Evidence*".

3.3.2 The Current Position

Published articles have been low in number but have included a range of different methodologies; the majority of published works are single case studies or use small sample sizes making wider application and interpretations difficult (Hodges 2003; Hollins & Sinason 2000). A number of different theoretical models of therapy have been presented, including systemic therapy (Baum 2006), however the majority are predominantly either psychodynamic or cognitive-behavioural in nature (Mason 2007; Hodges 2003).

Psychodynamic publications have been described as illustrating the application of psychological therapy with individuals with learning disabilities rather than providing outcome data (Royal College of Psychiatrist 2003). Beail and colleagues have produced a variety of studies concerning the outcome of psychodynamic therapy (Beail & Warden 1996; Beail 1998 & Beail et al 2005) and have found consistent reductions in symptoms. However, the small samples and lack of control groups have limited the interpretations possible from these studies (Willner 2005).

The experiences of individuals with learning disabilities involved with psychodynamic group therapy have also been researched, using a qualitative methodology guided by Interpretive Phenomenological Analysis (MacDonald et al 2003). Themes that emerged related to the group being highly valued, but individuals also acknowledged the process as painful and showed limited awareness of positive changes. The tentative conclusion from the study is that the individuals benefited from the group.

Cognitive-behavioural therapy has become the treatment of choice for many mental health and emotional problems within the non-learning disabled population (Department of Health 2004). Its application with individuals with learning disabilities has been documented in a number of publications, including Legget et al (1997), Haddock et al (2004) and Othamshaw & Haddock (2006); all of which have produced positive outcomes. Approaches to using CBT have been documented in a book edited by Kroese et al (1997) "*Cognitive-Behavioural Therapy for Individuals*

with Learning Disabilities". Lindsay (1999) reviewed the outcome of four groups (anxiety, depression, anger management and sex offenders) using an adapted version of Beck's 1976 procedure. The results indicated a significant decrease in symptoms for all groups.

Willner (2005) published a critical overview of the evidence for the effectiveness of psychodynamic, cognitive-behavioural and cognitive therapy with people with learning disability. He emphasised that literature is: "*extremely limited, and there is a conspicuous and unjustified poverty of randomized control trials."*(p.73) Willner concludes, however, that the available data supports the position that these approaches can be effective in people with mild learning disabilities and in a proportion of people with more severe conditions. He continues; "*There is also very little evidence regarding either the importance of specific components of therapeutic packages, or the optimal manner of delivering these interventions to people with learning disabilities."* (p.73). Willner's paper does not offer detail on what he regards to be the specific components of therapeutic packages.

Whilst Mason (2007) echoes many of Willner's comments stating that outcome studies are too few and too small in sample size, he suggests that there exists a general "*swell of opinion*" that psychological therapy is helpful (p.247). Mason sent questionnaires to clinical psychologists and psychiatrists working in learning disabilities to explore whether five proposed factors: perceived effectiveness, service resources, clinician competency, level of client's ability and diagnostic overshadowing bias, are important in influencing the provision of psychological therapy to individuals with learning disabilities. The results indicted that the latter three factors were deemed to be most important, suggesting that the debate in research is focused upon outcome, while clinicians are more concerned with skill level.

Mason's paper does not detail the concerns felt by clinicians regarding their therapeutic skills and as stated, Willner's paper does not offer detail on what he regards to be the specific components of therapeutic packages that need to be more understood. However, one component that is considered to have universal relevance and significance in psychological therapy is the therapeutic relationship (Clarkson 2003).

4. The Therapeutic Relationship with Individuals with a Learning Disability

4.1 The General Role & Significance of the Therapeutic Relationship

The therapeutic relationship can be broadly defined as the collaborative and affective bond between therapist and client (Martin et al 2000). The therapeutic relationship has been given a variety of terms throughout publications, including the therapeutic alliance, working alliance and the treatment alliance (Sandler 1992).

Research within the non-learning disabled population repeatedly demonstrates a high positive correlation between the quality of therapeutic relationship and the amount a client gains from therapy (Orlinsky et al 1994). There exists consistent and overwhelming research evidence of the therapeutic relationship's significance in positive outcome (Orlinsky et al 1994; Clarkson 1996; Keijsers et al 2000; Lambert & Barley 2001). Research has investigated the correlation between the therapeutic relationship and success in therapy, the development and course of the relationship, individual variables that influence the relationship such as the qualities of the client and therapist and in-therapy factors (Horvarth & Fraser 1993; Sanders & Wills 2005). It has also been suggested that for individuals with long-term complex difficulties and interpersonal conflicts, the therapeutic relationship becomes even more significant (Sanders & Wills 2005).

Research has also emphasised that the therapeutic relationship is one of the most important factors in facilitating change in clients, irrespective of theoretical approach (Cowie 1999). Originally considered a psychodynamic construct, the significance of the therapeutic relationship is now pan-theoretical, a construct that therapists converge upon from a variety of theoretical orientations (Whelton et al 2007). The role and significance of the therapeutic relationship however, alters across the differing theoretical paradigms. Psychodynamic and psychoanalytic traditions were the earliest theories to explore and value the relationship between therapist and client. These theories believe that the therapeutic relationship is a container which serves to allow clients to act out dysfunctional relationships and patterns from their lives. It is central to the therapeutic work, as the therapist observes the relationship and the

transference and counter-transference reactions, in order to inform further interventions. The humanistic and person-centred theorists believe the relationship to serve a healing purpose, with an emphasis upon an authentic interaction. Much importance has been placed upon Rogers (1957) core conditions for therapeutic change, acceptance, congruence and empathy. It is the quality of the relationship that is paramount. Within the cognitive-behavioural tradition, the therapeutic relationship is not regarded as central. There exists concern for developing rapport and collaboration however the relationship has been described as similar to that between a coach/teacher/scientist and student (McLeod 2003; Sanders & Wills 2005).

Despite variations in the nature of the emphasis and the approach to the therapeutic relationship, it is considered a common factor and concern for all practitioners and theorists (Clarkson 2003; McLeod 2003).

4.2 Considerations for Therapeutic Relationships with Individuals with Learning Disabilities

4.2.1 Empirical Evidence

Whilst the therapeutic relationship has historically received great attention in mainstream psychological therapy literature, there is a prevailing lack of empirical research concerning the nature and role of the therapeutic relationship with individuals with learning disabilities.

It has been to an extent an assumption that the therapeutic relationship is as important to the effectiveness of psychological therapy with individuals with learning disabilities as it is with the non-learning disabled population (Moss 1998). Two studies have provided evidence for this.

Bihm & Leonard (1992), used a survey to examine the perceptions and skills of mental health counsellors working with individuals with concurrent 'mental retardation and psychiatric disorders'. The specific area of skill given the highest rating by the ninety participants (all members of the American Mental Health Counselors Association) was establishing a therapeutic relationship.

In addition, Strauser et al (2004) conducted quantitative research which examined the perceptions of individuals with learning disabilities concerning the working alliance and three specific therapeutic outcomes: employment status, job satisfaction and self perception of employment prospects. Results indicated a positive relationship between levels of working alliance and positive outcomes for people with mild learning disabilities. Given the design of the study, with its focus upon client's perceptions and the quantitative nature of the instruments, the results provide limited detail as to the nature of the therapeutic relationship with this client group. However, the overall conclusion from the research remains that the relationship is an important variable in therapeutic outcomes for individuals with learning disabilities.

While there exists anecdotal and theoretical views from clinicians working with individuals with learning disabilities as to what a therapeutic relationship involves, there is a prevailing lack of empirical research (Emerson et al 1998). From a meta-observational position, it appears that the overall literature concerning people with learning disabilities is either the work of clinical psychologists or psychodynamic psychotherapists; each discipline informing contrasting elements of the literature. Whilst publications from the clinical psychological position tend to focus upon the theory of learning disabilities in terms of assessment, epidemiology and neurological aspects such as executive functioning, the contribution by psychodynamic psychotherapists has included exploration of the delivery of psychotherapy with individuals with learning disabilities. It is therefore observed that, the majority of the literature which has considered the therapeutic relationship with individuals with learning disabilities are publications by psychodynamic and psychoanalytic psychotherapists. These do not appear to have been developed from any empirical base and research from other theoretical models is limited.

4.2.2. Common Themes

Individuals with learning disabilities are known to have limited experience of relationships, especially of those with an emotional focus (Emerson et al 2001). This has the potential to impact on the therapeutic relationship in a number of ways such as confusion regarding what might be expected of them in therapy (Moss 1998).

Boundary confusions may exist, as individuals may not appreciate what is appropriate within a therapeutic relationship and, for example, confuse the role of the therapist with that of a friend (Caine & Hatton 1998). It has also been suggested that individuals with learning disabilities may benefit from looser boundaries in therapy. Suggestions include therapists being friendlier, session times being less rigid and employing a more tactile interaction (Royal College of Psychiatrists 2003).

A significant aspect of the life of an individual with learning disabilities is the extent to which the relationships they experience are formed and then broken, particularly true for individuals in care (Bungener & McCormack 1994). Throughout their lives the professionals they come into contact with, such as support staff in residential services and day services, will persistently change. As highlighted in section 1.6, staff turnover is a major problem within services for individuals with learning disabilities, which is known to have serious consequences for service quality (Hatton et al 2001). In turn, Bungener & McCormack (1994 p.369) suggest that this makes individuals with learning disabilities *"wary of yet another significant relationship [...] on offer in the form of psychotherapy"*.

Hollins & Sinason (2000) also refer to attachment problems in people with learning disabilities, which are predominantly of the insecure type. Adverse life experience in early attachment relationships, such as frequent rejection can result in long-term difficulties with attachment and trust, it may therefore be problematic forming the therapeutic relationships (Caine & Hatton 1998; Royal College of Psychiatrists).

Caine & Hatton (1998) consider that people with learning disabilities are often in less powerful positions in relationships as a result of their disability; this may in turn make it difficult for them to ask for clarity or interrupt the therapist. This also raises questions as to how a therapist might ensure a collaborative relationship as opposed to an authoritarian one (Kroese 1997).

Literature has also highlighted the importance of the motivation of clients with learning disabilities to engage in therapeutic relationships (Oathamshaw & Haddock 2006). This may be even more significant, given that these clients are often referred and brought to therapy by others, rather than self referring (Caine & Hatton 1998).

As individuals with learning disabilities often experience impaired communication and language skills it has been suggested that therapists should be skilled at taking advantage of all sources of communication provided by such individuals (Moss 1998). In addition to limited communication skills, individuals with learning disabilities are less likely to have received encouragement or experience of talking about their emotions. This makes interpretations concerning transference and counter-transference reactions and responses in individuals with learning disabilities particularly significant (Hodges 2003).

Literature has commented that individuals with learning disabilities display transference reactions "*that are more rapid, pronounced, and primitive*" (Caine & Hatton 1998 p.226). Bungener & McCormack (1994) mention a number of transference reactions commonly associated with people with learning disabilities. They suggest a person with a learning disability is unlikely to oppose the therapist and may try to *"mould themselves to the desires of others*" (p.377). They may also *"hand over"* (p.376) their abilities and thinking to the therapist symbolising a loss of self-determination, while simultaneously feeling envious of the therapists' skills. They may also bring with them to therapy expectations concerning abandonment and being unwanted.

Counter-transference reactions may place an emphasis on therapists becoming parents or advocates within relationships (Caine & Hatton 1998). A common counter-transference reaction with people with learning disabilities is tiredness and an inability to be alert (Bungener & McCormack 1994; Hodges 2003). It is proposed that the client may be experiencing something so unbearable that both the clients' and therapists' capacity to think is attacked. In addition, Bender (1993 p.9) questioned the desirability of developing a therapeutic relationship involving intimacy with someone seen as ultimately "*unattractive*". He suggested that the work may become more "*energy consuming*" ultimately resulting in feelings of disdain towards engagement.

Individuals with learning disabilities have also been described as *"buckets for projection"* (Hodges 2003 p.37). By viewing these individuals as objects of pity, therapists may split off and project onto them their own weaknesses and disabilities.

Symington (1992) describes how at a conscious level we may experience sympathy and pity, but at an unconscious level feelings of contempt towards the individual with a learning disability are experienced. He suggests that tendencies towards patronising individuals with learning disabilities illustrate this unconscious contempt which is based upon instinctive animal impulses to attack and kill the weak.

The concept of secondary handicap is also prominent in psychoanalytic and psychodynamic literature concerning individuals with learning disabilities (Sinason 1992; Stokes & Sinason 1992; Bungener & McCormack 1994). Hodges summarises this as *"a process that occurs when original or primary disability is exaggerated as a way of defending one's self against the painful feelings of difference, thereby making other people 'stupid' for not realising this exaggeration."* (2003 p.40). She goes on to suggest that it requires skill and judgement to see beyond these processes and work with them.

4.3 Delivery of Therapeutic Relationships

As emphasised by Strauser et al (2004), no research has investigated in-depth the therapeutic relationship between therapist and client when the client has a learning disability. This is despite literature which has proposed that there are complexities peculiar to the therapeutic relationship when providing psychological therapy to individuals with learning disabilities. Whilst these are issues that have been highlighted specifically in the context of psychological therapy, there is no reason to assume that these issues are not also of relevance to the relationships that are formed between all other professionals. As Waitman & Conboy-Hill (1992) emphasise, the knowledge obtained through psychotherapeutic practices with individuals with learning disabilities is useful and relevant for a whole variety of other professionals. There are a variety of people occupying supportive roles in the lives of individuals with learning disabilities, including day service staff, social workers, advocates, befrienders and community nurses (Hodges 2003; Royal College of Psychiatrists 2003; Brown & Marshall 2006). Whilst they may not be providing psychological therapy, they are nonetheless involved in helping relationships.

It is therefore suggested that further knowledge gained regarding some of the processes underlying psychological therapy with individuals with learning disabilities will have important resonances to a range of professionals.

5. Counselling Psychology & Individuals with Learning Disabilities

5.1. Counselling Psychology & the Therapeutic Relationship

Of the various professionals involved in working therapeutically with individuals with learning disabilities, counselling psychologists are in a particular position to offer a valuable contribution to understanding this therapeutic relationship.

Counselling psychology is a discipline, which, in terms of its understanding and approach to psychological therapy, places particular emphasis on the importance of the therapeutic relationship (Bellamy 2006). It is '*pre-eminent*' to the discipline and *"valued above any one theoretical model or doctrine"* (Rizq 2005 p.451). A number of other key philosophical principles set the discipline of counselling psychology apart from other applied psychologies such as clinical and health. Counselling psychology seeks to combine reflective and scientific practice in a way not common to other areas of psychology (Lane & Corrie 2006). The emphasis upon personal development such as the requirement for personal therapy during training is also distinctive features of the discipline (Macron & Shapiro 1998). Counselling psychology is underpinned by a humanistic value base, emphasising respect for the personal and subjective over and above assessment and diagnosis (Lane & Corrie 2006; Woolfe 1996. p.56):

> *"Counselling Psychology emphasises respect for persons and the fact that each individual is separate and unique. The qualities are not of course unique to counselling psychology. What counselling psychology does, however, is to elevate these beliefs to the heart of practice."*

Given the aforementioned complexities regarding therapeutic relationships that have been proposed to exist with individuals with learning disabilities and counselling

psychology's philosophical basis and emphasis on the therapeutic relationship, questions about the nature and role of the therapeutic relationship in psychological therapy with individuals with learning disabilities would seem to be of particular interest and relevance to counselling psychologists.

5.2 Counselling Psychologists working with Individuals with Learning Disabilities

Whilst it is referred to as a possible setting for employment (Bellamy 2006; Woolfe & Dryden 1996), nothing further appears to be documented about the discipline of counselling psychology's relationship with the field of learning disabilities. In a survey of members of the BPS Counselling Psychology discipline (Bor & Archilleoudes 1999) eleven of the seventy-three respondents who worked in the NHS worked within learning disabilities. This suggests relatively low numbers employed within the field. It is hypothesised that this is primarily due to the 'newcomer' status of counselling psychology, which obtained divisional status with BPS as recently as 1994 (Woolfe 2006). In addition, within the regulations and syllabus for qualification as a counselling psychologist produced by the BPS, there are no specific requirements for tuition or experience in learning disabilities (BPS 2004). Decisions as to whether to provide tuition to trainees, on the administering of psychological therapies for individuals with learning disabilities, is based upon university discretion. It could also be concluded that the historical strength of psychopharmacological approaches and applied behavioural models, synonymous with clinical psychology, have influenced clinicians' decisions about entering the field. However, as the use of psychological therapy with individuals with learning disabilities has increased over recent years, and as the numbers of counselling psychologist also rise (Bellamy 2006) it is anticipated that the discipline will be better represented within the field.

Given the lack of distinct contribution within literature concerning psychological therapy for individuals with learning disabilities by counselling psychologists, in addition to its newcomer status, it is also anticipated that the discipline has a great deal to learn regarding any potential role it has in the provision of services.

6. Research focus and question

6.1 Research Rationale

The literature has demonstrated that individuals with learning disabilities are at a significantly greater risk of developing mental health problems and are more likely to experience adverse life events. Historically, treatment has been dominated by psychopharmacology and applied behavioural models; however, an evidence base is growing, which advocates the use of psychological therapy with these individuals. In the non-learning disabled population, the therapeutic relationship between client and therapist is seen as a fundamental aspect in the outcome of therapy. It is suggested by Moss (1998) that the issues that are important in psychological therapy with the non-learning disabled population should not lose significance with individuals with learning disabilities. Despite this, there exists a poor empirical and theoretical understanding of the complexities of the therapeutic relationship, when the individual has a learning disability.

As a discipline, counselling psychology has a particular interest and skill base in understanding the therapeutic relationship and is therefore in a position to offer a valuable contribution to understanding the therapeutic relationship when an individual has a learning disability. An understanding of the therapeutic relationship from counselling psychologists will be of value to a variety of other professionals who regularly engage in therapeutic relationships with individuals with learning disabilities. These could include clinical psychologists, community nurses, residential support staff and creative therapists amongst others.

6.2 Research Question

The central research question for this study is: *How do Counselling Psychologists experience and understand the nature and role of the therapeutic relationship when providing psychological therapy to individuals with a learning disability?*

METHODOLOGY

1. Methodological Overview

1.1 Research Design & Rationale

The methodology used to answer the research question for this study was of qualitative design, utilising semi-structured interviews guided by interpretative phenomenological analysis (IPA). There are a number of reasons why this methodology was considered the most suitable approach for the study and these reasons are now explored further.

1.1.1 Quantitative vs. Qualitative

Traditionally psychological researchers have emphasised the significance of quantitative methodologies, such as controlled experiments and statistical analysis, in order to develop understandings and models of processes (Ashworth 2003). However in recent years there has been an "*explosion*" of interest in qualitative psychology (Smith 2003 p.1), 'The Psychologist', for example, publishing articles such as *"Qualitative Research... Emerging from the cocoon of science"* (Keegan 2006 p.668) and *"Free qualitative research from the shackles of method"* (Forshaw 2007 p.478).

Quantitative and qualitative approaches clearly differ. As stated by Silverman (2005), both quantitative and qualitative research is concerned with detail, but what counts as detail varies between the contrasting approaches. Whilst quantitative research seeks detail in numerical values and certain aspects of correlations between variables, qualitative research is concerned with detail in particulars of such matters as people's understandings and interactions. A quantitative design would not be able to offer the type of detail necessary to answer the research question in this study, in addition there is no tool developed that could aid quantitative exploration of the research question. By contrast, a qualitative design with its concern for "*exploring, describing and interpreting personal and social experiences*" makes it directly relevant (Smith 2003 p.2). Qualitative designs have also been described as the most suitable approach for

studying the therapeutic relationship particularly, offering the complex and ambiguous construct greater chance of illumination (Clarkson 2003).

1.1.2 Interpretative Phenomenological Analysis (IPA)

IPA is one particular approach to qualitative research that was considered highly compatible with the research question for a number of reasons. The central concern in IPA is how individuals make sense of their lived experiences (Smith & Eatough 2006). It offers researchers the opportunity to learn from the insights of the experts; the participants themselves (Reid et al 2005). The particular emphasis placed upon the "*individuals' experience*" (Smith 2004 p.40) makes it directly relevant in answering the research question in this study.

IPA's idiographic commitment, which is unusual even among qualitative methodologies (Smith & Eatough 2006), enables the detailed, in-depth exploration and level of analysis necessary to explore the counselling psychologist's perspective and fully address the research question. As highlighted by MacDonald et al (2003) the IPA approach provides an opportunity to *"explore sensitive and highly complex experiences, attitudes and interactions"* making it ideally suited to studying experiences of the therapeutic relationship. Its inductive approach and exploratory and flexible nature also makes IPA compatible with under-researched and complex topic areas (Chapman & Smith 2002) such as the therapeutic relationship with individuals with learning disabilities.

IPA is a relatively recent approach, over the last ten years it has developed (Chapman & Smith 2002) and become an established qualitative methodology (Smith 2004). It has been used in many areas of psychological inquiry, particularly health psychology (Gyllensten et al 2005) but has also received interest within the discipline of counselling psychology, in both the Counselling Psychology Quarterly and Journal of Counselling Psychology in articles by Golsworthy & Coyle (2001), Gyllensten et al (2005) and Macran et al (1999).

IPA is described as possessing dual epistemological underpinnings developed from the influences of phenomenology and hermeneutic inquiry (Smith & Eatough 2006).

The phenomenological influence within IPA draws attention to how individuals perceive and talk about a given topic, whilst the hermeneutic values emphasise how we make sense of these perceptions. Additionally, IPA has been described as a 'double hermeneutic' as two processes are occurring; the participant making sense of their experience and the researcher making sense of the participant making sense of their experience (Smith & Eatough 2006). This two stage process is dependent upon the interpretative activity of the researcher; they are dynamic and active within the process of analysis, to be a reflective researcher is a necessary capacity and distinguishing feature of this approach [10] (Smith & Eatough 2006).

There are many ways to collect data for IPA but the preferred method is through semi-structured interview (Chapman & Smith 2002). Semi-structured interviews facilitate rich verbal accounts which support the researcher in following up interesting and important issues. Interview schedules are used in a highly flexible manner and do not dictate direction. In addition, they facilitate good rapport and empathy which may further enable rich data (Smith & Osborn 2004).

1.1.3 Alternatives Discounted

The rationale behind using a qualitative design in this research and the appropriateness of IPA has been discussed, but it is additionally worth considering why some of the other qualitative approaches were discounted during the development of this methodology. *"...different qualitative approaches have different but overlapping epistemological underpinnings and theoretical and methodological emphases"* (Smith 2004 p.40). For example, discourse analysis retains the same commitment to language and speech as IPA and can also be used to deconstruct a whole range of data sources including interviews. However, the epistemological assumptions are different when considering the representation of data. Whilst IPA assumes that speech represents cognitions, discourse analysis holds an anti-realist stance and argues that speech provides insight into how participants have constructed reality. In order to make sense of accounts it is necessary to consider the social context and participants' interest within conversations, such as responding to a

[10] Refer to the sub-heading "Reflections" within the Methodology for an account of the researcher's own perspective and the influence this may have had upon the analysis.

question as if it were a challenge or an opportunity to complain (Willig 2003). The assumption of this research study is however, that a relationship exists between what a person says and believes.

Grounded theory could also have been considered as an appropriate qualitative methodology for this research, as it is suitable for investigating under-researched areas and niche experiences, in addition it possesses the realist stance that is opposed in discourse analysis. However, grounded theory is concerned with developing theory and it was felt that this research study was more focused on providing insight into the participants' experiences. In addition, grounded theory is highly time-consuming and with consideration of time constraints for this research it was deemed inappropriate.

2. Ethical Considerations

2.1 Ethical Approval

While the risks to participants in this study were considered to be minimal it was necessary to consider a number of specific ethical dimensions that could affect this study. All participants were anticipated to be employees of the NHS, as a result, prior to recruitment a favourable ethical opinion for conduct in the NHS was applied for and granted by the London Surrey Borders Research Ethics Committee (REC), in addition to the mandatory University ethical approval[11].

2.2 Briefing, Debriefing & Informed Consent

Participants were all provided with a letter inviting them to participate, a detailed information sheet and a consent form at least four days prior to the interview, thus providing them with adequate time to consider offering consent[12]. The consent form requested specific consent for direct quotations to be referenced within the write-up. The information sheet provided participants with a three page summary of the study

[11] Please refer to appendices 1 & 2 for a copy of the NHS letter of approval and the University approval.
[12] Please refer to appendices 3, 4 & 5 for copies of these items.

which included how they would go about making a complaint and offered them an opportunity to volunteer to comment upon the analysis stage of the project[13].

It was acknowledged that sensitive issues may arise for participants during discussion of their clinical practice. For example, participants may have questioned previously held beliefs about their work. Although the researcher felt that it was unlikely to cause any undue distress, details of helping organisations were provided to participants[14].

2.3 Confidentiality

Participants were advised of the steps that had been taken to ensure confidentiality and to preserve anonymity. This was made explicit on the information sheet and consent form. All information was kept anonymous, ensuring that personal identification could not be made and only the researcher knew the true identity of the participants. During transcription the researcher was conscious to remove any information that could result in the identification of the participants. During the analysis stage each participant was given a pseudonym to allow ease of discussion and respect confidentiality.

In addition to individual anonymity, efforts were also made to preserve individual NHS Trust anonymity as the research was England-wide. The preservation of Trust anonymity was made by removing identifiable information during transcription.

It was recognised that the research may bring to the fore questionable or unethical practices by participants, they were therefore made aware that the research was conducted within the British Psychological Society Code of Ethics and Conduct (2006) and on this basis the participants were aware of the limitations of confidentiality and the procedure for breaking confidentiality in accordance with these guidelines.

3. Participants

[13] Respondent validation with be explored within the "Validity" section of the Methodology.
[14] Please refer to appendix 6.

3.1 Purposive Sampling

In IPA purposive sampling is used to find participants for whom the research question will be significant, in addition it is usually concerned with finding a fairly homogenous sample to allow master themes to emerge (Chapman & Smith 2002). On this basis counselling psychologists providing psychological therapy for individuals with learning disabilities were recruited as a fairly homogenous sample. However, variety in experience was also desired in order to provide richness of data, therefore it was the decision of the researcher to ensure that all participants came from different NHS trusts[15].

3.2 Sample Size

IPA challenges the traditional relationship between the number of participants and the value of research (Reid et al 2005). With its idiographic focus IPAs' concern is with examining small homogenous groups and therefore it tends to have a small sample size. There is no right answer to the question of how many is enough (Smith & Osborn 2004). There is a considerable variety of sample sizes documented within published IPA articles but ten participants is at the higher end of most recommendations (Reid et al 2005). Smith & Eatough (2006) advise that when considering sample size IPA researchers need to consider the following; their commitment to case study level of analysis, richness of data, interest in comparing and contrasting cases and any pragmatic restrictions. This research had a sample size of eight. It was felt that this sample size was small enough to be able to retain an overall mental picture of the individual cases and the location of themes within them, as recommended by Smith et al (1999).

3.3 Inclusion Criteria

The inclusion criterion for this study was for participants to be qualified counselling psychologists providing psychological therapy to individuals with learning disabilities. Participants needed to posses a minimum of a year's experience in the

[15] Recruitment methods will be explored in "Procedure".

field; this was deemed a necessary prerequisite as the level of experience would provide greater richness to their accounts. It was accurately anticipated that all participants would be employees of the NHS within Community Learning Disability Teams, though this was not a specific criterion. Below is a table depicting the theoretical orientation and experience of the eight individuals who participated. Information concerning theoretical orientation was obtained during interview to help inform later analysis and context of the participants' beliefs and did not form inclusion criteria. All the participants were the only counselling psychologist working within their immediate team.

Pseudonym	**Theoretical Orientation**	**Experience**
Abby	Cognitive-Behavioural	Abby had five years post qualification experience, and
Bill	Integrative (influenced by person-centred, phenomenology and systemic theories)	Bill had eighteen years experience, six post-qualification.
Grace	Cognitive-Behavioural	Grace had three and half years experience, two post-qualification.
Joanna	Psychoanalytic	Joanna seven years post-qualification.
Kevin	Integrative (influenced by person-centred, social constructionist and narrative theories)	Kevin had eleven years experience, nine post-qualification
Kirsty	Integrative (influenced by cognitive-behavioural and systemic theories)	Kirsty had eight years within her team, five post-qualification.
Mac	Person-centred	Mac had seven years experience, four post-qualification.
Nehla	Cognitive-Behavioural	Nehla two years post-qualification.

4. Materials

Participants were all interviewed at their place of work, in a comfortable room, which was free from disturbance, and therefore convenient and amenable to their needs. The materials used before, during and after the interview included the following[16]:

- Audio Cassette Recorder
- Advert for Recruitment
- Letter of Invitation
- Participant Information Sheet
- Consent Form
- Helping Organisations Sheet
- Interview Schedule

The interview schedule was designed in line with recommendations from Smith (2003). He describes how the aim of the interview schedule is to encourage the participant to speak freely with as little prompting as possible. Smith advises that the schedule should include both general and specific questions and that the interview should move between the two seamlessly, the specific level questions acting as prompts if the participant is hesitant. Within the interview schedule for this research the more specific level questions are indented below the general questions.

5. Procedure

5.1 Recruitment

A great deal of thought was offered to the most appropriate method of recruiting participants because of the small number of counselling psychologists thought to be working in the field. Initially, it was not clear if there were eight participants that would meet the inclusion criteria.

[16] All of which can be found in the appendices.

An advertisement[17] was distributed via email through the Mental Health in Learning Disabilities (MHLD) network, facilitated by the Estia Centre, a training, research and development resource for staff working with people with learning disabilities. The email distribution list is UK-wide and reaches staff who have requested to be registered. The advert was also distributed to counselling psychologists who had registered with the BPS Online Directory of Chartered Psychologists and had expressed a specific interest in working with individuals with learning disabilities. The advert was also placed on the BPS Online Notice Board[18].

The response to the recruitment was very positive, within ten days all eight participants had been recruited, each from a different NHS Trust throughout England. A total of twelve volunteers had come forward, two other counselling psychologists and a psychotherapist and art therapist. The process of recruitment itself had been interesting[19].

5.2 Interview

At the start of the interview, participants were asked to read and sign a consent form. They were also asked if any questions had arisen as a result of the information sheet. Participants were reminded that if they were interested they could comment on the analysis which would contribute towards the validity of the analysis and involve them being contacted during early summer[20].

The interview was recorded via audio cassette and the interview schedule was used as a prompt. The interviews lasted between thirty-five minutes and an hour and fifteen minutes. At the end of the interview participants were thanked for their involvement and provided with a helping organisations sheet in the event that the interview had raised any sensitive issues.

After each interview additional notes were made to capture immediate personal observations and reflections concerning the interview which may not have been

[17] See appendix 7.
[18] www.bps.org.uk
[19] This is explored within the "Discussion" under Master Theme 9.
[20] Respondent validation will be explored in section 7.2.

captured by audio tape[21]. As Wengraf (2001 p.47) states *"There is so much more to speech interaction [...] than just words of the transcript"*. By making notes immediately after the interview it was hoped that the non-verbal whole body communications that take place could be captured and then later used to inform the analysis and ensure congruence across the verbal and non-verbal experiences.

5.3 Transcription

The transcription of the audio cassettes was completed by the researcher, this process contributed towards the analysis of the data as the researcher became thoroughly familiar with the interviews. The first stage of transcription was to listen through the interview and make notes. Wengraf (2001) suggests that during the first listen memories flood back and thoughts are provoked, this information was captured in the notes made post-interview. All eight interviews were completed and transcribed verbatim, including the interviewer's speech, before analysis. As mentioned, during transcription the researcher was conscious to remove any information that could result in the identification of the participants or their NHS Trusts.

6. Analysis Process

In the interest of maintaining a transparent position it is important to detail the analysis process[22]. IPA is not a prescriptive approach however guidance on the analysis procedure provided by Smith & Eatough (2006) and Smith & Osborn (2003) was followed.

The first stage in the analysis procedure involved the researcher becoming immersed with the data, a process referred to by Smith & Osborn (2003 p.64) as "*sustained engagement*". Repeated detailed readings of the transcript allowed the researcher to develop an in-depth knowledge of the transcript. During the first read, as with the first listen during transcription, immediate and initial impressions of the data were added to the post interview notes and were returned to check against at later stages.

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[21] Please refer to appendix 9 for an example of post-interview notes.
[22] A transparency trail has been developed within the appendices from appendix 9 to 16 which closely follows the stages represented here with examples.

Secondly, the researcher began annotating on the left-hand side of the transcript, highlighting initial impressions of the dialogue and significant phrases or words. Then, on the right-hand side, identification of emerging themes within the data were noted using terminology with a greater psychological emphasis. There existed evidence of a clear link between what the participant said, the notes on the left-hand side and the emerging themes on the right-hand side[23].

The emerging themes were then consolidated into a list of initial themes[24]. This list was then refined in order to identify associations, main themes and sub-themes. Smith & Osborn (2003) describe imagining a magnet pulling some sub-themes together, which are provided with descriptive labels as master themes. The transcript was frequently re-read to ensure that the final list of themes remained truthful to the experience of participants. This process of "*analytical and theoretical ordering*" (Smith & Osborn 2003 p.71) resulted in the production of a table, representing a coherent thematic analysis of the data[25].

There are different approaches when continuing analysis with more than one participant. Whilst some researchers prefer to begin this analysis fresh each time with each participant, the process used in this research was to use the first master list of themes to inform and orient the analysis of the second. Smith & Osborn (2003 p.73) emphasise that whichever approach is adopted, researchers "*need to be disciplined to discern repeating patterns but also acknowledge new issues emerging as one works through the transcripts*". Whilst exploring the shared experiences of the participants it was necessary for the researcher to maintain awareness of both convergences and divergences in the data, such as amplifications and contradictions within transcripts. This point was particularly resonant with this data in themes 5, 6 and 7 where there was contradiction and ambiguity between and within participants' accounts, which is explored during the narrative account of the themes[26].

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[23] Refer to appendices 10 & 13 for annotated transcript examples.
[24] Please refer to appendices 11 for an example.
[25] Please refer to appendices 12 for an example.
[26] See "Analysis".

Smith et al (1999) emphasises that there is no prescribed method of discovering shared themes. The researcher held a central list of themes which was developed and refined as each of the transcripts were analysed. The researcher found possessing a bird's eye overview (as advised by Smith & Eatough 2006) helpful during this process and large A3 pages enabled this creative process to develop[27]. At this stage, it was also necessary to repeatedly return to the transcripts. As a central list developed, some themes were dropped if they did not fit with the emerging structure. Through a further process of refinement, similar to that which is completed with the first transcript, greater coherence was sought and a final table of themes was developed.

The final stage of analysis was the translation of the table of themes into a narrative account (Chapman & Smith 2002). IPA seeks to capture meaning within individual's accounts and this narrative account of the analysis should move beyond the descriptive level to a more interpretative and psychological level (Smith 2004). During the process of writing and redrafting further insights and ideas were created and the analysis write-up became a crucial part of the analysis process.

7. Validity & Reliability

7.1 Appraising Qualitative Work

Validity and reliability are important considerations for qualitative research (Smith 2003), however there is a need for this methodological approach to be understood on its own terms rather than being 'shoehorned' into an existing scientific paradigm (Keegan 2006). With the increase in popularity of qualitative research there has been similar growth in the development of guidelines for assessing its quality (Mays & Pope 2000). There has been a debate concerning the development of a set of criteria distinctly different from quantitative approaches for assessing quality in qualitative research (Dixon-Woods et al 2004). However there is unease that such guidelines could risk compromising the unique contribution of qualitative research and that some of the most important qualities of such research are the hardest to measure (Mays & Pope 2000; Dixon-Woods et al 2004). Publications seem to advise against the

[27] The stages of this are represented in appendices 14, 15, 16.

development and use of guidelines in a definitive or overly prescriptive manner (Mays & Pope 2000; Barbour 2001).

This study incorporated a number of different methods of ensuring quality from publications that consider the universals features of all forms of qualitative research (Dixon-Woods et al 2004). Yardley (2000) has proposed broad principles for assessing quality in qualitative research which include: sensitivity to context, commitment, rigour, transparency and coherence and impact and importance.

Yardley argues that qualitative researchers should display sensitivity to the context in which the study is situated and this should include their attitudes to existing literature and their new data. Within this study the researcher presented their knowledge of existing literature within the introduction section. The study then went on to display understanding of the literature concerning the particular methodological approach used, IPA, within the methodology section. The review of such literature was felt to include a sophisticated interpretation of the data and the research was undertaken with a full appreciation of the literature encompassing this area. The researcher was sensitive to the influence of this knowledge during the analysis stages and worked to identify all themes that emerged rather than allowing any predisposition to overlook unexpected themes. Yardley also identifies a need for the researcher to show sensitivity to their relationship with the participants and their contribution to interactions between them, this was something felt to be well encapsulated within the broader approach to this research[28].

Secondly, Yardley talks about the importance of commitment, rigour, transparency and coherence in good qualitative research. Commitment can be understood in terms of thoroughness and prolonged engagement (Yardley 2000). The researcher felt that their experience of working with individuals with learning disabilities for over five years and their study of counselling psychology for four years was representative of their dedication. The process of analysis amplified their commitment, a process during which the researcher became totally immersed in the data and the topic area. In terms of rigour, it was felt that the data collected was comprehensive and sufficient to

[28] See the section entitled "Reflection" within the Methodology.

address the research question with great depth, which is demonstrated in the analysis section.

Transparency has been intrinsic throughout the process of this research study. Precision and honesty has been forthright from data collection through to the final list of themes. This is evidenced by the development of a transparency trail within the appendices, the explicit approach to sharing the analysis process and the use of quotes within the analysis section. In addition, in order to present a reflective stance throughout the research study and write-up, the researcher has also dedicated a sub-heading to reflective thoughts. The researcher's coherent approach is highlighted by the compatibility between the research question and the methodology used within the study. In addition, it is argued that coherence is portrayed within the analysis section which presents the reader with the themes.

Finally, Yardley talks about the role of impact and importance when assessing qualitative research. It is proposed that this research can be considered as important on the basis of its contribution to a significantly under-researched area. The influence and role of the interview was considerable within the data, and later became a sub-theme within the analysis. Participants spoke of the impact of their experiences within the research interview, as they were prompted to think about aspects of their work that they had not considered previously. Some participants went on to identify a link between their experience within the research interview and their future clinical practices; a similar process to that which is found within action research[29].

7.2 Respondent Validity

As previously mentioned, participants were invited to comment on the analysis on a voluntary basis. This technique contributes to the rigour of the study, as the researcher displays concern with ensuring the analysis provides an accurate reflection of participants' data, sometimes called respondent validation or member checking (Silverman 2005). Whilst it is recognised as a problematic procedure (Lincoln & Guba 1985), it is considered by some as one of the strongest checks on the credibility

[29] The impact and importance of this study is also explored in the Discussion section.

of research as it contributes to a process of reducing errors and reduces the likelihood of misrepresenting respondents' views (Mays & Pope 2000; Whitley & Crawford 2005).

Out of the eight participants interviewed, three agreed to comment on analysis. Respondent validation involved contacting the three participants via email, as agreed, on the completion of the analysis stage. Participants were provided with a covering letter and brief general summary of the overall themes that arose from the analysis of all eight interviews[30]. In order to make such a summary applicable to the individual specific illustrations from their transcripts were utilised in each of their summaries. It was felt that this was the most appropriate method of gaining validation in light of the small percentage of participants who were willing to offer feedback. The three participants did not respond which, as agreed indicated that they were happy with the congruence between their experiences and the analysis of their data.

7.3 Independent Auditing

Smith (2003, p.234) describes independent audit as an *"extremely useful way of thinking about quality in qualitative research"*. It was found to be a valuable approach that contributed to the quality of the transparency within the study. The process involved providing a researcher who was not involved in the study with access to all the materials from the study. This researcher then examined the materials to see if a coherent and logical trail existed from the raw data to the write-up of the analysis. This researcher reported to find transparency and evidence of the process of analysis and provided advice as to the inclusion of a transparency trail. This process was felt to contribute towards the overall credibility of the analysis (Smith 2003).

8. Reflections

> *"Researchers should reflect upon their role in the interpretative and collaborative nature of the IPA interview, data analysis and subsequent publication"* (Reid at el 2005 p.20).

[30] See appendices 18 & 19.

I have aimed to be reflective throughout the research process and have attempted within this section to look explicitly at factors that may have influenced the research. Whilst this study is concerned with the experiences of the participant, it needs to be acknowledged that accessing and interpreting these accounts has been dependent on me. I have been an active ingredient in this process.

To be a reflective researcher is not only congruent with the notions of a good qualitative methodology, but it is also central to IPA due to its double hermeneutic, as the analysis has been reliant upon my interpretative activity. In addition, the dual emphasis upon skills in reflection and scientific inquiry is part of the identity of a counselling psychologist (Woolfe 2006). Counselling psychologists are not only the participants within this study, I have been a student of the discipline for four years. Therefore counselling psychology is represented at two levels as both the participants and the researcher are representing the discipline.

In light of the researcher's central role it is important to acknowledge and reflect further upon my identity. I am a female counselling psychologist trainee who has many years of both personal and professional experience of individuals with learning disabilities. It is also important to recognise that this study forms part of my doctorate in counselling psychology.

One of the struggles I have encountered and should be honest about is an ability to objectify during the presentation of the literature. There is, for me, certain emotionality associated with the treatment and position of individuals with learning disabilities in society, the NHS, during my training and within research. These emotions range from frustration and anger to sorrow and pity. A conscious effort was made to consider these biases and interests during analysis and also during the review of literature as there was a part of me that wanted to campaign on behalf of a disempowered group of people.

My own theoretical position became a consideration in an unanticipated form, during the writing of the literature review and discussion. I experienced a strong countertransference, in the form of discomfort. There was a feeling of disjointedness

between the literature review and discussion, they jarred and dislocated from one another. I observed that the literature review presented the theory behind learning disabilities in a scientific and quantifiable way; I noted many of the authors were clinical psychologists. The discussion however, was different as I found I relied more heavily upon theories from the psychodynamic framework and referenced more psychotherapists. It is an opportune moment to reflect upon my own theoretical position as I am approaching qualified psychologist status. I believe this disjointedness within the research is representative of my own internal dislocation between my identity as a scientific practitioner and reflective practitioner, a cognitive therapist and a psychodynamic therapist, a clinical psychologist and a psychotherapist. My position as a counselling psychologist perhaps enables me to take a part of all of these, I hope through becoming qualified I will be able to assimilate these identities.

ANALYSIS

Overview

Analysis of the eight transcripts yielded a significant volume and richness of data. Ten master themes emerged from the analysis, initially these themes existed independently of each other, however during the course of the analysis it became increasingly apparent that links could be made and relationships existed between the themes. This analysis section will therefore replicate this process, initially presenting themes independently before offering consideration to the relationships between themes, illustrated with the presentation of a tentative model.

It is noted that the ten master themes are presented in a particular sequence; this order does not reflect the random nature in which the themes initially emerged. As part of the natural process of making sense of the data it was necessary for some order and logic to be imposed upon the organic process of analysis. The themes found a natural sequence and the way they are presented here reflects this. The ten master themes are presented below and overleaf in a pictorial overview together with their sub-themes[31].

Master Theme 1:
The Fundamentality of the Therapeutic Relationship
Sub-themes:
a. Fundamental b. Influential on Outcome c. Significant Above Theory

Master Theme 2:
Multiple Relationships
Sub-themes:
a. Triadic Relationships b. Systemic Relationships c. Confidentiality

[31] Within appendix 17 is a further table of master themes and sub-themes with identifiers for the supporting examples from each participant's transcript.

Master Theme 3:
Facilitating Reassurance
Sub-themes:
a. Praise & Comfort b. Modification of Boundaries i. Refreshments ii. Humour iii. Self disclosure c. Therapist's Caution

Master Theme 4:
Experience of Relationships
Sub-themes:
a. Role of Previous Relationships i. Negative ii. Lacking depth iii. Inconsistent b. The First Relationship c. Social Naivety

Master Theme 5:
Therapeutic Approaches
Sub-themes:
a. Directive b. Collaborative c. Tools & Techniques d. Language

Master Theme 6:
Difficult
Sub-themes:
a. Consuming i. Time ii. Energy a. Complexity b. Attachment & Loss c. Futility

Master Theme 7:
Individualisation
Sub-themes:
a. Recognition of the Individual b. Similarity vs. Dichotomy

Master Theme 8:
Therapist's Motivations & Values
Sub-themes:
a. History Context i. Emotionally Provocative ii. Evolving Services b. Satisfaction c. Familiarity

Master Theme 9:
Therapist's Needs
Sub-themes:
a. Supervision b. Reflection c. Search for Knowledge i.Uncertainty & Lack of Research ii.Role of the Interview

Master Theme 10:
Setting Culture
Sub-themes:
a. Removed from the person b. The Position of Counselling Psychology c. Disregard for the Therapeutic Relationship d. Resources

Master Theme 1:

The Fundamentality of the Therapeutic Relationship

One of the major themes that emerged from the participants' accounts was a belief that the therapeutic relationship was highly significant in the delivery of psychological therapy to individuals with learning disabilities. Their accounts clustered into three sub-themes; participant's identified the therapeutic relationship as crucial to their work, influential on the outcome of therapy and more important than theoretical approaches.

Sub-theme 1a:

Fundamental

Participants were asked to discuss their understanding of the role of the therapeutic relationship when providing psychological therapy to individuals with learning disabilities. They were all aware of how this relationship is fundamental to their work:

"... I see the therapeutic relationship as ... everything" (Grace, line 301)

"...it's absolutely crucial..." (Joanna 403)

"... it's paramount..." (Nehla 269)

"... it is the most important thing ..." (Kirsty 429)

The emphasis and phrasing used to describe the role of the therapeutic relationship implies certainty and alluded to a strength in participant's beliefs and extreme confidence in its cruciality and significance.

Nehla suggested that the therapeutic relationship with individuals with learning disabilities is of equal importance as with non-learning disabled people; including working with children, adult's with mental health difficulties and older adults.

Kirtsy (354) also viewed the therapeutic relationship as fundamental, to such a degree that she seemed to suggest its development is a pre-requisite for therapeutic intervention; suggesting spending time together before addressing the actual referral issue. This was also alluded to in accounts from Grace (522) and Nehla (420) who suggest developing the therapeutic relationship first.

Sub-theme 1b:

Influential on Outcome

The participants described a causal attribution, identifying the therapeutic relationship as responsible for facilitating change within their clients. Phrases such as the "*medium for change*" (Grace 302) and the "*vehicle*" to assist therapeutic work (Joanna 402 & Mac 548), emphasised the role of the therapeutic relationship in terms of process, and achieving a difference within the therapeutic work. Therefore it is illustrated that participants believe the therapeutic relationship directly influences the outcome of therapy.

Kirsty's account described the therapeutic relationship in terms of value, stating that a good therapeutic relationship would make therapy "*invaluable*" (431) whereas a poor relationship would result in an inability to understand the client's difficulties, making the client unwilling to disclose to the therapist and share the extent of their difficulties. She believed that the therapeutic relationship enables communication, trust and depth to therapeutic work (421). Joanna (403) also considered the case of psychological therapy without a good therapeutic relationship and concluded that "*not very much is going to happen*". Mac believed that the therapeutic relationship required respect due its powerful nature (Mac 456 & 548).

In addition, Grace (303) was explicit in her account of why the therapeutic relationship is influential on outcome, stating that it is the experience of a "*proper*

relationship" that contributes to facilitating change for clients[32]. She went on to suggest that if clients had developed a good therapeutic relationship they would benefit from therapy regardless of whether the initial goals of the psychological work was achieved (311).

> *"Even if they don't, do all the things that they have been referred in for, to reduce panic attacks, reduce the anxiety. If they don't do that its fair enough, but if they experience of a good relationship they are going to take away something."*

Grace implies that the relationship in itself has therapeutic value and can assist in making a positive change. Her account captures a belief that this is because the relationships usually experienced by her client's are not 'good' or 'proper' relationships, as a result when a good therapeutic relationship is experienced, this is significant and positive for them.

Sub-theme 1c:

Significant Above Theory

The participants expressed views that the therapeutic relationship was significant above the theoretical framework that they utilised.

> *"...I see it as the crux of all the work, I can work within, whatever model."* (Grace 307)

> "*Regardless of which orientation you are coming from. I think it underpins the work that you are doing."* (Nehla 635)

Kirsty's account (272) alludes to a degree of frustration due to a perceived preoccupation and debate concerning the most appropriate theoretical model therapists should use with their clients. She particularly associates this debate as being

[32] Participant's beliefs concerning individuals with learning disabilities' experiences in relationships are explored further in Master Theme 4.

a concern of adult mental health services, with a focus on different types of theoretical models. She showed concern that as a result of this interest in theoretical approaches the therapeutic relationship may be at risk of being overlooked. Kirsty emphasised that, within learning disabilities particularly, the theoretical model should not be of primary concern, but that the therapeutic relationship should be of greater importance. She described the therapeutic relationship in learning disabilities as "*key*".

> "*...people will often say to me what approach do you work in, I just kind of think, that's not the important thing, the important thing is that the client feels comfortable with me and the client likes me and the client trusts me.*" (Kirsty 431)

Kevin (630) reiterated this belief by downplaying the importance of theory and emphasising the importance of the therapeutic relationship:

> "*I guess it's less about psychological theory and more about developing a relationship that helps people to express and communicate and feel connected.*"

However, some of the participants recognised that their theoretical approaches often influenced the nature of therapeutic relationships. Mac supported (530) flexibility in the development and use of the therapeutic relationship, depending on the client and the theoretical framework being worked with at the time. He described how a more direct approach such as CBT would ultimately contribute to the formation of a different relationship than that in systemic work. This is a belief reiterated by Joanna (451) who felt that her psychoanalytic background ultimately influences the nature of therapeutic relationship she develops with her clients.

Master Theme 2:

Multiple Relationships

Participants identified that psychological therapy with individuals with learning disabilities often involved additional relationships to that which they developed with

their client. It was felt that a multitude of different relationships could form in addition to the therapeutic one. They emerged and clustered into three sub-themes: triadic relationships, systemic relationships and concerns over confidentiality.

Sub-theme 2a:

Triadic Relationships

'Triadic relationships' refers to cases in which a third person accompanies the individual with a learning disability during therapy sessions; examples included support staff, home managers or family members. Participants indicated that the decision to allow an extra individual to become involved in psychological therapy can be down to both the therapist and the client. Whether a triadic relationship was formed was dependent on the individual's circumstance, taking into consideration the nature and level of support they receive and the nature of their difficulties. For example, Kirsty (124) believed she would be more likely to work with clients individually on issues such as bereavement or abuse, whereas anger management might require triadic work.

Kirsty (369) indicated that her approach is led by a sense of what facilitates comfort for the client[33]. She identified a pattern, through which the therapeutic relationship is initially formed:

> *"...its very much what they feel comfortable with and then I've found that, you know, a lot of clients will come and will want their support worker stay for the first couple of sessions but by the third or fourth session 'actually now I feel comfortable to do this on my own'"*

During the early stages clients may want to be accompanied by an individual they know, however, gradually they recognise their ability to be on their own, as the therapist turns from a stranger to someone they feel comfortable with. Kirsty's use of

[33] This is explored in further depth in Master Theme 3

the first person, as her client, captures this recognition of the development of the therapeutic relationship.

Whilst it is not made explicit by participants, therapists are evidently required to be highly flexible in their delivery of psychological therapy, working to meet the specific and individual needs of their clients. This is illustrated in the quotation below from Mac (395):

> *"...a client can often ask a carer to come into a session. I have no objections to that ..."*

Participants do not imply that these triadic relationships and the need for flexibility are a catalyst for any complexities. In fact, participants identified a combination of benefits and reasons for developing triadic relationships. In addition to putting the client at ease, participants expressed the view that triadic relationships can also offer support to psychological work. Mac (320) identified the circular nature of this support; by providing the client with a member of their staff team, the psychological work in turn is enhanced.

> *"...it feels that our clients are often more supported and it feels that my work is more supported as well for the client, on the clients' behalf."*

Mac's (403) account captures much of the participants' beliefs that this is a "*very successful*" approach. He revealed further examples of the benefits of such triadic relationships in that between therapist, client and residential home manager; he described how clients may "*bounce ideas off with the home manager*". This is a belief also expressed by Kirsty (116) who felt that the benefits of this approach in terms of educating staff members with greater insight into the client's experiences, support in making environmental changes and reinforcing the psychological work outside of sessions.

> *" I found it really helpful to have a member of staff come in and sit in on the sessions. Because they then hear so much more about what the client is feeling about where they are living and that has a huge impact."*

Sub-theme 2b:

Systemic Relationships

'Systemic relationships' refers to the therapist's involvement with the individual's systems, such as carers and staff, as an addition to the therapeutic work undertaken with the individual. Participants acknowledged the process of working with the individuals' systems as distinctly different to delivering psychological therapy to the non-learning disabled population. Kevin (165) & Grace's (220) accounts captured much of the participants' sense of this difference. Kevin's use of the word *'staggering'* emphasises the extent of the difference in approach:

> *"The difference is really quite staggering, you know, in mental health I always worked with the person that had the mental health problem, in isolation, one person. Where as here we work across the board, we can even go into schools and day centres..."*

> *"I suppose when I am working in learning disabilities ... its not just the person that I am working with, it often can involve carer's and... the family."*

Grace's account (234) went on to identify a constant need for therapists to be aware of the different systems within the client's life, Bill (538) elaborated on the need for a multidisciplinary approach to delivering services to individuals with learning disabilities.

> *"Its often a counselling psychologist who sees the person because they've already spoken to the social worker, whose working on part of the plan which is working on housing or umm. And then when they've done that you need to talk to the OT about what adaptations they need in the house or whether they've got the skills for daily living."*

It was felt, that while therapists need to consider their clients' systems in terms of carers and support staff they also need to look inwardly to their multidisciplinary team

and the systemic relationships they may develop within that. It is clear that both therapist and client bring a whole host of bidirectional relationships with them to the psychological work and the therapeutic relationship. In Bill's account it was felt that psychological therapy makes up a relatively small proportion of this package of care. He also developed a causal attribution between the multitude of relationships and the theme of the work being difficult[34]. In contrast the majority of participants believed that the additional relationships they developed enabled and contributed positively to therapeutic work. Kevin identified a number of benefits. By working within systemic relationships in addition to the therapeutic work he has provided support workers and family's insight into their approach to the client. This in turn results in a positive change in their relationship with the client (485), he described this process in terms of a "*knock on effect*". Kevin suggested that with a combination of one-on-one therapeutic work with the client and additional work with the relationships available to the client, he is able to facilitate greater change. In particular, Kevin provided an example working with parents of individuals with learning disabilities (450):

> *"Parents, particularly, get stuck in the relationship and, there, there are obvious reasons that they may not want things to be different; even when things are difficult. But if they can see that in making slight adjustments to the way that they are or the way they see their son or daughter can actually make their lives better to them that's a really good thing and a positive thing."*

Working with the individual's systems can assist therapy by dealing with attitudes and cultures of people who live and work with individuals with learning disabilities.

Kevin's account provides a strong rationale for his approach to utilising the systemic relationships available to him and his client as part of the therapeutic work. He identified that working with individuals with learning disabilities in isolation would be unsuccessful due to their experienced disempowerment (36):

> *"...there is a belief that what you do in a counselling room is always minimised when as soon as the client leaves the room. So with a client with*

[34] The concept of the work being difficult is explored in Master Theme 6.

learning disabilities who is disempowered anyway, anything you do in the counselling room is going to be negated by the people around them, unless they are on board."

Mac (363) was the only participant to comment on how the extent of the client's learning disability may influence his reliance upon the systemic relationships within the client's life. He spoke of the need for an emphasis on behavioural approaches with the more non-verbal clients. This alluded to the need for a highly individualised approach to psychological therapy requiring the therapist to be flexible in their approach.

In comparison to other settings, participants related a sense that it was easier to adopt an approach that incorporated systemic relationships with individuals with learning disabilities. This is illustrated by the following examples:

"...you need to work with the whole system. Its so much easier to do that with people with learning disabilities."(Kirsty 104)

"*There is usually some kind of community support available, there's a social work team, most of our clients have an assigned social worker, so, so the system of support seems to be far greater than in learning disabilities*." (Mac 309)

Mac continued to compare this experience to that in adult mental health, where he experienced a significantly lesser degree of support. These experiences clearly contributed to the participants feeling their therapeutic work is supported.

Participants identified additional requirements for this systemic approach to work with their clients. Grace (471) described the importance of good communication between various relationships to ensure a collaborative approach to supporting the client, while Kirsty (437) emphasised the role of the therapeutic relationship. Her account highlighted the importance of developing a good therapeutic relationship in the beginning which would then set the scene for the later development of systemic

relationships with the client's support staff; thus making a good therapeutic relationship a prerequisite for working with the client's systems.

> *"...a lot of the work is not done in isolation, its not done just with the client, you end up having to work with staff teams and you can't do that well unless you've got a good therapeutic relationship because the client won't trust you to handle that staff team well and to protect them."*

Sub-theme 2c:

Confidentiality

The participants felt that the issue of confidentiality was an important aspect when working with the individuals with learning disabilities, their systems and a multidisciplinary setting. There appeared some tension within participant's accounts between a need to share and communicate but also to recognise that their work does not abide by the assumptions of traditional psychological therapy and confidentiality.

It was acknowledged by participants that the delivery of psychological therapy to individuals with learning disabilities is often not a confidential process. Bill (563) illustrated how if he personally had sought psychological therapy he could do so without anyone other than the therapist knowing; by contrast this is what he recounted for individuals with learning disabilities:

> *"... if you've got a learning disability, you've got you and the therapist, and your key worker and your mum and your GP and your social worker and your OT and they'll all want to know a little bit about what's going on and they all know that you are having therapy, but that's something very different about the way the system works."*

Bill clearly states that the people who form the support systems of an individual with learning disabilities are likely to know when they are engaging in psychological therapy. As such, Bill felt that confidentiality regarding the content of therapy is not

as stringent because of others wanting to know what is "*going on*". This is something Grace's account (226) also captured:

> *"...we are supposed to have is all about trust, its just going to be you and me working together. But it's not really like that. The other people want to know; 'What are you doing?', 'What's wrong with my son?'."*

Therapists delivering psychological therapy to individuals with learning disabilities are more likely share with others the nature of their therapeutic work due to the number of "*interested parties*" (Grace 237).

> *"...the issue of confidentially, our clients get so used to not really having any privacy, one way or another."*

Joanna's (127) account captured much of what Grace and Bill alluded to, suggesting that individuals with learning disabilities adjust to having limited privacy as multiple team members and support staff already know a great deal about them and their private lives. As a result of this she described her efforts to gain clarity with clients at the initial stages of therapeutic work as to their expectations and rules concerning confidentially.

Whilst participants recognise and value the need for triadic and systemic relationships, this contributes to limitations in their ability to adhere to traditional confidentiality. Evidently there is a distinct and contrasting approach to confidentiality with individuals with learning disabilities who receive psychological therapy concerning both their engagement in therapy and the content of therapeutic work. There was no explicit suggestion of any unease with the lack of confidentiality, but there existed a degree of tension within the participants' accounts combined with acceptance of its difference and the need to work through that appropriately with their client.

Master Theme 3:

Facilitating Reassurance

The theme 'facilitating reassurance' summarises a desire by participants to put individuals with learning disabilities at ease when establishing the therapeutic relationship. Three sub-themes emerged during analysis: offering praise and ensuring comfort, modification of some therapeutic boundaries and caution with regards to challenging or confusing individuals with learning disabilities.

Sub-theme 3a:

Praise & Comfort

Participants, displayed a conscious awareness and concern for their client's experiences during the initial stages of the therapeutic relationship, this was particularly captured by Abby and Kirsty's accounts. They identified a range of emotions that their clients experience, which was felt to include an element of hypothesising. A process emerged within participant's accounts. They described how the client's learning disability may result in unfounded, inaccurate expectations and ultimately uncertainty concerning the therapeutic encounter. The culmination of this emotion predominately manifested itself as general fear of the therapeutic session. This fear in turn facilitates a need within the therapists to praise and comfort the client.

Abby clearly identified a sense of intimidation involved in attending therapeutic sessions for an individual who has a learning disability. She described her clients as often feeling "*nervous*" (320) of the "*very daunting*" (324) experience. This was also made explicit by Kirsty who described the process as "*quite intimidating for someone with a learning disability"* (377).

These experiences were made sense of within the context of the individual's learning disability. Both Abby and Kirsty's accounts identified how the experience of attending psychological therapy is made more difficult as a result of the learning disability and the traits associated with it. For example, Abby spoke about "*prerequisites*" (323), suggesting that while non-learning disabled people possess expectations of 'psychology' individuals with learning disabilities may encounter

difficulty in the formal surroundings and unexpected circumstances. She was explicit in attributing the client's inability to assert their discomfort to the learning disability (324). In addition, Abby appears to believe that making the client feel at ease is almost a compensatory strategy for the client's learning disability.

> *"And more so than in the general population because they might not be able to assert that they are not very comfortable about being here..."* (Abby 323)

The client's learning disability and experienced discomfort appears to facilitate a need within the participants to comfort and praise the clients for their achievements. It is possible that the participants feel a degree of responsibility towards the clients, having 'subjected' them to this experience.

> *"I think I am very aware of making people feel comfortable."* (Abby 313)

> *" And I think its little things like that, you know being able to say to the client, 'well done you got here on time that was a difficult thing, how many buses did you have to catch, goodness me, you know that's a bit confusing isn't it'. Umm. I think its little things like that, being able to say that to them, letting them know that you know that life is difficult, helps." (Kirsty 544)*

In Kirsty's (390) account, she went on to identify that ensuring the client is comfortable is almost a therapeutic aim in itself.

It was thus apparent that by offering praise, the individuals with learning disabilities ultimately may feel better, less nervous and intimidated. This in turn, makes the therapist feel more capable and equipped to deal with the client's emotional state for which they seem to take a degree of responsibility. Being comfortable seems to be a priority for therapists when building the foundations of a successful therapeutic relationship. It is possible that this attentiveness and vigilance is due largely to the presence of a learning disability.

Sub-theme 3b:

Modification of Boundaries

The approaches adopted by the participants to facilitate reassurance in their clients included the modification of traditional therapeutic boundaries. These were clustered into; the use of refreshments, humour and self-disclosure.

i. Refreshments

> *"I find smiling a lot and giving a cup of tea is really helpful in the therapeutic relationship...."* (Kirsty 395)

A few participants referred to the use of refreshments as a way of reassuring clients during the initial stages of the therapeutic relationship. Nehla was one participant whose account explored the rationale behind this behaviour. She firstly acknowledged the offering of tea and coffee as "*not seen as appropriate necessarily for psychologists to be doing*" (486). Her account demonstrated a relationship between offering refreshments and the development of the therapeutic relationship. She described how refreshments commenced their relationship at a "*more social*" and "*friendly*" level (506 & 510) with clients subsequently more willing to trust her and engage in a therapeutic relationship. This alluded to a sense that the development of an informal relationship was a prerequisite for the therapeutic relationship. Her account described "*hooking people into a therapeutic relationship.*" (487) as an initial tactic (513). However Nehla also identified the need for clarity and balance between a friendly and a professional relationship.

ii. Humour

> *"Well you know, in your training there are these whole things about keeping your boundaries and everything like that and I just think, my clients have managed to get here, you know, I'm going to smile because that will help relax them and it's a friendly face..."* (Kirsty 400)

Kirsty advocated the use of smiling in the development of the therapeutic relationship, a shift from some traditional teachings. Moreover, Kevin was overt about using humour.

> *"So humour is, is a really big part of the work."* (253)

He was explicit in his belief that the use of humour has positive outcomes for the therapeutic relationship and that the client's appreciate his approach. He spoke of how humour facilitates a "*very warm relationship*" (233). Both Kirsty and Kevin's accounts suggest the use of a more social and friendly relationship when delivering psychological therapy to individuals with learning disabilities.

iii. Self-disclosure

Kirsty was the only participant who revealed how she may self-disclose to assist the therapeutic relationship. Although she did not allude to disclosing detailed personal information, her account showed a willingness to use examples from her own life to reassure and normalise client's experiences. She directly referenced her self-disclosure as making the client feel more comfortable (408).

> *"...I will tell them about a time that I've been angry, just to help them feel less anxious about the whole issue and more comfortable about talking about it."*

Sub-theme 3c:

Therapist's Caution

Whilst the participants identified some of the fears that the clients may have about the therapeutic encounter, they were also able to reflect on their own fears and reservations. When working with individuals with learning disabilities the participants seemed committed to ensuring their clients' comfort, their cautious approach suggests they are anxious of frightening, confusing or intimidating their clients. Participant's accounts highlight a delicacy and fragility in the establishment of the therapeutic relationship with individuals with learning disabilities.

"...it's a very softly, softly approach the way I take it." (Nehla 86)

"You know we will talk about things that aren't really too threatening for them, umm and things that they would really want to share and are easy for them to talk about." (Kirsty 357)

Abby illustrates this in her approach to working with individuals with learning disabilities and individuals without learning disabilities:

"...I think in the first few sessions, where in adult mental health that would be the time that I would get them used to me picking up on bits and talking about what's going on, in 'LD' maybe I give them more breathing space. Because I want them to feel comfortable." (Abby 327)

Abby also speaks of her concern about how she may "*come across*" (333) within the therapeutic relationship. She is keen for clients to believe psychology is "*embracing and warm*" (345) however, this in turn appears to restrict interventions and her ability to challenge clients appears to be of secondary importance to making them feel comfortable:

"I don't perhaps feel comfortable challenging people, probably unless it's a really risky thing ..." (Abby 333)

The cautiousness and hesitancy that is captured in the data is interesting. It appears that a fear exists with regards to working therapeutically with individuals with learning disabilities. The various accounts reveal a complexity that makes it difficult for therapists to challenge clients through fear of overwhelming them. Simultaneously, there is a desire to praise clients and make them feel comfortable. All this alludes to an overarching anxiety, belonging to therapists of causing discomfort, confusion or upsetting the individual with a learning disability. It is noted that data from participants Joanna and Grace did not contribute towards this theme.

Master Theme 4:

Experience in Relationships

Participants identified that the therapeutic relationship with individuals with learning disabilities was influenced by their client's previous experience within other relationships. These experiences were clustered into three sub-themes, the role of previous relationships, social naivety and the first relationship.

Sub-theme 4a:

Role of Previous Relationships

Participant's accounts identified how the role of previous relationships has impacted their subsequent ability to develop the therapeutic relationship. The role of previous relationships clustered into three: negative, lacking depth and inconsistent relationships.

i. Negative

Participants described how individuals with learning disabilities have experienced negative relationships both within their personal lives and additionally with professionals, including psychologists. Grace (188) felt her client's negative experiences in other relationships as "*one of the biggest things*" that she had noticed about working with individuals with learning disabilities. She described how the bad experiences her clients may have had effects what can happen between her and the client negatively. Grace felt that if individuals with learning disabilities had encountered strangers in the past who had been "*rude to them*" (212) or called them by "*derogatory labels*" (170) it may take longer to develop a therapeutic relationship. This is because the therapist needed to "*break down some barriers*" (170) and scepticism (176) that these negative relationships have created.

Mac, Grace and Nehla identified that client's have often had negative experiences within the setting in which they work, which they recounted as negatively influencing their own therapeutic relationship.

"... he was quite scared of my title as a psychologist. Because he had seen other psychologists before and at one point he said to me 'they ask me too many questions'..." (Nehla 456)

In addition, Kevin's account captured how the role of negative relationships influences his therapeutic approach and technique, particularly relating to the use of silences in his work.

"Because silence for somebody with a learning disability... they're more likely to have experienced people not talking to them, they've more likely experienced sitting in a room with somebody who is an authority figure and either been talked at or ignored." (Kevin 413)

ii. Lacking depth

Strongly prevalent within the narratives was the suggestion that individuals with learning disabilities do not have the experience of depth within their relationships.

"I think that also, our clients don't tend to have had the experience of a, of a long-term committed, understanding, supportive, empathic you know, that sort of environment." (Joanna 337)

Kevin described a scenario between individuals with learning disabilities and their support workers sitting in his waiting room, which emphasised his belief concerning the lack of depth in relationships. He identified how support workers may be with their client "*in body but not in mind*" (452), describing how the scarce interactions that take place, lack depth, meaning and quality. In addition, Kirsty (242) suggests the difference and opportunities within relationships that impede depth when an individual has a learning disability.

"They certainly don't often pick up the phone to somebody who can sit and listen."

Kevin was able to articulate a theory as to why the relationships that individuals with learning disabilities may be lacking in depth. He understands this limitation in relationships through the futility that people associate with the life of an individual with a learning disability. This results in avoidance and a lack in depth due to the perceived difficulties in talking about such losses.

> *"Because there is nothing that can be done about a learning disability. There is nothing that can be done about the fact that you might not have children or the fact you might never get married or might never leave home or you might never have a house of your own and so on. So people don't talk about those things ..."* (Kevin 244)

iii. Inconsistent

Particularly prevalent in the accounts of Nehla and Joanna was the belief that many of the relationships individuals with learning disabilities experience are inconsistent. Nehla identifies how staff turnover throughout the setting impacts upon client's ability to trust and 'open up' within relationships (124 & 129). Joanna's account reiterated this belief and identified how the frequent loss and change within the lives of individuals with learning disabilities makes the therapeutic relationship a challenge to develop.

> *"...there is even more of a challenge to build that bridge. Because they're expecting you to leave before you've even started in a way."* (Joanna 114)

Sub-theme 4b:

The First Relationship

There was an array of evidence from participants that individuals with learning disabilities have limited experience of a relationship like that of a therapeutic relationship. It was emphasised within the data that the therapeutic relationship was a novel experience for the clients and often the first relationship of this nature, a relationship where they are given time and are central to the process.

Kirsty identified how the therapeutic relationship can initially be bewildering, anxiety provoking and a surprising experience for clients (158).

> *"And I think for some of them its 'goodness me what's this all about', you know, somebody's sat here listening to me, that's never happened."*

She described a lack of "*opportunity*" (215) for her clients to have such meaningful interactions. Mac's account (103) reiterated this and described frequently working with individuals who find the therapeutic relationship 'unusual' or a new experience. He felt that it was 'rare' for individuals with learning disabilities to have one to one time for an hour, to sit and talk about themselves. He identified that whilst clients may find it daunting they predominately value this experience.

Kevin's account emphasised a belief that individuals with learning disabilities may not have any expectations of therapy, any expectations they do have are concerned with a belief that the interaction may not be meaningful (456).

> *"And I guess the role of the, the, the relationship is, is to help people see that they are not always in an environment where their voice and what they say is secondary to other people, that's primary, and that its important."*

Joanna (339) emphasised the significance of this first experience for her clients, in terms of value. She described how the therapeutic relationship and the therapist themselves are highly valued by the individual; this in turn appears to contribute to her experience of the work being rewarding. It is felt that this first experience of this nature of relationship sets the scene for later attachment issues[35].

> *"Often it might be the first time that that's happened so, I think the level to which you're valued as a therapist as well is huge. I think that's very rewarding."*

[35] These are explored further in Master Theme 6.

Sub-theme 4c:

Social Naivety

Some participants spoke of a sense of social naivety in the form of honesty and openness when developing therapeutic relationships with individuals with a learning disability. Bill was explicit that this social naivety impacts upon the therapeutic relationship in a positive way, describing the interactions are "*more straight forward*" and with greater clarity (299).

> "*...because of perhaps some social naivety they're open about their feelings or their experiences in a way that people that don't have a disability sometimes are not. So there can be a ... a really delightful kind of openness and connection and truthfulness about how it is.*"

Nehla also identified the positive influence of social naivety upon the therapeutic relationship, describing it as "*liberating*" (141); she was also specific that this was a trait associated to individuals with a learning disability. She also illustrated her experiences with an example (refer to 143).

However, Nehla showed awareness of the negative consequences of this social naivety in terms of confusing the therapeutic relationship with friendship. She identified a need to offer clients clarity as to her role and the limitations of this role, such as not attending parties, as perhaps a support worker might (652).

This sense of social naivety was also captured in other participants' accounts who felt individuals with learning disabilities may possess inaccurate expectations about the therapeutic work. Kirsty used the example that individuals may expect to be "*told off about a problem that they've got*" (203). Abby's account (382) also described a fear concerning the ambiguous nature of the therapeutic relationship for someone with a learning disability. In addition, Abby described how easily individuals with learning disabilities are predisposed to self blame during the development of the therapeutic relationship. She illustrated this in an example in which she fed back to a client her experience within their therapeutic relationship (111). This was something also

alluded to within Mac's account. He identified an experience that individuals with learning disabilities may often be hyper vigilant to inadvertent criticisms (720).

Master Theme 5:

Therapeutic Approaches

Participant's spoke of a number of therapeutic approaches and techniques within the data. Some participants described a need to be directive within the therapeutic relationship, whilst conflictingly other participants reported being heavily client led. It was felt that participants' theoretical orientations were a salient and mediating factor within the therapeutic approaches they adopted[36]. Participants also identified particular tools and techniques, to aid the relationship and therapeutic work. In addition, appropriately accessible language and alternative communication methods were also described as important.

Sub-theme 5a:

Directive

Some participant's were explicit about their directiveness within therapeutic relationship. Kirsty reflected upon her own approach, describing herself overtly as more directive when working with individuals with learning disabilities (314), this is comparable with her adopted theoretical orientation of cognitive-behavioural therapy. She described this as asking "*very direct questions*" (283) and working like a "*detective*" (284) and "*probing*" (321) more than with non-learning disabled groups. She identified a number of skills needed for this approach.

> *"...your always having to, with our clients, having to almost second guess and give a range of options for them to choose which is the best, what your best hypothesis is."* (Kirsty 289)

[36] Please refer to 'Methodology section 3.3 for a table depicting all participants' orientations.

In addition she identified a need to implement an agenda and structure within her therapeutic work in order to provide clients with a safe and predictable environment, something she felt they may lack in other areas of their lives. She acknowledged that this approach was also influenced by the CBT methodology (334).

Bill's account captured this requirement to be direct, though his data did not use this exact terminology, he used words like "*persistent*", a need to "*stick with it*" and be "*dogged*" (443).

Participants were able to offer a rationale for this therapeutic approach, predominately identifying the individual's learning disability as responsible for their need to be more persistent. Kirsty explained that her directiveness was as a result of her client's limited "*insight*" into their difficulties (286). Within her account she reflected on whether she should be as directive but acknowledged it was the most successful way she had experienced of working with individuals with learning disabilities. This suggests that this need to be directive and persistent with their clients is almost a compensatory strategy, developed by therapists to account for the limitations and loss of skills inherent in the learning disability. Kevin illustrates this in his account, whilst discussing his beliefs concerning the use of silences with individuals with learning disabilities (465).

> *"Rather than sit and wait for what will, invariably not happen. Because the client isn't thinking in an abstract way about what that might mean, isn't bringing other things, isn't working things through in the same way as somebody else..."*

In addition, within Bill's narrative and his use of the word "*carry*", there exists a further suggestion that this is a compensatory strategy adopted by therapists as a result of the learning disability (272).

> *"...the person with a learning disability may not always see the benefit of persisting or umm, it might be some umm, ... umm, effort on part of the therapist to carry the person to a point where they can then see that its worth them investing in it."*

Sub-theme 5b:

Collaborative

Paradoxically, Nehla and Mac emphasised greater collaboration within the therapeutic relationships. In addition, Mac described a predominately person-centred approach to psychological therapy with individuals with learning disabilities and a desire to be non-directive as far as possible (191).

> *"I think that one is almost like in an interdependent relationship for me. Because I very much need the clients help...."*

He expressed a belief that it is important for the client to feel they have contributed to the therapeutic relationship in order for it be a meaningful and valuing experience for them. He described how this might be achieved through the development of the client's goals (110)

> *"And I strive to make that quite valuing in so far that I am always interested in what the client wants to achieve rather than what I want to achieve initially."*

Both Nehla and Mac also talk about the influence of power and authority within the therapeutic relationship. They identify a power imbalance which provides them with a catalyst to work more collaboratively. Nehla describes her need to overcome her doctor title and the assumptions a client may have as a result of it, such as the fact she might "*know everything*" (222) should be an "*expert*" (220) and may "*tell them what to do*" (195), as opposed to working collaboratively. Nehla described herself as a predominantly cognitive-behavioural therapist. Within Mac's account he described ensuring the client's maximum involvement in the therapeutic relationship and the process of psychological therapy in order to achieve collaboration (639).

Sub theme 5c:

Tools & Techniques

Participants were able to identify a range of tools and techniques that support them in the development of the therapeutic relationship and the therapeutic work itself. These included widget and bliss standardised computer software (Bill 349), storyboarding (Bill 377), rehearsing work (514), wipe boards (Nehla 205), talking mats communication tool (Mac 444) and drawing (Joanna 119). Abby (58) identified how therapists working with individuals with learning disabilities dedicate a great deal of time developing their therapeutic techniques and tools.

> *"However, in learning disabilities, I think we spend a lot of time, and a lot of extra time planning how we are going to present material to a client and how we are going to explain what therapy is on offer."*

There was a suggestion of the need for a great range of skills amongst participants and a need to be creative and flexible within the therapeutic relationship and during the delivery of psychological therapy.

Sub-theme 5d:

Language

Strongly prevalent in all narratives was the importance of language when working with an individual with learning disabilities. It was identified not only as important to use accessible language to avoid confusing clients, but also how the use of a client's language by the therapist can facilitate the development and maintenance of the therapeutic relationship.

Bill (737) described using language that is *"...plain and simple"* he also identified with using slang or colloquialisms. Joanna (232) recognised the importance of using simple short words and sentences and the need to avoid using abstract ideas. Grace emphasised the importance of assessing and understanding her client's use of language. She described an individual she worked with who confused the words angry and sad (162).

Kevin and Joanna additionally felt there to be a link between finding a common language and the development of the therapeutic relationship.

> *"And when we have a mutual language, then that's how the relationship begins to develop."* (Kevin 217)

> *"Because I think with anybody that you engage in a therapeutic relationship with, you search for a common language and you find yourself mirroring..."* (Joanna 228)

Whilst it was not explicitly identified, it appeared that the use of language was significant because of the individual's impairments in communication combined with the intrinsic importance of being able to communicate within the relationship. Kevin's account (621) captured most directly why communication is paramount particularly in learning disabilities.

> *"They do hurt. They do get angry. The do get sad. They do have regret. They do have sorrow. They do have all of the same sorts of things as everybody else, its just the language they have to express that may not be as easily discernable as in some other areas. And I think it's important for people to accept that what we need to do as therapists is to try and understand their language, whatever it is..."*

Master Theme 6:

Difficult

> *"It's probably what a lot of people are going to say, but it can be very difficult."* (Abby 49)

Out of all the master-themes and sub-themes that emerged from the data, this theme was one of the most consistent experiences, common to all interviewees. Participants found the therapeutic relationship with individuals with learning disabilities difficult. Their accounts demonstrated that the relationship is both time and energy consuming and complex. Participants identified that individuals with learning disabilities'

experience of attachment and loss contributes to difficulties within the development, maintenance and ending of the therapeutic relationship. They also spoke of a sense of futility regarding the therapeutic work and relationship, instilled by perceived limitations in achievement.

While participant's were unambiguous concerning their beliefs about the therapeutic relationship being difficult they demonstrated an unequivocal need to off-set this against the rewards they experience. Within Bill's account, for example, there was a suggestion of defensiveness. He seemed unwilling and reluctant to explore the difficulties and was preoccupied with the positive and rewarding elements of his work. This tension was overtly evident within Bill's account but was also apparent in a number of other participants' accounts.

Sub-theme 6a:

Consuming

i. Time

Participants, including Nehla, Grace, Kirsty, Kevin and Joanna, were explicit about therapeutic work with individuals with learning disabilities being time consuming.

> *"It's difficult and it can be slow."* (Grace 452)

Participants identified that all areas of the therapeutic work are more time consuming. They described how the therapeutic relationship is often slower to develop and the assessment is more time consuming, as therapists need to initially assess and explore the client's level of understanding. Being able to formulate the client also takes longer, as does working on and implementing the interventions.

> *"It can take absolutely ages to really kind of have that light bulb feeling where you kind of go 'oh yes, yes its all become clear now'."* (Kirsty 295)

"It's not like in adult mental health where you are given only six sessions. It might take that length of time for just them to feel comfortable sitting in the room with you." (Grace 459)

Kevin (207) identified a need for therapists to be patient and to avoid expecting "*too much too soon*" when working with individuals with learning disabilities. In addition, Joanna (110) acknowledged a need to be committed and dedicated to clients for the "*long-haul*". Within her account she explored the need to wait for emotional congruence within the therapeutic relationship. She described how this could take anything from a few sessions to a year to achieve (271).

"...I suppose it feels like a, a waiting, just waiting for someone to arrive almost..."

She also considered the need to maintain expectations at an appropriate level, and used the term "*baby steps*" to emphasise the nature of any changes. She seemed to acknowledge these small developments as great achievements for herself and the client.

ii. Energy

Many of the participants suggested that therapeutic relationships with individuals with learning disabilities could be energy consuming; this was captured most explicitly by Kevin and Bill.

"It's not that it's difficult. It's that it's demanding, in a way. That you can't float. You can't just breeze through it. You can't pretend. You have to be in it." (Kevin 264)

When Kevin reflected upon this further he suggested it was an experience specific to working with individuals learning disabilities. He felt that without dedicating this additional energy and concentration he might "*lose*" the client (282). His account seemed to emphasise a responsibility he felt to ensure the success of the therapeutic work and to compensate for the client's learning disability, describing it as

"*incumbent*" (283) on him to be focused and alert during the work. He confirmed within his account that it is "*tiring*" work (293).

Bill was explicit about the work being a "*difficult process sometimes*" which expended "*a lot of energy*" (202). He also identified a need to be more flexible than in other settings. Similarly Bill found the demand for heightened concentration contributed to the difficulty of his work.

> *"You concentrate and you try to, umm make a connection with the person and your listening to what they're saying and you find it hard to listen because perhaps their speech impediment makes it difficult to actually understand what their saying. You know. You're trying to, to, to help them form the thoughts that they are putting forward, it's intensely hard work."* (Bill 624)

Sub-theme 6b:

Complexity

Therapeutic relationships with individuals with learning disabilities were also described as complex. Kevin (102) expressed a belief that therapists should posses an experienced background in order to deal with the complexities and demands of working with individuals with learning disabilities. The complexities described in participants' accounts could be understood with the use of theoretical concepts such as transference, and countertransference, though these terms were not directly referred to. Bill (329) alluded to how a person's learning disability may project onto the therapist, he described the need to be careful not to be *"...disorientated yourself by the disorientated person."*.

Joanna highlighted how she could often feel engagement in "*very complex dynamics*" (301) within the therapeutic relationship, referring to key themes such as abuse, rejection, attachment disruption and loss. She identified these as being difficult dynamics to operate under comfortably. Joanna and Mac also revealed that they can sometimes personally experience some of the difficulties and traumas that the clients have been through.

"...if you're responding empathically enough and genuinely enough in that therapeutic relationship, I think you often feel echoes of what the client is feeling, you often feel echoes of what the clients experienced." (Mac 250)

Joanna's account went on to identify further complexities of working therapeutically with individuals with learning disabilities. She identified a need to manage human's instinctive nature and acknowledged the therapist's possession of contempt for individuals weaker than themselves (358). In addition, Joanna identified the concept of secondary handicap and its complex influence upon therapeutic work (105) Her interest in these dynamics are a reflection of her psychoanalytic orientation.

"But then over the course of time you begin to see that actually there is a secondary handicap, i.e. the way they feel about their learning disability is more severe than actually the original learning disability."

Kirsty's account identified how the learning disability itself is the complexity and ultimately responsible for creating difficulties. She identified how the individuals' limitations, such as being unable to verbalise their experiences (164) and display insight, (147) as responsible for the difficulties she has experienced. Bill summarised a similar experience in his account by describing some of his clients as "*hard to reach*" (261).

Sub-theme 6c:

Attachment & Loss

Prevalent in the majority of the participant's narratives was the significance of loss for individuals with learning disabilities and the consequences of this upon the development of the therapeutic relationship and their attachment to the therapist.

Joanna described the difficult task of developing a therapeutic relationship with individuals who have a "*whole history of loss*" (168) and "*attachment disruption*" (145). Kevin used the term "*multiple losses*" to capture his belief that individuals with

learning disabilities not only deal with symbolic loss, such as the loss of the perfect self, but also experience greater prevalence of actual loss (94).

Mac discussed the losses that individuals with learning disabilities, their families and the professionals involved with them, may experience as a direct result of the learning disability itself; and the associated difficulties in coming to terms with such loss. He used the example of a client striving to meet the expectations of their family and society (733).

It was felt that through a combination of loss and previous negative experiences in relationships, the individual with learning disabilities may naturally become attached to the therapist. This was captured within the data, however, it was also clear that the therapists themselves became attached. This was particularly captured in Nehla's account. She described an inherent need in individuals with learning disabilities to develop and attach to a meaningful relationship (692). Her account was explicit when she described endings being hard for "*both myself and the clients*" (706). Part of her rationale behind this experience was acknowledging the importance and significance of her relationship with her clients:

> "*It's quite hard to leave people, because I feel quite sad or umm, because you have developed such a good relationship with people*" (737).

Kirsty also captured this sense in her account, acknowledging the "*special place*" (251) and the "*very privileged position*" that she feels she is in as a therapist (262). She reflects on why this is difficult:

> *"On the other side though, it makes me, its sad, that there isn't anybody else there for the clients and I just kind of think, I don't see all the people with a learning disability here, what about the rest of the population who aren't having that opportunity."* (Kirsty 253)

These identified feelings of attachment and loss are further emphasised by participants' beliefs that the therapeutic relationship is the first relationship of its kind of individuals with learning disabilities[37].

Sub-theme 6d:

Futility

> *"I think, someone once likened working in LD to working in palliative care. I can kind of see why. There is a sense of futility I think. Things aren't going to get better for a lot of people, they're not going to wake up tomorrow and their learning disability is going to be gone, you can't give them a magic pill or a course of therapy that's going to mean that they can go and get a job, get married, have children you know. And I think you are, you are just a bit subject to that. I think it's quite a burden, not only, obviously for the individual clearly it is, but I think for services and individual clinicians, there is a sense of burden a lot of the time."* (Joanna 509)

Joanna's account describes a sense of hopelessness regarding the very nature of working with individuals with learning disabilities. She also alludes to a desire to cure people of their disability. Without the ability to cure or make dramatic changes to individuals' lives she seems to feel the weight of responsibility and futility. Similarly, Kevin identified that ultimately the learning disability would not "*go away*" (378) and that improvements in people's lives are only very small. Curing the individual of their learning disability seems to be an unconscious aim or desire that therapists posses but this is entirely futile.

Other participants also address this sense of futility, hopelessness and negativity. Kirsty, describes never having felt the experience her clients have of "*failing at every step of the way*" (521) and the "*daily battle*" (527) that she believes individuals with learning disabilities live with. Kevin is explicit that this sense futility and the

[37] Please refer to 'The First Relationship' 4.b.

experiences that individuals with learning disabilities have had, is often quite difficult to cope with as a therapist.

> *"You have to see somebody who's damaged and that damage is, is palpable and that is perhaps what's difficult to deal with. The reality of seeing somebody whose life has not had a chance right from the beginning, is, is quite difficult to cope with ..."* (Kevin 387)

Kevin goes on to identify how other people are able to distance themselves from the learning disability by objectifying or infantilising (383). However it is evident that this is not something he is able to do when engaging in the therapeutic relationship. Bill acknowledged that sometimes therapeutic work *"just doesn't work"* (211) he alluded to this being difficult to acknowledge and accept. Additionally, when participants felt that they had made progress within the therapeutic work, their efforts seemed inconsequential and futile in light of impact of their learning disability. Joanna described the difficulties associated in sustaining any gain (491).

> *"You might work on a whole series of loss and traumas but then they are going off - back to continued loss and trauma."*

Kevin (480) identified the need to acknowledge with his clients that as a result of their learning disability they are likely to continue to experience disempowerment and poor treatment by others and that despite their therapeutic work *"nothing actually will change"*.

Master Theme 7:

Individualisation

Throughout participants' accounts there was a persistent need to recognise the individuality of the therapeutic relationships they had formed with people with learning disabilities. There was also an emphasis on the individual and reluctance from participants to generalise. Participants also emphasised a conflict between

acknowledging the dichotomy of learning disabilities versus the similarity and comparability with the non-learning disabled population.

Sub-theme 7a:

Recognition of the Individual

Throughout the interview data there was a strong recognition of the individual. Participant's emphasised the importance of individualised approaches to the therapeutic relationship and therapeutic work. A need to adapt work to each individual client's strengths and weakness was identified. This suggested a flexibility amongst therapists to create and work with individual differences. Whilst this was evident in all the participant's accounts apart from Joanna, it is best captured in the following quotations.

> *"You can't just bolt on things, it just doesn't work. Everything is tailored made really..."* (Bill 206)

> *"Umm, but I, I think a one size fits all approach doesn't work ..."* (Mac 462)

Grace identified a need to assess the client's abilities and adjust her approach as necessary in response to their level of understanding (259) and warned against making the type of assumptions about an individual that might be made in non-learning disabled settings (290). Both Grace (278) and Kevin (197) suggested that it is not possible to use the same materials with different clients but there is a constant need to adapt and individualise:

> *"Because, you cannot come into a room with somebody and think 'ok I'll just work the way I did last time'."*(Kevin 197)

Not only did participant's accounts specify their recognition for individual differences in terms of their approach to the therapeutic relationship, it was also evident in some of their response within the interview. Some participants experienced difficulties in

generalising their experiences and in answering some of the interview questions acknowledged individual differences.

> *"I think its, it's a qualitative experience in its self. Its not something that its always like this, because I think it's different in, in each case, umm."* (Mac241)

> *"...well, I don't think it's a one size fits all kind of answer to that you know, I think you see and infinite amount of variation"* (Bill 291)

This desire for individualism and the perceived hesitancy to generalise people with learning disabilities is complicated further by the following sub-theme which captured participant's concern for an approach to collectivism.

Sub-theme 7b:

Similarity vs. Dichotomy

Within the participant's data there emerged a struggle concerning how best to view individuals with learning disabilities collectively. Participants displayed tensions between recognising individuals with learning disabilities as different from the non-learning disabled population and a desire to view them as the same. Whilst some participants aligned themselves to one belief during their interview, others switched between the opposing positions during their accounts. Mac & Bill presented a belief that there is no dichotomy or delineation between individuals with learning disabilities and those without.

> *"Because I'm not sure there is this dichotomy between people with learning disabilities and people without learning disabilities. I think its probably a continuum..."* (Mac 352)

> *"I'm not really big on things being that different. No. Methods might be a bit different but the core isn't I think ..."* (Bill 748)

Both Kevin (406) and Mac (351) also emphasise how they have tried to work with individuals with learning disabilities in exactly the same way, as much as possible, as those who do not have a learning disability. This approach possibly reflects Kevin's social constructionist ideology. Mac alludes to his frustrations with services and describes a desire for integration with other services for people without learning disabilities.

Within Joanna's account she acknowledges some of the differences between the delivery of psychological therapies for individuals with and without learning disabilities, sighting differences in time frames, boundaries and confidentiality. However she stresses that despite this the "*fundamental qualities*" of the therapeutic relationship that she is striving to develop are no different (205). Bill's account is similar as he emphasises how the therapeutic relationship is no different, describing "*the nugget of feeling*" (735) as being no different.

Paradoxically, Kirsty expresses a wish for the difference between individuals with learning disabilities and mainstream adult mental health to be asserted. She described "*huge differences*" (494) between individuals with and without learning disabilities and alluded to a frustration at a lack of recognition for this, describing learning disabilities services a the "*poor relations to adult mental health*". She went on to question why there is no assertion that individuals with learning disabilities are "*different*" (490). Kirsty additionally explored her frustration with the approach of adapting mainstream psychological therapy for individuals with learning disabilities. She questions why a specific theoretical model has not been developed for learning disabilities. Abby (149) summaries the lack of simplicity concerning this debate in the following quotation:

> "*... I don't know if it's as simple as thinking, 'oh learning disability its this' 'in the general population its that'.*"

Within Joanna's account she displayed strength in her conviction concerning the negative implications of collectivism and labelling (69).

"...people are just people and categorising people into having, defining them by their learning disability is not actually very helpful, its quite disability in general."

Both the desire for individualism, captured in both the participant's explicit reports and hesitancy to generalise, combined with the struggle for appropriate collectivism, between recognising individuals as a different collective or the same collective as non-learning disabled populations, is of particular interest. The data captures this tension between individualism and collectivism, something which appears uneasy for the participants. There is a sense that the participants have their own profoundly individualistic nature as therapists which creates an additional dynamic to their beliefs.

Master Theme 8:

Therapist's Motivations & Values

At the start of their interview participants were asked to talk about what attracted them to work with individuals with learning disabilities, much of their responses were brief and circumstantial. The majority of the data that contributed to the current theme emerged during later stages of the interview without direct prompt. This suggests that the therapist's motivations and values and the relevant clusters that appeared within the data, form an intrinsic part of their overall work. It suggests that these motivations and values ultimately not only impact upon the therapeutic work but additionally the therapeutic relationship. The identified clusters were sub-themed as follows: the historical position of individuals with learning disabilities, satisfaction and reward of the work and the familiarity within the specialist field of learning disabilities.

Sub-theme 8a:

History Context

i. Emotionally Provocative

Strongly prevalent in the accounts of Mac and Joanna are their views concerning the historical context of people with learning disabilities. The data captures, to a degree, what was clearly an emotionally provocative topic.

Within Mac's interview he referred to the history of people with learning disabilities and the social stigma associated with learning disabilities as making unpleasant reading (773). Within his account he referred to the mass institutionalisation of people with learning disabilities (757), how members of the public would pay to watch people for entertainment (756) and the "*horrific*" and prolific physical and sexual abuse (692). In addition, Mac recounted what he believes the "*biggest day on history*" (760) for individuals with learning disabilities when the first of all the Nazi Germany gas chambers were used to "*slaughter*" tens of thousands of individuals with learning disabilities. Mac identified how the history and remaining social stigma concerning learning disabilities impacts upon a client's presentation within the therapeutic relationship (725).

> *"And umm around attitudes towards people with learning disabilities. That comes in a lot into the relationship and the work that I do with clients."*

In addition, Mac identifies a link between the historical position of individuals with learning disabilities resulting in a later need for psychological therapy. He describes how the abuse these individuals are often victim to "*sets the occasion for people needing later psychological umm input*" (693).

The historical context of people with learning disabilities appeared to have particular resonance for Joanna as well, citing similar episodes in history as Mac. She used words within her account which emphasised the emotionally provocative nature of the history, "*disgraceful*" (467), "*hideous*" (470) and "*unbelievable*" (473). Similar to Mac, Joanna also identified how, as a result of the historical position of people with learning disabilities, there is a greater need for psychological therapy (474).

> *"...a group of people who have a history of being so neglected and abused even more so need the opportunity to, to talk about their lives and their*

feelings and try and link up what they think and feel more. Umm. So I think it, it makes me feel more committed to it I'd say."

There was a sense of disbelief and shame evident in Joanna's account, this appeared as a catalyst for her commitment to working in the field and a significant motivating factor similar to some form of moral obligation (466).

"I think it makes me want to champion it even more... "

ii. Evolving Services

There was evidence within the data that historical shifts in the position of individuals with learning disabilities have facilitated a large degree of change within services. This was particularly relevant to Mac, who was able to reflect on the developments within society as a whole and subsequently service changes. He also identified the need for continued growth and development (713).

"So, so you know we are evolving, services are evolving I think, umm, and long may it continue and long may the inclusion continue too, you know."

Within the interview he was able to reflect on how the evolving nature of services over recent years have been a contributing factor to his motivation to work within the field and have kept him "*excited*" (68).

"... more that I think about it maybe that's also what attracts me to this area of work. Because I think there is so much to discover, there is so much to, that, that there's so much, there's so much, there's so much good practice yet to be discovered." (777)

Mac is seen to have felt highly motivated not only by the evolving service he works within, but predominately as a result of the historical treatment of people with learning disabilities. There is a suggestion in his data of optimism in the face of adversity from the past and a degree of responsibility to further develop services. It seems he is making sense of the past through putting his energies in the future.

This motivation for disempowered people is something Kevin touches upon within his account of working in the field. He describes a belief of people with learning disabilities being at the "*bottom of the pile*" (132), *"Without people being umm, either enthusiastic and skilled, hopefully both, they weren't going to get a good deal."* (133). This account also holds a suggestion of obligation concerning the support of individuals with learning disabilities.

Sub-theme 8b:

Satisfaction

Working with individuals with learning disabilities was highly satisfying experience for the participants and was made explicit within the majority of the accounts, using terminology such as very or incredibly "*rewarding*" (Nehla 330, Grace 475, Joanna 335).

Participants were also specific in identifying the therapeutic relationship as the fundamental element that made their work a rewarding experience for them, as it is often the first relationship of that nature for their client. Nehla (740) described how the difficulty of ending the work with a client is counterbalanced with the feeling of reward that a "*good thing*" has happened. Joanna framed her feeling of satisfaction in terms of the value her clients place upon her and their relationship (345).

> *"...it makes you feel valuable and there's something about, you know my own narcissism that quite likes that (laughs)."*

Mac identified his satisfaction in terms of the client overcoming "*hurdles*" that are initially seen as insurmountable (253). Bill describes the work as having "*fulfilled*" (108) him as a result of a sense that he feels he has been "*contributing to society*" (107). This suggests some level of societal responsibility or obligation concerning working with individuals with learning disabilities.

Kirsty understood the reason behind staying in the field for eight years as the variety in her work. She also identified how other settings have not been able to provide her with equal satisfaction and suggested limited empathy for working with individuals without learning disabilities (86).

> *"I love the variety and I love the everyday is different and it's a whole range of issues that I work with. Umm, I couldn't work in adult mental health, that would just, bore me, bore me rigid."*(75)

The majority of the participants lacked clarity in their understanding as to what had resulted in them choosing to work with individuals with learning disabilities, there was a sense within some accounts such as Kirsty's that it was an unintentional decision, but the subsequent level of satisfaction had contributed to her remaining in the field, outweighing any of the difficulties identified in theme 6.

> *"...it wasn't something that I had always wanted to do but once I started doing it I think I was converted."* (65)

Sub-theme 8c:

Familiarity

All participants reported to having had some degree of experience or familiarity with people with learning disabilities prior to working as a qualified counselling psychologist. Mac, Abby, Kevin and Nehla all reported to having worked as some form of support worker for individuals with learning disabilities and or physical disabilities during their lives. In addition, Grace, Joanna, Abby, Mac, Bill and Kirsty experienced working with individuals with learning disabilities as assistant / trainee psychologists.

There existed a possible pattern within accounts and a suggestion at the longevity involved in working with individuals with learning disabilities. Mac had worked in his team for seven years, four post qualification; Bill had eighteen years experience, six post qualification; Kirsty had eight years within her team, five post qualification;

Grace had three and half years experience, two post qualification; Kevin had eleven years experience, nine post qualification. The distinction was less clear with the others, though Abby had five years post qualification experience, Nehla two years and Joanna seven years. This reiterates the point made earlier by Kirsty that she had been "*converted*" (65) to work in learning disabilities, as it appears that many of the participants are long-standing employees of the field.

Participant's early experiences and familiarity were felt to have led to an interest in working in the field. Mac described his experience as a care worker during his teenage years resulting in a foundation of knowledge in the field. There is a suggestion in his account that his early experiences resulted in familiarity and comfort associated with his skills in this field (46).

> *"...I would more frame it in terms of familiarity, and, and what, I, I suppose is that I was drawn into this work because it was what I, what I knew really. It was originally back when I was a teenager as a care assistant."*

Bill was the only participant to share how experiences within his personal context had influenced his decision to work in the field, when he described a family friend (87):

> *"...I knew and know a person with a learning disability, well all my life. Well, my neighbour, a girl of my age, almost identical, two months younger than me I think."*

He identified how familiarity in terms of 'growing up' (92) with an individual with learning disabilities had made him aware of its existence (97). It is also interesting how Bill identified with this person describing them as "*identical*" apart from a two months age gap and a learning disability.

It was noted that consistency amongst the participants to stay within their teams and within the setting of learning disabilities contrasted against their previous acknowledgement for the inconsistencies and staff turnover that people with learning disabilities often face in relationships (theme 4). This suggests a need by participants to impose some form of consistency through their long-serving positions.

Master Theme 9:

Therapist's Needs

Participant's identified a number of needs for themselves whilst engaged within therapeutic relationships with individuals with learning disabilities. In particular, clusters emerged concerning supervision, reflection and introspection and a search for knowledge.

Sub-theme 9a:

Supervision

Supervision was felt to be an important need for participants engaging in therapeutic relationships with individuals with learning disabilities. The narratives accounted for the significance of supervision in terms of the difficult nature of the work, this is captured within Joanna's account below (183).

> *"... it can be very frustrating, you need good supervision I think, to do this, this sort of work."*

Joanna described a number of needs that she felt were necessary in order to provide psychological therapy to individuals with learning disabilities and engage in therapeutic relationships. She identified supervision as supporting her to manage and deal with a variety of complex issues that have made her feel a "*whole rainbow of feelings*"(325). Joanna also highlighted how her own personal therapy (191) had aided her in understanding some of her experiences within therapeutic relationships with individuals with learning disabilities. This has included exploration some of her own disabilities which has enabled a better understanding of her reactions to other's disabilities. This is an interesting point to consider as not all therapists working with individuals with learning disabilities have received personal therapy.

Nehla also identified how her experience such as that of frustration (136) are supported through supervision and additional group supervision she attends (173). She describes her group as her "*sanctuary*" (373) emphasising the importance which she attributes to it.

Abby felt her own need to "*debrief and reflect*" (510) after difficult clients but a lack of opportunity to do so. She describes a culture of highly driven clinical supervision due to the dominance of clinical psychologist in the field, with limited opportunity to reflect (517).

Sub-theme 9b:

Reflection

Participants' need to reflect upon sessions with clients was identified as an important element to their work. Different methods were identified by participants in supporting them in their need to reflect.

> *"After a session, sometimes I like some time to sit and reflect and write my notes a couple of hours later, so that I can digest them."* (Abby 485)

> *"I'll write something down, I'll go to the kitchen, have a coffee, share a joke. And then you, that's a way of unwinding and then I can get my head together for the next client coming in."* (Kevin 332)

The use of the word "*digest*" and "*get my head together*" suggests a need to understand the process that has taken place. Both Abby (487) and Kevin (322) additionally identified the need for a space between sessions and their experienced difficulties in going from one client to the next. This need suggests the cognitive weight of the therapeutic work and their identified need for self care.

Kevin's also spoke of a need to examine his own thoughts and feelings concerning if he or a family member had a learning disabilities. It was suggested that he should

attempt this level of introspection to avoid his pre-conceived ideas about how people should react, influencing negatively upon the therapeutic relationship (668).

Joanna's narrative emphasised the importance of conscious acknowledgement and reflection upon some of the feelings she experiences when working with individuals with learning disabilities. She was direct and honest about some of her experiences (362).

> *"...sometimes you can look at someone and sometimes you can feel revolted, someone's got food on them, their dribbling a bit or you know, maybe they've wet themselves and your job is to find some, some, some love for someone it can be difficult to do. You can feel contempt in a way. I think again its something you have to acknowledge and hold and be conscious of umm, and work with it."*

Joanna also identified the importance of reflecting upon her own disabilities in order to manage the primitive instinct of contempt for those less able. She described it as highly complicated and suggested a need for sophisticated self introspection for such issues to be prevented from impacting the therapeutic relationship negatively.

Sub-theme 9c:

Search for Knowledge

i. Uncertainty & Lack of Research

Participant's described a search for knowledge due to feelings of uncertainty as to their approaches to psychological therapy and the therapeutic relationship with individuals with learning disabilities.

A number of participants cited the general lack of research in the field as a need and as responsible for contributing to feelings of uncertainty. Grace (409) was explicit in identifying a need for research from a counselling psychologist's perspective; whilst Kirsty (459) expressed a wish for research from the client's perspective, concerning

their experiences of therapy. Kirsty (474) also described a need for standardised assessment tools specific for learning disabilities; she alluded to frustrations concerning merely adapting that what is used with non-learning disabled individuals.

This was something additionally illustrated in the account of Abby (86) who described the limitations in merely adapting approaches used with non-learning disabled, specifically with regards to the therapeutic relationship; she highlighted the lack of literature and her lack of training as contributing towards her uncertainty. Both Nehla (72) and Abby (90) were explicit in their accounts that their training did not include working with individuals with learning disabilities and it was essentially an unmet need.

All these experiences contributed to an overwhelming sense within the accounts that participants were uncertain whether what they are doing was right. This uncertainty was increased as often they were the only counselling psychologist working in their team.

ii. Role of the Interview

The interview provided an opportunity for some participants to reflect on their needs and experiences of working therapeutically with individuals with learning disabilities. It was felt that the interview itself provided a chance for participants to consider elements of their work that they had previously not reflected upon in depth. This was particularly evident in Abby's account, on a number of occasions during the interview, she identified how the interview itself was a catalyst for reflection. She had felt that as a result of working in learning disabilities, in a clinical psychology dominated field she had lost some of the elements or emphasis of her training[38] and the interview had given rise to an opportunity to retain some of these principles. She described the interview as (557):

> *"I think it's been a very useful experience. And it's made me already start to think about, what I am doing with my clients. And I have I lost the culture of training.*

[38] This is explored further in Master Theme 10.

And your questions have led me down that path, to think, about I'm a counselling psychologist, not just an applied psychologist somewhere."

Master Theme 10:

Setting Culture

Participants reported a particular culture in the learning disabilities setting; a professional culture, concerning attitudes and approaches to psychological therapy and the therapeutic relationship. Four sub-themes emerged from their accounts which include: being removed from the person, the position of counselling psychology, disregard for the therapeutic relationship and resources.

Sub-theme 10a:

Removed from the person

Participants identified that the specialist setting of learning disabilities has a culture which is predisposed to the removal of the individual from psychological work. There was a belief that approaches were predominately behavioural and environmental and not necessarily concerned with the individual. Grace (99) was explicit in stating that "*the person is very much removed away from the intervention.*", she went on to discuss how as a counselling psychologist she attempted to challenge this approach which is "*missing the person*".

Bill described not doing as much therapy as he would like to due to the emphasis on responding within the restrictive behavioural paradigm and the concern with "*what can be done*". This is summarised this in the following (410):

"... there's quite a focus on doing, rather than being ..."

Mac was one of a number of participants to highlight the limited availability of therapy for people with learning disabilities (680). Joanna acknowledged the lack of

tradition in offering psychological therapies to people with learning disabilities and the need to "*fight*" and "*justify*" the need for the service (90).

Participants identified that even on receipt of referrals for therapeutic work there existed a level of disregard for the individual. It was felt that clients may simply acquiesce to the therapy referral, even though they may hold a different perspective on the referral issues (Kirsty 183). Mac identified difficulties with the referral process, particularly how this subsequently impacts upon the therapeutic relationship. He described how the referring person, such as a home manager, may refer on the basis of their own belief rather than the wishes of the client. If the client has not come on their on volition this creates another obstacle to be overcome in the development of a working therapeutic relationship (12). Abby identified how the setting culture can influence the therapeutic work; she described how therapy can become concerned with giving advice as opposed to relationship building (73).

Sub-theme 10b:

The Position of Counselling Psychology

Participants reflected on their role as counselling psychologists within the professional setting and their experience and treatment. Within the narratives there existed a sense of counselling psychologists being a minority within the specialist setting of learning disabilities and a number of difficulties were associated with this.

Grace described how people have informed her that the field of learning disabilities is a "*strange*" place for a counselling psychologist to work (81). She attributes this belief to the common perception that working in learning disabilities is removed from the person, concerned with testing and environmental changes, thus conflicting with counselling psychology's philosophy. Despite this Grace believes it as a "*perfectly natural place to work*" (116), as she wishes to advocate on behalf on her clients and provide them the opportunity for a therapeutic relationship (125).

> "*...I find it a natural enough place for me to come in and work. But more so now that I can see other people's perceptions of what a psychologist would do*

in learning disability. Because, and this is not for your data, because of the erm, the focus we have on the relationship."

Kevin shares this opinion concerning the role of counselling psychologists in learning disabilities. He describes a need to promote awareness of people with learning disabilities and a need to help them feel they belong and have a voice (452).

Bill however, is one of a number of participants who express some of the difficulties associated with being a counselling psychologist, a minority, in the setting. He describes awkwardness in questioning approaches and the workforce culture (429).

"All those kinds of questions that a counselling psychologist might ask I suppose about the kind of, err, what the motives are and whose motives are they and what's the direction and what are the motivators. Umm, there's less space amongst my colleagues for hearing that I feel sometimes."

Bill questions himself during the interview, asking if he is really doing counselling psychology work or whether he has moved away from therapy (384). Abby's account goes further to emphasise the disregard that she experiences from her colleagues concerning her position as a counselling psychologist. She alludes to a disregard for her therapeutic work and philosophy as a counselling psychologist (482).

"*That language of 'your doing your touchy feely stuff' or 'oh isn't an hour enough for that'. There is not enough understanding or acceptance that as counselling psychologists we need space, we need time to explore.*"

Abby (455) is explicit that it is a setting which is dominated by clinical psychologists, who she describes as less concerned with the therapeutic relationship, again emphasising the minority status of counselling psychologists. She describes that on occasion her clinical psychology colleagues do not understand her therapeutic and professional needs. This is also reiterated by Grace (512) who describes how professionals find it difficult to understand what they should expect from her.

Sub-theme 10c:

Disregard for the Therapeutic Relationship

Some participants also identified that the specialist setting of learning disabilities has disregard for the therapeutic relationship as a concept.

> *"... other professionals won't understand it very well: 'what do you mean establish the relationship?' So, I find myself up against that sometimes, from people who might see psychologists as going in and testing and changing behaviours and so on."* (Grace 483)

This theme was reiterated in Abby's account. She felt that the setting culture, particularly the emphasis on behavioural approaches, has sometimes made it difficult for her as a therapist to maintain her own philosophical position concerning the therapeutic relationship. She was explicit that the therapeutic relationship can easily be overlooked (53).

> "*...I feel it's something you can ignore if you are not prompted to think about it.*"

She described how this is a significant contrast to working in adult mental health where the therapeutic relationship is "*the first thing*" she talks about in supervision. Abby also recognised the ambiguous nature of the concept of the therapeutic relationship and suggested that a fear of confusing her clients could lead to her overlooking it. Predominately, she referred to experiences in a culture where others did not have a good understanding of the needs of a therapeutic relationship. She recalled how people within her team need to be reminded not to interrupt therapy sessions (475) and how there is a lack of knowledge concerning the differences and varieties of psychological work.

> *"Psychology work, is psychology work. You need a room and it needs to be your room for an hour. I don't think people have deconstructed that any further in terms of sexuality and IQs and asperger's assessments are very different from therapy.*" (500)

Sub-theme 10d:

Resources

The setting culture was also identified as having a bidirectional relationship with resources. Time pressures and the need for service delivery were identified as impacting negatively upon the therapeutic work. Bill (419) and Nehla's (727) accounts suggested that unrealistic demands were placed on services which were difficult to achieve with individuals with learning disabilities. In theme 6 participants identified the time consuming nature of the therapeutic work with individuals with learning disabilities and this concern was again emphasised here.

> *"...I don't think in the NHS, people really respect the space you need."*(Abby 468).

In addition, participants were particularly vocal concerning the limits to environmental and physical resources they have available to them. Bill (146) identified how the local family centre have "*two way mirrors and microphones from the ceilings and cameras and ear pieces*" all of which he would like for his team.

Nehla (553) experiences tremendous difficulty in simply accessing rooms for conducting her therapeutic work. She describes often having to work in the community using inappropriate rooms such as client's homes. She identifies how this specifically influences the therapeutic relationship.

Abby identifies how the rooms in her department are not conducive to therapy or to facilitating a positive therapeutic relationship. She describes how the entire multidisciplinary team share the same meeting rooms (465):

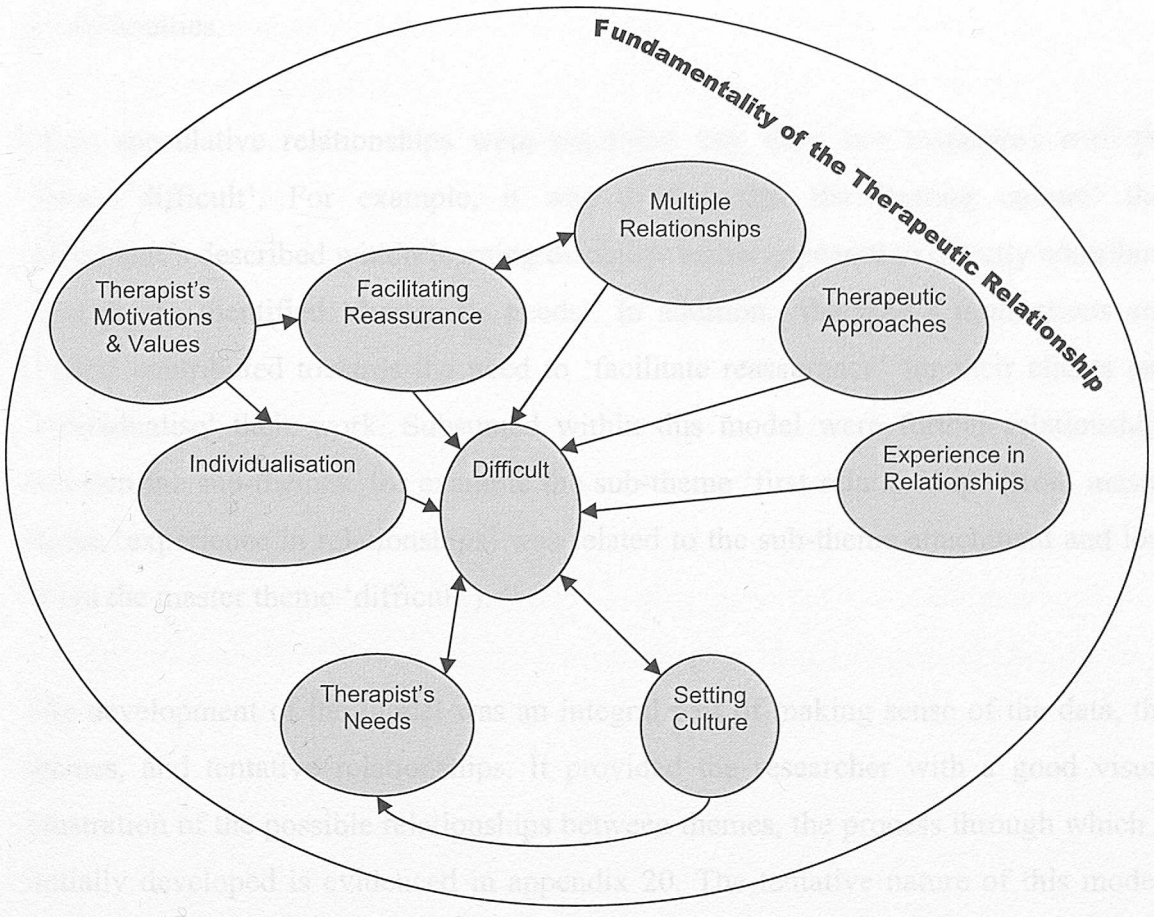
> *"So a client might be sitting in one room talking about sexual abuse, and the next week they'll be in the same room talking about benefits."*

Joanna (82) also identified the difficulties for clients in making therapeutic commitments as they are often dependent on others to support them getting to and from therapy, support which is not always available to them.

The participants were largely dissatisfied with the resources made available to them. These environmental limitations combined with the setting culture including disregard for the therapist, client and the relationship, had significantly undermined the potential for positive therapeutic work to be conducted with individuals with learning disabilities. Some implied that in certain circumstances they would, as a result, avoid therapeutic work, whilst others struggle to challenge the beliefs of others.

Possible Relationships between Themes

During the analysis it became increasingly apparent that possible links and relationships could be made between themes. A combination of explicit suggestions made by participants, and additional interpretation contributed towards the formation of a tentative model of themes associated with the nature and role of the therapeutic relationship when delivering psychological therapy to individuals with learning disabilities:



Nine of the master themes were subsumed by the tenth master theme, 'the fundamentality of the therapeutic relationship', as it was felt that this theme was possibly overarching and influential upon the entire model and all themes. All the nine themes contained within it relied upon the therapeutic relationship's significance.

The speculative relationships between the nine interior themes are represented with connecting arrows which are both unidirectional and bidirectional; this is illustrated by the arrow heads. During analysis it was felt that a majority of the themes were associated with the identification of the difficulties associated with the therapeutic relationship with individuals with learning disabilities. As a result the theme 'difficult' became central to the model with the majority of other themes contribution towards its formation including: individualisation, facilitate reassurance, multiple relationships, therapeutic approaches and experiences in relationships. In addition, bidirectional relationships with the theme 'difficult' were developed with the 'setting culture' and the 'therapist's needs'. For example, the 'setting culture' appears to both contribute towards the therapeutic relationship being 'difficult' but also is a result of the difficulties.

Other speculative relationships were identified that were not associated with the theme 'difficult'. For example, it was evident that the 'setting culture' that participant's described within learning disability teams appeared to directly contribute towards the identified 'therapist's needs'. In addition, 'therapist's motivations and values' contributed towards the need to 'facilitate reassurance' for their clients and 'individualise' their work. Subsumed within this model were further relationships between the sub-themes, for example the sub-theme 'first relationship' (from master theme 'experience in relationships) was related to the sub-theme attachment and loss (from the master theme 'difficult').

The development of the model was an integral part of making sense of the data, the themes, and tentative relationships. It provided the researcher with a good visual illustration of the possible relationships between themes, the process through which it initially developed is evidenced in appendix 20. The tentative nature of this model,

combined with the essence of exploration intrinsic within this study, does not allow for further conclusions from the model at this stage.

DISCUSSION

1. Overview

The themes that emerged from the analysis are now returned to for further discussion in the context of existing literature. Implications for theory, service provision, service plans and training will be explored, followed by a critical evaluation of the study. Suggestions and considerations for future research will then be discussed, together with some final reflections and concluding thoughts.

2. Review of Themes in the Context of Existing Literature

It should be emphasised that people with learning disabilities need to be treated on an individual basis, as there is a great deal of heterogeneity within the learning disabled population. The results of this thematic analysis can be helpful however in gaining knowledge of this population's relative therapeutic engagement as experienced by the counselling psychologists within this study, which in turn will be useful in informing various aspects of the work. Therefore we need to be able to generalise the counselling psychologists' experiences of individuals with learning disabilities somewhat in order to understand possible implications for our clinical practice.

It is observed that psychodynamic theory emerged as perhaps the most relevant and applicable out of all the different theoretical models when relating the ten master themes to literature and theory. This is a possible reflection of the emphasis and significance that psychodynamic theory places upon the therapeutic relationship, coupled with the fact that theoretical developments in psychological therapy have only relatively recently been adapted for people with learning disabilities.

2.1 The Fundamentality of the Therapeutic Relationship

One of the major themes that emerged from the participants' accounts was a belief that the therapeutic relationship was highly significant in the delivery of psychological therapy to individuals with learning disabilities. Participant's identified the therapeutic relationship as central to their work, influential on the outcome and more important than theoretical approaches.

The role of the therapeutic relationship with individuals with learning disabilities has not previously been the focus of empirical research; this theme therefore offers empiricism to the anecdotal views that have previously been portrayed in literature. Participants confirmed Moss' (1998) view that the issues that are important in psychological therapy within the non-learning disabled population, in this instance the therapeutic relationship, should not lose significance with individuals with learning disabilities.

This theme also reflects a meta-theoretical perspective shared by the participants in the study and the counselling psychology discipline, as they both emphasise the value and significance of the therapeutic relationship. It was also interesting that participants described the experience of a therapeutic relationship itself as beneficial for individuals with learning disabilities, regardless of the theoretical framework or whether the initial goals were achieved. This suggested the therapeutic relationship itself possesses strong therapeutic properties, a concept emphasised by person-centred and humanistic paradigms (McLeod 2003). This was a further meta-theoretical perspective shared by the participants and the counselling psychology discipline, as the humanistic value base is intrinsic to the discipline's philosophy (Woolfe 1996).

The findings also suggested that the therapeutic relationships with individuals with learning disabilities may be of particular importance. It was felt that due to the demands placed upon the relationship, such as the use of multiple relationships during therapeutic work and adopted flexibility with confidentiality, there existed a need for a particularly good therapeutic relationship.

2.2 Multiple Relationships

Traditionally, psychological therapy has been concerned with working with individuals in isolation, on a one-to-one basis (McLeod 2003). The results of this study suggest that this practice is altered when working with individuals with learning disabilities. One participant, Kevin, described the use of multiple relationships in the delivery of psychological therapy to individuals with learning disabilities as creating 'staggering differences' in comparison to other settings, such as adult mental health. Participants identified that developing a triadic relationship, facilitates comfort and reassurance, in addition to providing reinforcement to the work. Participants felt that the systemic relationships available to the individual should be involved in the therapeutic process in order to ensure that advances made during therapeutic work are reinforced and sustained after its completion.

Using the multiple relationships available to individuals with learning disabilities (such as carers and support staff) in the implementation of general psychological interventions in this field, such as assessment and behavioural work, is not a novel approach (Bates 1992; Caine & Hatton 1998). Support staff have also been identified as important in the delivery of psychological therapy, specifically in terms of the completion of homework, such as mood monitoring charts (Hardy et al 2006) or in terms of liaisons to see how clients are coping (Bates 1992). Staff responsible for the referral of the client have also been described as occupying an important role during assessment as they help to avoid misunderstandings or unhelpful interventions (Hodges 2003). However, the participants were explicit that these relationships are used to a much greater extent in the delivery of psychological therapy and in the development of the therapeutic relationship. This approach and rationale is original. It could be suggested that this approach is a possible compromise with the behavioural theories, predominately adopted with this client group. The use of staff reinforcement and environmental manipulations are a reflection of the behavioural paradigm. However, with the approach described by participants here, the person is central, the first relationship is with the individual, something criticised as lacking in the use of traditional behavioural theories (Hodges 2003; Jones et al 1997).

It was illustrated by participants that these relationships also result in a distinct and contrasting approach to confidentiality with individuals with learning disabilities who receive psychological therapy, concerning both their engagement in therapy and the

content of therapeutic work. There was no explicit suggestion of any unease with the degree of loss of confidentiality, merely an acceptance of its difference and the need to work through that appropriately with their client. This is something also identified within previous literature (Bungener & McCormack 1994 p.372):

> *"Many people with learning disabilities have grown up in an atmosphere of poor boundary keeping, where personal privacy is at a minimum."*

The reason for this flexibility is likely to be a result of the dependency associated with having a learning disability (Bungener & McCormack 1994). Participants also spoke of the pressure they experience from staff or carers who want to know about the work, this pressure on the therapists is something briefly referred to by Bungener & McCormack (1994) who attribute such desire for knowledge to carer anxiety. Hodges (2003) also identifies multi-disciplinary working as influencing the parameters of confidentiality.

This tension is particularly interesting as respect for confidentiality is a fundamental aspect of psychological work (BPS 2006). However, it appears documented within literature and confirmed within this study, that the boundaries of traditional confidentiality appear more flexible when working with individuals with learning disabilities (Royal College of Psychiatry 2003)

2.3 Facilitating Reassurance

The theme 'facilitating reassurance', was felt to be a particularly interesting and unique finding. It summarised a desire by participants to put individuals with learning disabilities at ease when establishing the therapeutic relationship. This desire is managed by ensuring they are comfortable, offering them praise and exercising a degree of caution within the therapeutic relationship.

The need for therapists to put individuals with learning disabilities at ease during therapeutic work is not something identified in previous literature. It is not a counter-transference reaction noted by psychodynamic theorists nor is it an approach documented in cognitive-behavioural theory. It is evident however, that participants

felt that there is some complexity within the therapeutic relationship with individuals with a learning disability, which requires the therapist to be more attentive and vigilant to the client's comfort. This undoubtedly impacts upon therapeutic relationships and processes, as the therapists themselves identified that they may not be as willing to challenge a client with a learning disability.

One explanation is that the therapists are acutely aware of the predisposition for people with learning disabilities to be in passive positions within relationships in which they find it difficult to express negative feelings towards those whom they rely on (Bungener & McCormack 1994). It is suggested that the participants attempt to avoid the development of a dependent relationship by facilitating an environment where individuals with learning disabilities are given the opportunity to self-advocate, to be equal and feel comfortable in questioning the therapist.

In the absence of existing literature, an alternative hypothesis was also developed utilising psychodynamic theory, an approach particularly interested in interpreting the reactions evoked within therapists during their therapeutic work (McLeod 2003). Symington (1992) and Sinason's (1992) theories concerning pity, sympathy, guilt and contempt were particularly adaptable in interpreting the findings of this theme. Symington[39] has proposed that a cycle of contempt, guilt and pity may occur when working with individuals with learning disabilities. He describes how, at an unconscious level, feelings of contempt are directed towards individuals with learning disabilities as a result of instinctive animal impulses to attack and kill the weak. He describes that this in turn creates feelings of guilt, which are managed and compensated for by advocating pity and sympathy.

It is therefore hypothesised that the participants in this study may experience contempt and an unconscious instinctive impulse to attack the weak. They may struggle to acknowledge this murderous aspect of themselves and develop an omnipotent[40] phantasy that they are persecuting their clients. They may phantasize that they are therefore inadvertently bullying the client, illustrated by the participants' fear of causing discomfort, confusion, intimidation or upset. The ability for a therapist

[39] Please refer to "Introduction" 4.2.2. for an introduction to Symington's theory.
[40] A fear that our thoughts and fantasies can alter the external world (Sinason 1992)

to challenge an individual with learning disabilities may be influenced by this fear of persecuting them, a fear of producing insecurity and discomfort in a client who may be struggling with their self-esteem, confidence and a fear of annihilation. The fears belonging to the client exacerbate the therapist's experiences and phantasy concerning persecution.

The result of these conflicts is guilt, a core theme associated with individuals with learning disabilities (Sinason 1992 p.74):

> *"... guilt must be dealt with, guilt of the patient for his handicap and guilt of the worker for being normal."*

It is suggested that the participants experience the manifestation of guilt on a number of levels. Not only are they feeling guilt for a belief they are persecuting their client but they may also be attempting to manage their feelings of guilt concerning their own lack of learning disability. It is proposed that the therapist feels guilt for the anxiety and fear induced in the client by inflicting upon them the experience of a therapeutic encounter. They may experience further guilt due to the historical treatment of people with learning disabilities, as it is noted that a number of the participants attributed working in this setting due to some level of social responsibility. In addition, individuals with learning disabilities themselves may be predisposed to feelings of guilt, about being born and surviving, guilt which may then project onto others (Sinason 1992).

These feelings of guilt are then managed and compensated for by advocating pity and sympathy. The pity advocated by participants in order to overcome this guilt, may then manifest itself in the cautiousness and hesitancy and the need to comfort and praise the client. Symington (1992), suggests this cycle of contempt, guilt and pity stifles the therapeutic work as we do not desire development or change in someone we feel this pity for: "*guilt cripples and is in-effective*" (p.137). He argues that therapists need to acknowledge these feelings for therapeutic change to take place.

As stated, in the absence of existing literature, the above is a speculative explanation of this theme, however further research is needed to further understand this finding.

The significance of this theme is likely to be heavily influenced by theoretical orientation. Whilst cognitive-behavioural theorists may not display as much concern for the feelings evoked within therapists during therapeutic work, these experiences or counter-transferences are of particular significance to psychodynamic theory. However the fact that this theme was deduced from the accounts of participants with a range of theoretical positions suggests it is a factor which has implications for theory and practice of any orientation.

Participants also described how the modification of therapeutic boundaries was considered helpful in facilitating reassurance in individuals with learning disabilities and developing a friendlier relationship which subsequently engaged clients in the therapeutic relationship.

The Royal College of Psychiatrists (2003) has suggested that individuals with learning disabilities may benefit from looser boundaries in therapy such as being friendlier, having less rigid session times and employing a more tactile interaction. The need for a warmer and friendlier element to the therapeutic relationship when working with people with learning disabilities, has also been described by Bates (1992 p 82):

> *"I tried to open each session in as friendly a fashion possible."*

Bates believes this friendliness aids the lowering of defences of a person with a learning disability and increases the possibility of her being accepted as a valid person attempting to develop a relationship with them. The use of humour during therapy with individuals with learning disabilities is briefly mentioned by Kroese (1997) who described that whilst it can help create a relaxed atmosphere, it is necessary to ensure clients posses the cognitive pre-requisites to comprehend humour.

The participants did not comment on the need for less rigid session times or a more tactile interaction that has been suggested in literature. The suggestions of the participants in this study include the use of refreshments, humour and self-disclosure to facilitate the therapeutic relationship; this offers an original perspective to the existing knowledge base.

The suggestion that a form of friendship is advantageous in the early stages of the development of the therapeutic relationship is especially interesting. Accounts captured a sense that it was sometimes necessary to spend time together, getting to know each other, before addressing the actual referral issue and commencing psychological work. This is a novel finding, as the participants describe a creative and adaptable approach to developing the therapeutic relationship, however, this may arguably set the scene for later attachment difficulties[41].

2.4 Experience in Relationships

As the participants suggest, the previous relationships that their clients experience are often negative, lacking in-depth and inconsistent, these sub-themes are substantiated in existing literature. It is acknowledged that as one of the most vulnerable groups, people with learning disabilities often experience devaluation and discrimination in the relationships they form, be it with support staff, carers, or the general public (Waitman 1992).

People with learning disabilities also frequently experience having to make relationships with people employed to help them (Hodges 2003). Support staff in residential and day services are poorly paid, it is described as low status, low pay shift work, associated with debt, stress and bad housing (Brown 1992; Hodges 2003). Carers are also often young and lacking in training and experience, literature describes how "*they and, through them, the clients, are vulnerable*" (Conboy-Hill 1992, p.168; Sinason 1992). Turnover is also a major problem within services for individuals with learning disabilities and this is also recognised as having serious consequences for service quality (Hatton et al 2001). The impact of these losses is believed to be huge, as these relationships are particularly significant for individuals with learning disabilities, it is suggested that these losses are often underestimated (Hodges 2003; Bungener & McCormack 1994 p.369):

[41] Please refer to Master Theme 4, "Experience of relationships" and Master Theme 6, "Difficult" for further exploration of attachment.

"One aspect of life for people with a disability is the extent to which they have to form, and then break relationships with significant others."

The accounts of the participants within this study re-emphasise the concerns identified within existing literature regarding the treatment of individuals with learning disabilities in relationships. The experience of the participants supports literature in suggesting that these relationships also have significant implication for the development of the therapeutic relationship (Bungener & McCormack 1994; Hodges 2003).

Within this study, it has also been possible to highlight how the limitations of these experiences influence the actual significance of the therapeutic relationship. Individuals with learning disabilities are known to have limited experience of relationships, especially of those with an emotional focus (Emerson et al 2001). The sub-theme 'first relationship' emphasises that the therapeutic relationship is often the first relationship of its kind for individuals with learning disabilities. Grace for example, described how the therapeutic relationship may be the first 'proper relationship' a first opportunity to engage in an equal relationship where they are empowered within the interaction. It is therefore suggested that as a result of their limited experiences, the therapeutic relationship has greater therapeutic impetus for individuals with learning disabilities.

In addition, participants identified how an element of social naivety is present within the therapeutic relationship, possibly due to their learning disability or their limited relationship experience. This suggests that the therapeutic relationship has the potential to become ambiguous and for individuals with learning disabilities to confuse the relationship with friendship. Boundary confusion is something alluded to in literature; individuals may not appreciate what is appropriate within a therapeutic relationship (Caine & Hatton 1998). It is hypothesised that this may be further increased by the adopted techniques in the development of a therapeutic relationship, such as friendliness and looser boundaries. It is noted however that the participants found this social naivety to be, not only an endearing and liberating quality, but that it aided the therapeutic relationship through honesty and openness. They did not

associate it with the difficulties or confusions in roles that have been suggested in literature (Caine & Hatton 1998).

2.5 Therapeutic Approaches

Participant's accounts captured a tension between those who described a need to be directive within the therapeutic relationship and others advocating a client led approach. Whilst theoretical orientation was felt to be a mediating factor it was not a consistent factor. Participants also identified particular tools, techniques and language to aid the relationship and therapeutic work.

Participants felt they were at times directive within the therapeutic relationship, this manifested itself through a belief that they ask direct questions, are probing, persistent and dogged. It is an original observation that therapists may need to become more directive within the therapeutic relationship with individuals with learning disabilities. The need to be directive is perhaps more commonly associated with cognitive-behavioural therapy (Sanders & Wills 2005). Whilst some of the participants that described a directiveness referred to the influence of cognitive-behavioural therapy within their theoretical approach, not all did. This suggests that this approach is additional to the theoretical orientation, possibly intrinsic with delivering psychological therapy to individuals with learning disabilities. It is suggested that this may be some form of compensatory strategy adopted by the therapists in order to balance the limitations and loss of skills inherent in the learning disability.

Bates (1992, p.91) briefly mentions the concept of 'naggotherapy' a term she has coined to refer to her need to, on occasions *"indulge[ing] in a repetitive, nagging and directive approach*". She describes a need to do this with clients who deny ownership of their behaviour. Little further is documented in her account, but she appears to be describing a similar experience to that captured by the participants in this study.

This approach is an interesting contrast to the participants' descriptions of needing to comfort, praise and avoid challenging clients. It is hypothesised that this directiveness occurs later within the therapeutic work when the relationship between therapist and client is further developed.

The description of directiveness was a considerable contrast to the emphasis upon collaboration explored by some of the participants. For these participants there existed a need to be non-directive, person-centred and a need to avoid where possible allusions to power differences. Whilst theoretical orientation was again felt to be a salient influence, it was not a consistent factor for all participants. This approach highlights further not only the need to put the client at ease, but also a gentleness with which this 'first relationship' may develop and the authentic opportunity that individuals with a learning disability have for engaging in a healing relationship. The description of participants' approaches is also possibly akin to counselling psychology's humanistic values and principles.

Participants were able to identify a range of tools and techniques that support them in the development of the therapeutic relationship and the therapeutic work itself. These included Widget and Bliss standardised computer software, storyboarding, rehearsal work, wipe boards, Talking Mats communication tool and drawing. This emphasised a diverse and skilful approach to psychological therapy and the benefits of developing the therapeutic relationship with individuals with learning disabilities in a creative and flexible way. As Cullen (1992, p.viii) suggests:

> *"Some flexibility and new thinking may be needed to deal with clients who are less verbal and articulate."*

An example of how some therapeutic approaches are not so easily transferred to the delivery of psychological therapy was provided by Kevin, he felt that the use of silences was unhelpful. He felt that individuals with learning disabilities do not experiences silences as a time to reflect upon the therapeutic work, but that they find it intimidating and it serves to remind them of their disempowerment. This is an interesting and original suggestion. Sanders & Wills (2005) discuss the use of silences in the delivery of cognitive therapy to the non-learning disabled population. They suggest that whilst silences may offer an individual time to reflect, they may also induce anxiety or a feeling of being threatened. The use of silences is perhaps more commonly associated with other theoretical orientations such as psychodynamic

theory, but there is a lack of comment regarding its use with individuals with learning disabilities in the associated literature.

The emphasis upon the use of a shared language when delivering psychological therapy is a concern documented in non-learning disabled literature as well as within this literature review (McLeod 2003). With an individual with a learning disability whose communication is limited, language becomes of even greater importance. Language and abstract concepts used within therapy should be adjusted and chosen carefully to meet the level of understanding and needs of the clients (Kroese 1997; Hodges 2003). These were all points that the participants of this study emphasised within their accounts, illustrating that the results of this study reflect the current and existing knowledge base.

2.6 Difficulties with the Therapeutic Relationship

Out of all the master-themes and sub-themes that emerged from the data, this theme was one of the most consistent experiences, common to all interviewees. Participants were concise and clear; they experienced difficulties within the therapeutic relationship with individuals with learning disabilities.

Difficulties with Difficulties

While participants were unambiguous concerning their experiences, they demonstrated an unequivocal need to off-set this against the rewards they experience. There existed an overt tension within some participants' accounts, a degree of reluctance to explore the difficulties and a preoccupation with the rewarding elements of this work. This was particularly interesting, there was a suggestion that some participants were in denial or did not wish to highlight the difficult work they had encountered.

A number of hypotheses could account for this reluctance. One proposition is that the participants are struggling with the nature of the work and the specialist skills required to complete it. Yet this seems unlikely given the breadth of experience they have within the field. It may be uneasy or awkward for the participants to admit to the

difficulties they experience, due to the expectation that psychologists should be knowledgeable and able to manage difficulties, or due to fear about being accepted as a counselling psychologist in the field because of its minority status[42]. It is also perhaps easier to talk about the satisfaction and the rewarding nature of work. By confessing and highlighting these difficulties participants and those around them will be forced to alter their perceptions of themselves and their beliefs about their skills. It is possible they do not wish their belief that the work is easy and enjoyable altered.

An alternative perspective is that participants prefer to emphasise the positive and rewarding elements of the work because of a fear of discouraging other psychologists into the field. It is common knowledge that there are recruitment difficulties in learning disability teams, it has even been described as an unpopular place to work (Mckenzie et al 2005; Hodges 2003).

It is also possible that participants are fearful of blaming people with learning disabilities for the difficulties or labelling them as 'difficult'. This may result in a fear of culpability within participants who do not want to further disadvantage this group. This may further be influenced by the humanistic value base from which the participants draw upon, due to their training as counselling psychologists. They may not wish to blame or label and therefore are reluctant to acknowledge the difficulties.

Time & Energy Consuming

One of the challenges in the delivery of psychological therapy for people with learning disabilities is that these individuals are usually slower functioning, the parameters of time focused/time limited work need to be adjusted to be flexible to the abilities of the client (Smith 2005). This was also an experience captured within participants' accounts. They highlighted a need for patience and commitment particularly during the early stages of the therapeutic relationship.

Participants also suggested that the therapeutic work could be particularly energy consuming. This is reflected in literature by Bender (1993) who described how the

[42] This is explored further in "Final Reflections".

energy consuming nature of delivering psychological therapy to individuals with learning disabilities results in therapeutic disdain. In addition, Sinason (1992, p.71) refers to people describing the work as 'therapeutic effort' rather than 'psychoanalytic treatment'.

A number of other authors have also commented upon this experience. Hodges (2003) for example, draws an interesting parallel between the evidence of working with people with autism and her experience of delivering therapy to people with learning disabilities. She cites work by Alvarez and Reid (1999, p.7):

> *"the therapist must have a mind for two, energy for two, hope for two, imagination for two"*

Bungener & McCormack (1994 p.376) describes how a disabled person may "*hand over*" their abilities in a "*parasitic*" way to the therapist, such as the act of thinking, even if they are capable of doing it themselves. They believe this symbolises a loss of determination, a lack of belief in their ability and an envy of the therapists' skills. This theory could explain the experiences of the work being energy consuming.

It could also be suggested that therapists delivering psychological therapy to individuals with learning disabilities may take on more responsibility trying to make the intervention succeed than in other settings. It is questioned whether the presence of the learning disability results in the therapists burdening themselves with the success of the work to a greater degree.

Complexities

It is evident within both published literature and the outcome of this study that the therapeutic relationship with individuals with learning disabilities is complex. There exists a diverse range of particular complexities and dynamics that need to be understood and managed. Literature has commented that individuals with learning disabilities display transference and counter-transference reactions "*that are more rapid, pronounced, and primitive*" and, that we should be particularly aware of these reactions with people with limitations in cognition, communication and social

functioning (Caine & Hatton 1998 p.226). Whilst psychodynamic theory is possibly best equipped to explore and understand these experiences, it was interesting that these complex dynamics were highlighted by participants who did not describe themselves as influenced by the psychodynamic framework. It possible, that the feelings experienced by therapists are of such intensity that regardless of theoretical orientation, therapists are aware of them and felt a need to share them.

Participants spoke about having the learning disability projected onto them and becoming disorientated as a result. In addition, they described experiencing echoes of the abuse and traumas suffered by their clients. Other core conflicts that were identified by participants also reflect the writings of Sinason (1992), Hollins & Sinason (2000) and Hodges (2003), themes included abuse, rejection, attachment disruption, loss, trauma and secondary handicap.

It is noted that, as described in the introduction, the common counter-transference reaction with people with learning disabilities is tiredness and an inability to be alert (Bungener & McCormack 1994; Hodges 2003). Whilst participants described their experience of the work being energy consuming, their accounts did not capture this phenomenon.

Attachment & Loss

Prevalent in the majority of the participant's narratives was the significance of attachment disruption and loss for individuals with learning disabilities. These themes are well-documented in literature, the results of this study serve to further emphasise these experiences and understand their consequences for the therapeutic relationship.

Adverse life experience in early attachment relationships, are thought to contribute towards attachment problems in individuals with learning disabilities, which are predominantly believed to be of the insecure type (Hollins & Sinason 2000). Stokes & Sinason (1992, p.57) described that "*however lovingly responded to*" when the 'wished for baby' does not appear, it is difficult for even the most resourceful parents to feel deeply attached. Rejection heightens the infant's need for attachment but, they will remain "*unwelcome guests of the family*" (Sinason 1992, p.62). These attachment

difficulties are also felt to be exacerbated after infancy in an individual with a learning disability. Literature has also cited how proper separation from the mother never occurs because of the differences in the life stages of a person with a learning disability (Stokes & Sinason 1992). Closely linked to the theories of attachment are those pertaining to loss, a very significant issue for people with learning disabilities (Hodges 2003). Experiences of loss are traced in literature from the birth of an individual with a learning disability, as the parent and infant experience loss of the perfect self, through to further persistent experiences of loss at all subsequent developmental stages and critical periods (Bungener & McCormack 1994).

Such long-term difficulties with attachment and loss has a number of implications for the formation of the therapeutic relationship, such as fear of further rejection and loss (Caine & Hatton 1998; Royal College of Psychiatrists 2003; Hodges 2003). Participants described methods of overcoming these defences during the development of the therapeutic relationship, such as the modification of therapeutic boundaries. They additionally cited how as a result of these experiences, people with learning disabilities may become attached to the therapist and the relationship.

Futility

Participants appeared weary of an element of futility associated with their therapeutic work, they described how sometimes individuals were simply not able to make use of therapeutic interventions. Those who they were able to develop therapeutic relationships with sometimes made only slight improvements; there was also a sense that such improvements were unlikely to be sustained after the completion of the therapeutic work. Bungener & McCormack (1994 p.376) describe that for individuals with *"good family, community or vocational support, sustaining the gains is more possible*".

Additionally, when participants felt that they had made therapeutic progress, their efforts seemed inconsequential and futile in light of the impact of the learning disability. It was also felt that curing the individual of their learning disability seemed to be an unconscious and entirely futile aim or desire of therapists. Sinason (1992) has described the challenge of working with damage and not being able to repair it or put

it right. It is hypothesised that the participants may, at an unconscious level, believe that curing the learning disability is the only way of improved psychological health, as they see damage that requires repair. In addition, it is debatably an aim of society to eradicate learning disabilities with advances in genetic testing and greater flexibility with abortion laws (Emerson et al 2001; Moser 1995). Stokes & Sinason (1992) have described how the inability to cure people of their learning disability results in feelings of guilt and workers devoting themselves to the impossible task of curing clients. It is questioned how these feelings may impact upon the therapeutic relationship.

2.7 Individualisation

The participants of this study emphasised a need to recognise the rich and vast differences that exist between people regardless of the presence of disability. Participants highlighted the individualised nature of their therapeutic relationships and work, describing a need to adapt work to each individual client's strengths and weakness. They described a persistent need to individualise their therapeutic approaches, demonstrating that assumptions regarding language or understanding cannot be made and that therapeutic work need to be constantly adapted and tailor-made. This highlights the creativity and flexibility of the therapists. This theme emphasises the existing knowledge base regarding the heterogeneity of people with learning disabilities and the difficulties associated with this socially constructed group.

Literature has emphasised how people with learning disabilities need to be treated on an individual basis and that there is a great deal of heterogeneity within the learning disabled population (Hodges 2003; Rapley 2004). Clements (1998) describes how individuals with learning disabilities display slow but normal functioning in addition to a variety of domain specific impairments. As previously discussed[43], there exist a vast range of ways in which a learning disability may impact a person's functioning. This is captured in the accounts of the participants who tailor-made their therapeutic approaches to the individual presentation of the client. As a socially constructed

[43] Please refer to "Introduction" section 1.5.

concept, 'learning disability' has emerged to include a large number of syndromes and many different disorders. Leonard & Wen (2002 p.117) have questioned the sense of:

> *"the lumping together of so many different underlying disorders and pathological processes within a single entity".*

In addition to being a reflection of the heterogeneity of people with learning disabilities and the influence of the social construction of the concept, this theme also reflects the participants' shared perspective with the counselling psychology value base. Recognising individual differences is an important emphasis and part of the culture and training of counselling psychology (Woolfe 1996). It is also noted however, that participants felt the need to individualise the work as a contributing factor to making the work difficult.

The desire for individualism, captured in both the participant's reports and hesitancy to generalise, was further complicated with a tension regarding appropriate collectivism, either recognising individuals as a different collective or the same collective as non-learning disabled populations. The accounts capture a tension between participants who wished to view individuals with learning disabilities as similar or dichotomous to the non-learning disabled population. Whilst participants Kevin and Mac emphasised their therapeutic approach to be the same regardless of the presence of a learning disability, Kirsty emphasised a need to accept the overwhelming differences. It was also felt to a degree that there existed conflict within Kevin and Mac's accounts, as they also spoke about the vast differences between people with learning disabilities and those without. It is hypothesised that this tension reflects a desire to avoid the negative implications of dichotomy between two collectives. Individuals with learning disabilities are a minority group and have experienced many of the negative implications of this position. Sinason has described this in the quotation below (1992 p.54):

> *"Difference in gender, race, size, shape, ability, appearance, culture voice are intrinsic to a rich experience. [...] However, difference evokes envy (when we*

perceive ourselves to be lacking) or guilt (when we perceive someone else to be lacking).”

It is easy to create a distinction of ‘them and us’ and easier still for this to result in the persecution, discrimination and denigration of others for being different (Hodges 2003; Sinason 1992). The tensions between recognising the similarity and dichotomy with the non-learning disabled population, is a further reflection of the participants’ position as counselling psychologists. Not only do counselling psychologists place particular emphasis upon the individual, but their humanistic value base involves a commitment to respect the personal, diverse and subjective (Woolfe 2006), as a result the concept of collectivism and the ability to generalise is restricted.

2.8 Therapist’s Motivations & Values

Participants described a number of motivations and values that influence not only their choice of work but the therapeutic relationship. Clusters were sub-themed as follows: the historical position of individuals with learning disabilities, satisfaction and reward of the work and the familiarity within this specialist field.

It is within relatively recent history that people with learning disabilities have suffered innumerable cruelties and devaluation (Hodges 2003). Throughout the last century individuals with learning disabilities were forcibly hospitalised under the Mental Deficiency Act (1913) where they were subjected to all manner of cruelty, abuse and suffering (Caine et al 1998; Sinason 1992). In Nazi Germany people with learning disabilities were among the first minority groups to be gassed due to a fear that the intelligence of the race would deteriorate if they were allowed to reproduce (Bungener & McCormack 1994).

This history was a particular poignant for participants Mac & Joanna, it was evidently an emotionally provocative subject. They expressed disbelief, shame, horror and disgrace. However these provocative emotions provided them with a catalyst and commitment to working in the field. The historical treatment of individuals with learning disabilities appeared to be a significantly motivating factor, there appeared to be some moral obligation or responsibility to atone for the atrocities of the past. Little

is known about the factors that motivate psychologists to work within the field of learning disabilities, a lack of exposure is thought to influence recruitment, combined with a belief that the work is unrewarding (Mckenzie et al 2005).

Whilst people with learning disabilities continue to be one of the most socially excluded and vulnerable groups in Britain (Department of Health 2001), there exists a general consensus in the literature that the setting of learning disabilities is shifting and evolving from its historical position and that certainly individuals in western civilisations are experiencing an improved quality of life (Hodges 2003; Conboy-Hill 1992). As Sinason (1992, p.57) highlights in the below quotation, there have been considerable advances in the field:

> *"...history also provides us with an important sense of developmental progression as a backdrop".*

This was also something captured by the participants in this study. For example, Mac described that while there is continued need for developments in the setting, it is an exciting place to work as there is potentially great practice still to be discovered. The need to introduce hope and motivation in the field is captured in the writing of Sinason (1992), she describes over forty different names that have been used to describe individuals with learning disabilities. She believes that no other human group "*has been forced to change its name so frequently.*" (p.39). She describes that each new worker brings a new term in the belief that the new words will bring hope and a new period of healthy historical change. But, she comments, this hope is irrational as each new term coined will become a euphemism over time because of the painfulness of the subject.

Working with individuals with learning disabilities was however, a highly satisfying experience for the participants. The development of the therapeutic relationships themselves was a fundamental element that they identified as making their work a rewarding experience.

Interestingly, all participants reported to have had some degree of experience or familiarity with people with learning disabilities prior to working as a qualified

counselling psychologist. Whilst for some there was a sense that it was an unintentional decision to work in the field, it was felt that participant's early experiences and familiarity led to their interest. This hypothesis is further confirmed by Mckenzie et al (2005 p.25) who describe how the experience of working as an assistant in learning disability teams *"can help challenge and dispel misconceptions"*, as a lack of exposure is thought to negatively influence recruitment.

Participants described their satisfaction in terms of feeling fulfilled, doing a 'good thing' and valuable work. Some participants also described a belief that they were contributing to society. It is clear that the level of satisfaction outweighed any of the difficulties identified in master theme 6. The longevity of service was also interesting, participants found the work familiar and many had made a career in the specialism. It was noted that consistency amongst the participants to stay within their teams and within the setting of learning disabilities contrasted against their previous experience of high staff turnover which often occurs in the field of learning disabilities. It is possible that this suggests a need by participants to impose some form of consistency in the lives of individuals with learning disabilities through their long-serving positions. These points provide a valuable insight into the limited existing knowledge base concerning this topic.

2.9 Therapist's Needs

Participant's identified a number of their own needs that arise whilst engaged within therapeutic relationships with individuals with learning disabilities. In particular, clusters emerged concerning supervision, training, reflection and a search for knowledge.

Supervision and reflective time were identified as an important need for participants. It was felt that this theme was very much related to participants' experiences of the difficulties involved with this therapeutic work. Difficulties such as the complexities of the work, the reactions evoked within therapists, the energy consuming nature of the work and the associated futility were all factors which they felt required a heightened sense of reflection and a need for supervision. These experiences support the existing knowledge base. Hodges (2003, p.109) states that supervision and

personal therapy are essential in understanding the very complex relationships created through this clinical work:

> *"working with people with learning disabilities can be extremely distressing, especially if one allows oneself to experience all their projections and recognise their realities. Support for this is needed on several levels including proper supervision, training and personal therapy."*

It is emphasised that therapists may therefore need the additional support of supervision and reflective time to manage some of the complex and powerful feelings they identified. The emphasis upon the need to reflect, the use of supervision, and by some participants the benefits of personal therapy are all attributes aligned with their professional identity. As counselling psychologists it appears that the participants possess many of the philosophies associated with the discipline. Counselling psychology is committed to scientific and reflective practice, an emphasis which makes it distinct from other applied psychologies (Lane & Corrie 2006). This commitment to reflective practice, personal development and the supervision associated with the discipline, appears particularly influential for the participants of this study.

Participants highlighted a need for experience to work in this setting due to the complexities associated with it[44], this is also reflected upon by the Royal College of Psychiatrists (2003) who identify a need for specific training for the delivery of psychological therapy to individuals with learning disabilities and improved further training opportunities. The high level of skill required to work with this client group has been documented in existing literature (Mason 2007). The specialist nature of delivering psychological therapy to individuals with learning disabilities has raised questions about clinicians' competencies. Mason's (2007) study found that psychologists were particularly concerned with their perceived skills and competencies. It is suggested that the results of this study serve to further emphasise Mason's findings.

[44] Please refer to Master Theme 6, "Difficult" for further information.

Participants also described a search for knowledge as a result of feelings of uncertainty regarding their approach to the therapeutic relationship with individuals with learning disabilities. These experiences contributed to an overwhelming sense within the accounts that participants were uncertain whether what they are doing was right. They described a search for knowledge and need for further research but it was also felt that further specialist training could be of use.

The concern for this search for knowledge is of further interest if considered within the context of the process of recruitment during the early stages within this study. The response to the advert, circulated via email[45] was felt to be of particular interest. On the day of the advert being circulated three individuals volunteered, within ten days all eight participants had been recruited. This response was felt to be exceptional on the basis of the haste and motivation with which the participants volunteered. The researcher believed there to be only a small number of counselling psychologists working in the field, initially it was not clear if there were as many as eight participants that would meet the inclusion criteria. It is felt that this response further emphasises the search for knowledge and uncertainty felt by participants. These feelings resulted in a need or desire for involvement with this research. They may have felt it presented them with an opportunity to express their feelings of uncertainty, search for further knowledge, to find out if others find the work difficult, or maybe it was an opportunity to simply meet a colleague within the field. It is also felt that this response is a reflection of the position of counselling psychologists as a minority, not only within applied psychology generally but specifically learning disabilities.

2.10 Setting Culture

Participants reported a particular culture in the learning disabilities setting, a professional culture, concerning attitudes and approaches to psychological therapy and the therapeutic relationship. This was a particularly interesting and novel description. It is felt that a number of factors documented within existing literature can help explain this experience.

[45] Please refer to section 5.1 within the "Methodology".

Firstly, the removal of the individual and disregard for the therapeutic relationship could be reflective of the settings emphasis and traditional usage of psychopharmacology and behavioural analysis. This predisposition to the use of such approaches have been described within literature as lacking awareness of the subjective experience of the individual with a learning disability and a resulting lack of collaborative or reciprocal relationships (Bender 1993; Jones et al 1997).

The historical dominance of psychopharmacology and behavioural approaches have resulted in a lack of tradition of offering psychological therapy to individuals with learning disabilities. As Hollins (2003 p.viii) states:

> *"Many specialist learning disability health and social care professionals have trained in centres where counselling and therapy have not been recognised as valid interventions."*

The resulting impact of this is that, as participants suggest, individuals are overlooked and therapeutic relationships are disregarded due to a lack of tradition and therapeutic culture.

Participants also reflected on their own role as counselling psychologists within the professional setting and their experience and treatment. There has been nothing documented within literature concerning the role of counselling psychologists within learning disability teams, the observations of the participants are therefore particularly novel and interesting. Within the narratives there existed a sense of counselling psychologists being a minority within the specialist setting and a number of difficulties were associated with this.

It was recognised that while it was an unusual place for counselling psychologists to work, the firm belief that their philosophy and culture had a great deal to offer the setting, provided some of the participants with a reason to remain in the setting. There was a sense however that it was difficult for participants to introduce elements of their philosophical positions such as humanism, the therapeutic relationship and client-led rather than medical approaches, as these were not fully accepted. Bellamy (2006) has

stated that the counselling psychology client-centred way of thinking has been described as uncommon in mainstream applied psychology, the participants of this study appeared to experience difficulties with introducing such approaches into a heavily medical and behavioural culture.

A further difficulty identified by a couple of the participants was the implication that working within such a setting has on their skills and positions as counselling psychologists. Participants Abby and Bill described a belief that they had lost some of their philosophical identity and approach, because of the setting culture and requirement for non-therapeutic psychological work, such as specialist psychometric assessments. This perhaps serves to further emphasise the influence and power of this medical and behavioural culture.

The participants were also largely dissatisfied with the resources made available to them. This is a direct reflection of the existing knowledge base, for example Mason (2007 p.247) describes resources for individuals with learning disabilities and additional mental health problems as being "*inadequate*". It was felt to be a novel observation by participants in this study that these resource limitations combined with the described setting culture was felt to significantly undermine the delivery of psychological therapy and the potential for positive therapeutic relationships. These findings conflict somewhat with that of Mason's (2007) study that concluded that psychologists felt service resources were less important than he had hypothesized. Mason questioned whether methodological issues, such as the various interpretations of the term 'resource' could account for this conclusion. It appears that the findings of this study serve to emphasise the importance of resources in the delivery of psychological therapy to individuals with learning disabilities.

As stated, existing literature has described the limitations of resources in this setting, Conboy-Hill (1992 p.159) echoes some of the descriptions offered by the participants of this study who experienced difficulty in accessing a room for therapy, she described the use of:

> *"bedrooms, empty cafeterias, the manager's office [...] and on one miserable occasion, in a large sports equipment cupboard."*

This serves to further emphasise the existence of a culture unprepared and ill equipped for therapeutic work.

3. Implications of Findings

The findings of this research are felt to have made a significant contribution to the existing knowledge base concerning the delivery of psychological therapy and the therapeutic relationship with individuals with learning disabilities. Not only does the study highlight the need for further research in this field[46], the findings also have considerable implications for current theory, service provision, service plans and training.

3.1 Implications for Existing Theory

Predominately, it is felt that the findings have served to re-emphasise the importance of the therapeutic relationship in the delivery of psychological therapy to individuals with learning disabilities. Existing literature pertaining to psychological therapy and other interventions with individuals with learning disabilities are currently lacking in any awareness of the therapeutic relationship. In light of its identified fundamentality, this absence is arguably unacceptable. The therapeutic relationship with people with learning disabilities not only needs to be better understood in theory, it needs to be acknowledged within literature in the first place.

3.2 Implications for Service Provision

The findings also highlight considerable implications for current service provision. It could be argued, that the evidence of the fundamentality of the therapeutic relationship offers further weight to an argument advocating the use of psychological therapy and the need for greater person-centred approaches within psychopharmacology and applied behavioural models. Whilst evidence and usage of

[46] Explored in "Future Research".

psychological therapy with individuals with learning disabilities is growing, psychopharmacological and applied behavioural approaches continue to be the primary approach (Chapman et al 2006; Nagel & Leiper 1999). This is significant, considering that these approaches have been described as rarely offering a collaborative or reciprocal relationship (Jones et al 1997). In light of the findings from this study, it is perhaps therefore pertinent for clinicians to consider the possible role for a therapeutic relationship in the delivery of these approaches, due to its identified significance.

The findings may also have a number of contentious implications regarding service provision and the actual usage of psychological therapy with individuals with learning disabilities. Participants described how the therapeutic relationship can become incredibly significant and beneficial for individuals with learning disabilities. It is suggested that as a result of experiences of attachment disruption and loss, combined with inexperience in positive relationships, individuals with learning disabilities may naturally become attached to the therapist and the therapeutic relationship. Contentiously, it could be suggested that there exist a number of implications for attachment and subsequent loss of such a significant relationship. The participants of this study were clearly aware of their unique position in developing these therapeutic relationships. As a result they described it as sometimes difficult for them to end their work with clients. If this relationship has such an impact upon the therapist, it is proposed that such a loss will have an equal impact upon the client. It is questioned what the implications for the clients are to experience another loss of relationship, and whether this outweigh the benefits.

A further consideration is the participants' experience of futility associated with the psychological work. Participants identified how therapeutic advances may not be sustained outside the therapeutic relationship due to a lack of appropriate support. This raises a controversial issue concerning those without such support and their ability to sustain gains and advances achieved through therapeutic work. It is worth considering the implications of experiencing such a positive relationship and the subsequent impact of the client returning to relationships that the participants have described as negative, inconsistent and lacking in depth. It could be suggested that whilst individuals with learning disabilities may be able to benefit from therapeutic

work, the wider support systems, or society as a whole, are not adequately prepared or trained to support their gains. It is questioned whether it is therefore worth engaging in the first place.

This issue is further captured by the participants' accounts of the setting culture within learning disability services. It could be suggested that the reported predisposition to remove the person, disregard the therapeutic relationship, disregard the counselling psychologists' position and the limited resources, is unsurprising. There are indications within literature that such a culture exists. However, the participants have raised the profile of this culture with perhaps an unexpected degree of intensity and consistency within their accounts.

Participants described an entrenched culture, which is ultimately impacting negatively upon therapeutic work. It could be argued that without change in attitudes towards individuals with learning disabilities, combined with vast improvements in services, staff and carer training, the benefit of psychological therapy for individuals with learning disabilities is limited. The challenge which lies ahead for theory and practice within the setting is to consider how such a negative and disempowering culture can be altered and how a therapeutic culture can be developed within the setting?

3.3 Implications for Service Plans & Protocols

The findings also have a number of implications for service plans. For example, participants emphasised that individuals delivering psychological therapy to people with learning disabilities need to have access to appropriate supervision. Something Waitman (1992) feels is lacking, as she highlights the need for high quality, regular supervision from qualified and experienced clinicians. Whilst the lack of supervision was not an explicit difficulty raised by participants of this study, their accounts serve to emphasise the importance of supervision for the services as a whole.

In addition, the identification of the energy and time consuming nature of the therapeutic relationship has implications for service plans, as they need to appropriately account for the time consuming nature of the therapeutic work in order to avoid further pressure on therapists, such as lengthy waiting lists.

The findings from this study also have implications for protocols and procedures. For example, there appears to be a lack of sufficiently clear guidelines regarding confidentiality when delivering psychological therapy to individuals with learning disabilities. The advice within literature and the conclusions reached by some of the participants is to ensure the parameters of confidentiality are clarified with the client, carers and other professionals involved, at the start of the therapeutic work (Royal College of Psychiatry 2003). However, it is questioned whether therapists would benefit from further in-depth guidelines concerning confidentiality particular to this setting. This could encourage good practice and provide useful advice to clinicians, such as methods of explaining confidentiality to clients. This may also serve to prevent any implicit devaluing of people with learning disabilities and avoid any risk of the contents of therapy being disseminated around the office on an unnecessary basis, as opposed to a need-to-know basis only. Such a recommendation has also been made by the Royal College of Psychiatry (2003).

It is also proposed that individuals with learning disabilities may benefit from some accessible information pertaining to the nature of psychological therapy and the therapeutic relationship from the outset of the therapeutic work. This may help avoid confusion of boundaries or roles when developing therapeutic relationships due to the identified presentation of social naivety due to inexperience of relationships.

3.4 Implications for Training

The findings from this study also have implications for training not only for the therapists delivering psychological therapy to individuals with learning disabilities, but also the wider support services and those involved in other forms of helping relationships.

Multidisciplinary Community Learning Disability Teams, and staff in other services involved with the wider provision of health and social care, need to receive further training and education concerning the potential role of psychological therapy and therapeutic relationships with individuals with learning disabilities. By highlighting this potential role and the lack of tradition in offering psychological therapy to this

group, practice might be altered. This could have a knock on effect in terms of service demand, the provision of resources and create a greater therapeutic culture. It is emphasised that individuals with learning disabilities require support and others to advocate on their behalf, the responsibility therefore rests on the shoulders of staff in the setting to make referrals and demands on services.

It is also possible to highlight a number of implications for training for the therapists delivering psychological therapy to individuals with learning disabilities. Participants themselves also highlighted a need for experience working in this setting due to the complexities associated with it, a suggestion which has implications for training and recruitment. Currently within the regulations and syllabus for qualification as a counselling psychologist, there are no specific requirements for tuition or experience in learning disabilities (BPS 2004). Decisions as to whether to provide tuition to trainees, on the administering of psychological therapies for individuals with learning disabilities, is based upon university discretion. The need for improved training routes is also reflected upon by the Royal College of Psychiatrists (2003) who identify a need for specific training of the delivery of psychological therapy to individuals with learning disabilities.

Participants' emphasis upon the heterogeneity of people with learning disabilities has important implications for training and skill level. For example, it would be difficult to develop a cognitive-behavioural manual for people with learning disabilities flexible and open-ended enough to take into account the variations in domain specific impairments. This emphasis illustrates the need for experienced clinicians to deliver such therapeutic interventions as they require a skill level that moves beyond manuals and technique focused guidelines, in order to encompass and meet the needs of this diverse heterogeneous group.

A further interesting observation which should be considered is the range of tools and techniques used by participants, such as Widget and Bliss and Talking Mats. These tools, traditionally developed and used by speech and language therapists, have not previously been identified within literature as useful in the delivery of psychological therapy with individuals with learning disabilities. This is not only a novel use of such

equipment, it also emphasises their creativity and flexibility in the delivery of psychological therapy. It also identifies a possible training need.

The advantage of having experienced personal therapy when engaged in therapeutic relationships with individuals with learning disabilities is documented in both existing literature (Hodges 2003) and this study. Currently no other division of the British Psychology Society requires trainees to experience personal therapy other than the division of counselling psychology (Macran & Shapiro 1998). This subject, combined with the emphasis upon the need for reflective skills and appropriate supervision, has a number of implications.

The conclusions from literature and the participants of this study has implications for those engaged within therapeutic relationships with individuals with learning disabilities who do not have experience of their own personal therapy. It is questioned whether those who have not had the opportunity for personal development, should be engaged with a client group as complex and requiring such high skill levels as individuals with learning disabilities.

The search for knowledge and feelings of uncertainty described by participants has further implications. It is possibly unsurprising that this experience was identified in light of the limited knowledge concerning the application of psychological therapy to individuals with learning disabilities. It is a new and evolving field, with its recency pertaining to huge implications for those in practice. It is questioned whether the participants are somewhat subject to this recency and feel uncertainty and desire further knowledge as a result. It is hoped that this study may serve to highlight some of these uncertainties and fears in a more congruent and open forum, thus providing impetus and motivation for further research.

4. Critical Evaluation of the Research

This study has made a number of unique and valuable contributions to the existing knowledge base of an under-researched area. Whilst the study possesses originality in terms of its research question and findings, it also has limitations.

One variable that provided a challenge was the heterogeneity of the participants. Interpretative phenomenological analysis (IPA) seeks to identify a fairly homogenous sample in order to allow master themes to emerge (Chapman & Smith 2002). Counselling psychologists providing psychological therapy to individuals with learning disabilities were recruited as a fairly homogenous sample, variety in experience was also desired in order to provide richness of data, therefore all participants came from different NHS trusts. The challenge encountered however, was the influence of heterogeneity concerning broader theoretical underpinnings, the participants' personal theoretical orientation. The researcher attempted to emphasise at relevant points throughout the analysis and discussion where themes may have arisen which reflect theoretical beliefs but the assimilation of these variations proved challenging. It would not however, have been possible to complete this study looking at one theoretical orientation alone without a significant reduction in sample size due to the limited number of counselling psychologists in the field. However, as Smith (2004) states, it is possible to extend the idiographic nature of IPA to single case study analysis.

In addition, the generalisability of this study is questioned. In light of IPAs idiographic commitment, the themes identified within this study are particular to the experiences of these participants (Smith 2004). Therefore it could be argued that the study offers limited generalisability. However, as Smith & Osborn (2003) suggest IPA can offer theoretical, as opposed to empirical, generalisability, as readers may create links between the findings, their own experiences and literature. In addition, what this research hopes to provide is further impetus and guidance to other researchers which may be conducted with other groups, therefore gradually enabling more general conclusions to be reached.

It is also interesting to comment on what issues were not raised within the data. As mentioned previously, the effectiveness of psychological therapy with individuals with learning disabilities was not explored, neither was the level of cognitive ability required to engage in such work. These are both prominent themes in current literature (Mason 2007)[47].

[47] Explored further in "Future Research".

During the course of the analysis and this discussion, the relationships between themes have been emphasised. The development of a tentative model of the nature and role of the therapeutic relationship when delivering psychological therapy to individuals with learning disabilities[48], served to provide a visual representation of the way the themes related to one another as captured within the data. As the study was guided by interpretative phenomenological analysis there was no explicit intention to develop a model. The tentative model developed naturally out of the fluid process of making sense of the data with a combination of explicit suggestions made by participants and additional interpretation by the researcher.

The tentative model itself provides great potential for future research. The model may benefit from further exploratory studies such as that of a grounded theory methodology, which has a particular interest in theory development. The tentative nature of this model, combined with the essence of exploration intrinsic within this study, serves to further emphasise the under-researched nature and the recency of developments within this field.

5. Future Research

As Bihm & Leonard (1992 p.226) describe there exists "*a dearth of information*" concerning the delivery of therapy to individuals with learning disabilities. This proved particularly challenging in the development of this exploratory study. The study was investigating an under-researched yet broad topic, the challenge was to recognise but also amalgamate threads such as the influence of theoretical orientations, the multifaceted elements of the therapeutic relationship and the philosophy of counselling psychology. There exists an overwhelming need for further comprehensive research at a microscopic level of analysis, accounting for each of the varying elements and influence of the therapeutic relationship with people with learning disability.

5.1 Implication for Current Research

[48] Please refer to "Analysis" sub-heading "Relationship between Themes".

It was noted that although participants were not directly asked during the interview, they did not refer to the current debate concerning the evidence base for psychological therapy for individuals with learning disabilities. This lack of acknowledgement combined with the fact they are all practicing psychological therapy in this setting, suggests that they feel any questions concerning its effectiveness have already been answered either through literature or their own therapeutic work and they feel that it is essentially of use.

This is a belief supported by Mason's 2007 paper. He suggests that there is a general "*swell of opinion*" that psychological therapy is helpful (p.247). His paper also concludes that whilst the debate in literature tends to be distracted by issues of effectiveness, the clinicians themselves are more concerned with their own skill level[49].

It is suggested that literatures' pre-occupation with effectiveness studies and the comparison of opposing theoretical positions, has limited resonance with the clinicians who are currently delivering psychological therapy to individuals with learning disabilities. Not only did participants overlook the debate concerning effectiveness during their interviews, they also expressed frustration and concern for theoretical orientations, as they perceived the therapeutic relationship to be of greater influence on outcome. The results of this study emphasise that any future research concerning outcome should take into account the influence of the therapeutic relationship, in addition to the adopted theoretical framework, which participants believed to be of secondary importance.

In addition, whilst current literature comprehensively documents problems with service quality, no research has investigated how this may influence the outcome of psychological therapy and the therapeutic relationship. It is suggested that future studies should have a greater longitudinal emphasis in order to confirm effectiveness over longer time periods. It is suggested that outcome studies should take into account the influence of support staff, carers and resources, on the abilities of clients to sustain

[49] Please refer to "Introduction" section 3.3.2 for further information on Mason's study.

gains from therapy. For example, evidence of poor long-term therapeutic change could be a result of the influence of these relationships rather than any inability on behalf of the client or therapist.

5.2 Further Research with Therapists

There is a significant need to better understand the difficulties associated with therapeutic work with individuals with learning disabilities, in order to better support therapists and ensure clients are receiving appropriate services. A qualitative study using semi-structured interviews would be ideally suited to such an investigation as it would help facilitate good rapport and comfort in order to share such difficulties. Discourse analysis could be an appropriate methodology as its anti-realist stance and interest in social context and participants' interest within conversations, could provide greater insight into the participants beliefs concerning the difficulties. This approach would help take into account the problems participants may experience in exploring and talking about the difficulties with their work and their need to offset this against the rewards. A proposed research question could be: What are the perceived and actual challenges in delivering psychological therapy to individuals with learning disabilities?

It would also be highly valuable to explore whether therapists delivering psychological therapy feel they have the skills to complete their work, an issue highlighted by Mason (2007), through either qualitative or quantitative methodologies. Quantitative research could capture the frequency and extent of concerns pertaining to skill level over a larger population such as both clinical and counselling psychologists, whilst a qualitative study could explore the nature of these concerns and recommendations for future training within interviews.

Further research concerning complex reactions and experiences identified by participants could be highly valuable to the therapeutic relationship and also training. Therapists practising psychodynamically could be interviewed as part of a qualitative methodology such as IPA, regarding common countertransference reactions experienced when working with individuals with learning disabilities.

Further research could also examine not only the motivations for psychologists working with people with learning disabilities, but also which of the therapists' needs are being met through their work, what they get from this work and how this might influence the therapeutic relationship.

5.3 The Role of Clients within Further Research

It is emphasised that individuals with learning disabilities themselves have a valuable contribution to make regarding research concerning the therapeutic relationship. Whilst there would be methodological challenges in terms of communicating and obtaining informed consent with clients with more severe learning disabilities, such research would be advantageous and empowering. The exact same methodology for this research study could be applied to individuals with learning disabilities in order to gain their experiences of the nature and role of the therapeutic relationship during the receipt of psychological therapy. Interview schedules would need to be appropriately accessible and semi-structured interviews relaxed enough to develop good rapport. Gaining clients' perspective on the impact of the loss of the therapeutic relationship through interviews could also be highly enlightening.

6. Final Reflections & Concluding Thoughts

It is only in relatively recent years that psychological therapy has been considered a viable treatment option for individuals with learning disabilities (Beail et al 2005). As previously highlighted, Willner (2005 p.73) stated that there is very little evidence "*regarding either the importance of specific components of therapeutic packages, or the optimal manner of delivering these interventions to people with learning disabilities*".

This study has examined a fundamental element of the therapeutic package; the therapeutic relationship. The results of this study offer a number of new perspectives to the existing knowledge base concerning the delivery of psychological therapy and the nature and role of the therapeutic relationship with individuals with learning disabilities.

It has emphasised the importance of the therapeutic relationship, in addition to various difficulties associated with this relationship, due to variables such as the client's experience in relationships, the need for multiple relationships, the experience of needing to facilitate reassurance and the necessary skills for therapeutic approaches. The study has also offered some insight into the therapist's motivations, values and needs when working with this client group and conflicts concerning individualisation and the setting culture.

The results suggest that the therapeutic relationship with individuals with learning disabilities requires therapists to be flexible with some of the traditional assumptions of psychological therapy. The flexible and creative approaches adopted by the participants influenced confidentiality, therapeutic boundaries, techniques and the traditional one-on-one relationship; however, as suggested, one consistent factor remained fundamental, the significance of the therapeutic relationship.

This study has considerable implications for a range of multi-disciplinary professionals who are involved in helping relationships with individuals with learning disabilities as well as theory, service provision, service plans and training which may aid the development of a greater therapeutic culture for individuals with learning disabilities.

This study also provides a truly unique insight into some of the experiences of counselling psychologists working with individuals with learning disabilities. Little is known about the work of counselling psychologists currently employed within community learning disability services. Its is possible to make some tentative conclusions about the potential that the discipline of counselling psychology has to offer the setting. It is evident that as a new and developing discipline counselling psychologists have a great deal to learn from colleagues and those counselling psychologists already working in learning disability teams regarding any potential role we have to provide such services. The numbers of counselling psychologists are increasing (Bellmay 2006) and as Bor (2006) states we should not underestimate the potential impact counselling psychologist have to make in so many different contexts.

Throughout this study it became interesting to reflect upon some parallels that exist between the experiences of counselling psychologists and individuals with learning disabilities. Essentially they are both minority groups and as a result can share some of their experiences of disempowerment and discrimination.

As a smaller and newer group, (Bellmay 2006), counselling psychologists have struggled with their identity and associated individualism and collectivism. This is somewhat reflective of the struggles of people with learning disabilities described in master theme 7. They have considered similarities and differences to counsellors, psychotherapists, clinical psychologists and the wider collective of applied psychologists. This minority position has resulted in discrimination at various levels including employment practices (Bellamy 2006).

Counselling psychology is possibly well equipped to working with minority groups, such as individuals with learning disabilities, because of its own experience as a minority within applied psychologies. In addition, it is felt that the discipline's philosophical basis has a great deal to offer learning disability services. Counselling psychology's emphasis upon humanism, client-centred work, individuality, reflective practice, wellness as opposed to diagnosis and medical models and the emphasis on the relationship (Woolfe 1996; Bellamy 2006) are all philosophical underpinnings that have significant potential in the setting.

It has been suggested that over the last decade psychological therapy for people with learning disabilities has advanced in both interest and delivery (Beail et al 2005; Willner 2005). Similarly over these same ten years counselling psychology has developed, recently celebrating ten years of divisional status (Woolfe 2006). Whilst these two developments are not necessarily linked, they both allude to changes within the interest and provision of psychological services, in addition to possible cultural and attitude changes within our wider cultures. It is hypothesised that counselling psychology, with help from multi-disciplinary colleagues, has the potential within learning disability services, to help adapt traditional medical model approaches and introduce or emphasise a greater therapeutic culture. A therapeutic culture which is arguably much needed.

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APPENDICES

Appendix 1. Letter of Ethical Approval NHS

London - Surrey Borders Research Ethics Committee
St George's University of London
South London REC office 1
Room 1.13,
1st Floor, Jenner Wing
Tooting, London
SW17 0QT

Telephone: 020 8725 0262
Facsimile: 020 8725 1897

15 December 2006

Miss Rachel Ann Jones
Trainee Counselling Psychologist
Croydon PCT - Rees House
2 Morland Road
Croydon
CR0 6NA

Dear Miss Jones

Full title of study: **Therapeutic relationships with individuals with learning disabilities: A qualitative study of the Counselling Psychologists experience.**

REC reference number: **06/Q0806/116**

The Research Ethics Committee reviewed the above application at the meeting held on 13 December 2006. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

The Committee have suggested you amend the Information Sheet as follows

- Larger Font
- Headed Paper
- Delete the Committee Co-ordinators contact details

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to

inform Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Application		27 November 2006
Investigator CV	1	01 November 2006
Protocol	1	01 November 2006
Covering Letter	1	06 November 2006
Letter from Sponsor	1	07 November 2006
Peer Review	1	01 November 2006
Interview Schedules/Topic Guides	1	01 November 2006
Advertisement	1	01 November 2006
Letter of invitation to participant	2	24 November 2006
Participant Information Sheet	2	24 November 2006
Participant Consent Form	2	24 November 2006
Email Re: Sponsorship change	1	25 November 2006
Indemnity Arrangements	1	03 August 2006
Helping Organisations	1	01 November 2006
Supervisor's CV	1	01 November 2006

Research governance approval

You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q0806/116	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs Sheree Manson
Committee Co-ordinator

Email: sheree.manson@stgeorges.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

Standard approval conditions

Copy to: Dr Heather Liddiard
CJCLDT, Rees House, 2 Morland Road, Croydon
CR0 6NA

London - Surrey Borders Research Ethics Committee

Attendance at Committee meeting on 13 December 2006

Committee Members:

Name	*Profession*	*Present?*	*Notes*
Dr Hervey Wilcox	Consultant Chemical Pathologist	Yes	
Dr Steve Hyer	Consultant Physician	No	
Canon Christopher Vallins	Head of Pastoral Care	Yes	
Mrs Sylvia Aslangul	Lay Member	Yes	
Mrs Wendy Brooks	Stroke Nurse Consultant	Yes	
Mr Derek Cock	Chief Pharmacist	Yes	
Mrs Anne Davies	Chief Pharmacist	No	
Mr Eddy Digman	Lay Member	No	
Dr Rim El-Rifai	Consultant Paediatrician	Yes	
Mrs Nikki Evans	Cancer Research Nurse	Yes	
Mr Christopher John	ENT Surgeon	No	
Mrs Louise Kedroff	Physiotherapist	Yes	
Mrs Sally Kerry	Senior Lecturer in	Yes	

	Medical Statistics		
Dr Lawrence Webber	GP	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mrs Sheree Manson	*Committee Co-ordinator*
Miss Barbara Janicek	*REC Asistant*

Appendix 2. Letter of Ethical Approval University

London Metropolitan University, Department of Psychology

DEPARTMENTAL RESEARCH ETHICS REVIEW PANEL

Doctoral Students. Project Proposals 2006-2007.

Student	Supervisor	Project topic	Cat	Ethics advisor	Recommendation
Surname, First name	Full name	Title can be shortened as long as the topic is clear	A, B or C	Your initials	Here please either simply state: "No concerns" or give a short account of your concerns and any changes you would like to recommend
Jones, Rachel	M. Donati	Counseling psychologists' experiences of therapy (learning disabilities focus)	A	JMcC	No concerns with respect to her research proposal. Concerns regarding facts include, for example, have there been absolutely no studies of psychologists or therapists more generally (e.g., clinical, psychotherapy); does 45 mins. interview imply "in-depth"? I could not see a report from the committee she mentions. The letter of invite, para' 3, could say that she wishes to meet, or would like to meet, rather than "am interested". Something one needs is more than an interest. Ownership of need could be considered a relevant ethical issue by some. No need for re-submission provided supervisor clarifies these issues.

Note: 'Cat' refers to Category, i.e. the overall judgement of the supervisor of the ethical issues raised by the project.

A = Routine ethical issues raised which are addressed adequately by the proposal
B = Major ethical issues raised which are addressed adequately by the proposal
C = Ethical issues not addressed adequately by the proposal

Appendix 3. Letter of Invitation to Participants

(headed paper)

Address / Email / Telephone

Dear X

I am a Trainee Counselling Psychologist working towards my Practitioner Doctorate with London Metropolitan University. As part of my training I am conducting a research study that is interested in developing an understanding of how Counselling Psychologists view the nature and role of the therapeutic relationship when providing psychological therapy to individuals with learning disabilities.

No research has investigated in depth the therapeutic relationship between therapist and client when the client has a learning disability. In light of Counselling Psychology's emphasis on the importance of the therapeutic relationship the profession are in a unique position to share their understanding and experiences of this relationship.

I am interested in arranging to meet at your convenience to conduct a semi structured interview of approximately 45 minutes in length, to gain your perspective on the therapeutic relationship when providing psychological therapy to individuals with learning disabilities. If this is something that interests you please contact me at the above postal or email address. Alternatively, please contact me via telephone. You are under no obligation.

For your information, I will be supervised by Dr. Mark Donati of London Metropolitan University and working under the British Psychology Society Code of Ethics and Conduct.

I look forward to hearing from you.

Yours Sincerely, Rachel Ann Jones

Appendix 4. Participant Information Sheet

(headed paper)

Title of Project: Therapeutic relationships with individuals with learning disabilities: A qualitative study of the Counselling Psychologists' experience.

Name of Researcher: Rachel Ann Jones

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

I am a Trainee Counselling Psychologist working towards my Practitioner Doctorate with London Metropolitan University. As part of my training I am conducting a research study that is interested in developing an understanding of how Counselling Psychologists view the nature and role of the therapeutic relationship when providing psychological therapy to individuals with learning disabilities. No research has investigated in depth the therapeutic relationship between therapist and client when the client has a learning disability. In light of Counselling Psychology's emphasis on the importance of the therapeutic relationship the profession are in a unique position to share their understanding and experiences of this relationship.

Why have I been chosen?

You have been approached to participate in this study as you are a Counselling Psychologist providing psychological therapy to adults with learning disabilities.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you take part, you will participate in a semi structured interview lasting approximately 45 minutes. This interview will be recorded on audio tape and subsequently transcribed, and direct verbatim quotations maybe referenced in the write up

You are also offered the opportunity to comment on analysis of the project. If you are interested in this, then please provide your email address at the bottom of this form. You will then be contact when analysis is complete around May 2007, otherwise, no further contact will be made.

Contact email (if you wish to comment on analysis).....
Name: .....

What will happen to the results of the research study?

As the research study forms part of a student project, a copy of the study will be kept at London Metropolitan University Library. In addition, it is possible that the study will be published.

You will be given a copy of this Information Sheet and of signed consent form.

Ask if there is anything that is not clear or if you would like more information.

Take time to decide whether or not you wish to take part.

Thank you for your interest in this research study.

Appendix 5. Consent Form

(headed paper)

Title of Project: Therapeutic relationships with individuals with learning disabilities: A qualitative study of the Counselling Psychologists' experience.

Project number: AB/95078/2

Name of Researcher: Rachel Ann Jones

Please initial box

1. I confirm that I have read and understood the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐

2. I understand that my participant is voluntary and that I am free to withdraw at anytime, without giving any reasons, without my legal rights being affected. ☐

3. I understand the interview will be recorded on audio tape and subsequently transcribed, and direct quotations maybe referenced in the write up. ☐

4. I understand that my information and the data from this interview will be kept anonymous and locked, ensuring that personal identification cannot be made. ☐

5. I agree to take part in the above study. ☐

----------	----------	----------
Name of Participant	**Date**	**Signature**
----------	----------	----------
Researcher	**Date**	**Signature**

Appendix 6. Helping Organisations

Samaritans	08457 909090	www.samaritans.org.uk
British Psychology Society	0116 254 9568	www.bps.org.uk
DoH - Support line for survivors of professional abuse	08454 500 300	www.doh.gov.uk
NHS Direct	0845 46 47	www.nhsdirect.nhs.uk

Appendix 8. Interview schedule

CRQ: How do Counselling Psychologists experience and understand the nature and role of the therapeutic relationship when providing psychological therapy to individuals with a learning disability?

Can you tell me a little about the setting in which you work? How long have you worked in this setting?

Can you briefly tell me what attracted you to work with people with learning disabilities?

Can you tell me about your own experience of what it is like to develop a therapeutic relationship with an individual who has a learning disability?

What is it like? / How does that feel?

Is the nature of the therapeutic relationship different? In what way?

Have you adapted your approach to work with this client group? How?

Can you tell me about the way you understand the role of therapeutic relationship when providing psychological therapy to an individual with a learning disability?

What issues do you think are important to furthering our understanding of psychological therapies for people with learning disabilities and the role of the therapeutic relationship in particular?

Is there anything else you feel that is relevant to your experience and understanding of the therapeutic relationship with individuals with learning disabilities?

Would like to add anything to our discussion?

Prompts: *Can you give me an example?*
Can you tell me a little more about what you mean by that?

Appendix 9. Example of Post-Interview Notes

TRANSPARENCY TRAIL

Abby –

We both remained nervous throughout the interview, spurred on by disruption outside the interview room which included someone being verbally abusive to a member of reception staff.

There was a sense, evidenced by some of her body language, of incredible cautiousness on her part specifically when discussing the supervision she receives and her experiences of working in an environment dominated by clinical psychologists.

She shared in the interview that she believes she overlooks the therapeutic relationship for a number of reasons. Firstly because it is a difficult construct for someone with a learning disability to comprehend and secondly because she is not supported by her peers to consider the therapeutic relationships perhaps as much as she should. Throughout the interview she tended to focus on the use of the therapeutic relationship within therapeutic work, as opposed to what might naturally occur between two people.

She was also an individual who found the process of the interview served as a reminder of her culture of training and the path her own journey in learning disabilities has taken. It was felt to be quite a significant opportunity for her.

Abby predominately describes herself as a CBT therapist. She has worked as a psychologist in learning disabilities for five years, three years post qualifying. She worked as a support worker in learning disabilities before this.

Appendix 10. Example of annotated transcript

I: Right.

P: Absolutely.

I: And you've stayed?

P: Yes I've stayed. You know I've stayed working here for eight years and umm, I love the variety and I love the everyday is different and it's a whole range of issues that I work with. Umm, I couldn't work in adult mental health, that would just, bore me, bore me rigid. I think. I like the fact that one day I can see a couple of clients in, in the little clinic and in the afternoon I can be out and about in a day service working with clients. Or I can be running a group. Umm. In a different setting. Its really varied.

P: Mmm. And have you worked in other settings during your training? Like adult mental health.

I: Yes. Yes. I did a placement in umm, a GP surgery and umm, which umm, I kind of just saw people who didn't really have … , I mean, life wasn't going well for them but I, I, I had very little patience for those clients, as they had, you know, adequate cognitive abilities. They had the ability to think through things and to take responsibility for their life and they chose not to. And I found that really frustrating. That people would just allow themselves to kind of, wallow in their own unhappiness and they'd want a magic fix. And there wasn't anything really stopping them. Apart from themselves. And I found that really frustrating because with our clients you work with people who are struggling who are desperately trying to make their lives better, umm, but because of their limited abilities that, that's really difficult for them. And it can be really overwhelming. So, I, I, there is no way I can work in primary care and then I did a placement in adult mental health, you know that wasn't much better than primary care. I just, again there were a lot of people who, who intellectually were, were very bright and, again weren't happy, weren't … they wanted to blame somebody else. Rather than taking responsibility of their lives and weren't really motivated and umm, and, … the ethos was very much you work with the, with the client, you know they come in and you work with the client. Where as for me I work

pleasure enjoyment as a result of the variety

therapist's -ive experience in LD.

boredom/dissatisfaction with the setting

dissatisfaction lack of empathy with non LD.

impatience

frustration with individuals with abilities

therapist's -ive experiences elsewhere

Suggestion people with LD need her help, those without can help themselves. — LD entitles people to help.

frustration with outcome in AMHS.

LD matched her theoretical orientation - systemic approach.

in a very systemic way and umm, little progress was made in adult mental health, I think often actually you need to work with the whole system. Its so much easier to do that with people with learning disabilities. Umm. And I certainly didn't enjoy it as much as working with this client group.

use of systems in LD

I: And do you work with just individuals with learning disabilities or do you work with err, staff groups and families.

individualised, varied use of systems

P: Yeah. Yeah. Yes. Yes it varies. Umm. There will be some people that I will see individually and that will umm depend very much on their circumstances. You know if their living on their on and they have very little support then I will see them on their own or umm, if, and again it depends on their problems and issues. I mean sometimes we get clients referred for anger management and often its about the environment they are living in. So I found it really helpful to have a member of staff come in a sit in on the sessions. Because they then hear so much more about what the client is feeling about where they are living and that has a huge impact. They are able to go away and have a much better understanding of what's going on for the client. And then they are also able to hear, you know, umm, some of the coping strategies that I am giving the client. So they can reinforce that in the home environment. And I think, that has been really useful to do that, kind of at the beginning of therapy to get things more stable at home and then later on, umm, I've seen the client on their own. Where we've maybe moved onto much more personal issues rather than just the anger management, maybe looking at issues of bereavement or abuse, and I've done that without the staff member there. And yeah, I think having staff is useful and I think sometimes its necessary to see people on their own as well.

staff support in sessions

insight

joint working

multiple relationships

I: You seem to be talking about the fact that its umm, important to have a touch with the wider networks of people with learning disabilities.

individualised differences, use of systems.

P: Yeah. Yes. Yes. Absolutely. Its not necessarily just about the home environment, you know, there are, some, some people that I work with where actually its really helpful to find out what's going on in the day service or at work. Umm. And so I will go and meet with the service staff or their colleagues and we'll talk about what's going on. And that gives me a much clearer picture of how that clients behaving and

- multi disciplin. working at a broader level.

day services too.

what brought the issues up and then maybe we can umm, raise those in the sessions. Yeah.

I: Ok. Great. Umm. Can you tell me a little bit about your own experience of what its like developing a therapeutic relationship with a person with a learning disability?

P: Ahhh. Umm. … … My own experience, oh yeah. I think it varies. I mean with some, with some clients its … its fine and its really, really easy and you know, you just kind of click with the person and with others it can be much more difficult. And I'm not sure if , that's, that's dependent on things like, you know, their own anxiety about coming to see a psychologist. … It can often be about their limitations in that you know, they are not able to understand what they are doing here. They are not able to, verbalise what's going on for them. So that can be difficult. Umm. What I have found is as I've worked here for so long, that there is a real, a umm, community out there in our day services and because I've been around the days services and various people have come to see me over the years, umm, sometimes building that therapeutic relationship can be easier. Because they go 'oh I know you, you're the person who came into see so and so and they had a really good time with you and liked seeing you'. For some people its easier because there is already that kind, there's a reputation there, that they know about. 'oh its you, alright then'. And so its much, much easier. I think people who are completely new to our service umm, its maybe a little bit more difficult. Umm … And I think for some of them its 'goodness me what's this all about', you know, some bodies sat here listening to me, that's never happened. Yeah.

Yeah.

I: Mmm. Mmm. You seem to be talking about the importance of famil … familiarity with people.

P: Yes. Yeah. It does seem. Yeah. Over the years I've had, I've seen some people and then closed them and a couple of years later they've been referred back. If we've had a good therapeutic relationship in the past we've been able to pick up, you know, they've seen it as a welcome return. 'I'm just going through a difficult patch I'll just come and see (name), she can help me and then once I've got through this difficult patch I won't see (name) again'. And there are some clients who know that every now

and again they need to come back and see me. And I know that, they know that and everybody else around them knows that. And its, umm … its kind of … its … its like seeing old friends for them. Its very much this is familiar, 'this is somebody who is my friend and is there to support me'.

I: Mmm. And you said in contrast there are some people will come in and are, or think 'what's this all about?'

P: Yeah. Absolutely!

I: Can you tell me what you mean by that?

P: Well, you know often they won't be, you know, they'll have maybe seen the psychiatrist and they'll have said 'I'm going to refer you to psychology, is that ok with you, for a bit of counselling' and the client goes 'alright then', 'you know to talk about your feelings' and the client goes 'ok'. And umm, I think for some of them they don't actually want it. You know. I had a chapped referred. Umm, and really its coz his mum kept banging on about how difficult he was at home. He didn't want to see anybody, he was quite happy with himself and he didn't turn up. And I was like 'fine that's his choice'. Umm. And I think often there is that idea that we can help everybody, well actually some people don't see it as a problem, its not their problem, its everybody else's problem. … And there are those, who, who, who come along and they are really not sure about what is going to happen. They are really quite anxious about it. And umm, … are just, you know, kind of bewildered about what's going to happen in the session.

I: Mmm.

P: But then are generally more than happy by the end of the first session to come back and see me again. You know. They've found that hour enjoyable or maybe not, you know, not enjoyable as in I've had a nice conversation because often, you know, they are quite distressed in that session. And we will talk about difficult issues in the assessment … but there is this kind of relief that somebody is going to talk to me

about this issue, instead of just telling me off. And I think often people are quite anxious about coming to be told off about a problem that they've got.

I: Right

P: And they're quite relieved that that's not what this is about. That its about giving them an opportunity to talk about things.

I: You seem to be hinting at the fact that maybe they're not, it's a different type of experience for them, to see you, than they have in the wider world.

P: Yeah. Yeah. Yeah. I don't think many of our clients have the opportunity to sit down and really talk about themselves. Umm. A lot of our clients, their lives are, they are in day services during the day, where there are lots of other clients. Umm. And the other clients are not so great at listening or umm, empathising or even thinking about where the other person is coming from. And there are lots of day centre staff who are really busy, dealing with all the other clients or having their own concerns about what's going on with the other staff. And you know, I don't think that clients regularly get that, that time and space with somebody with whom they can sit and have a meaningful conversation with. Umm. And I think those that maybe live at home with parents, its, its probably quite difficult within the family home to have a meaningful conversation about really personal things, often because families have got into a way of being. They've got, they've got how they are, They've got their patterns umm and, you know, often some of the issues that our clients have it because of the way their family is with them, so our clients aren't going to be able to sit and say 'mum I get cross because I get fed up of you nagging me', you know.

I: Mmm.

P: And then those that are living independently or with a family or maybe have support workers or residential staff, I just think that homes are such busy places. They kind of seem to be an extreme, they are either really quite with no staff there or the staff are busy cleaning the bathroom, or doing shopping list or sorting people's money

out. Or its just so busy with other clients that the clients really doesn't have the opportunity to have one to one with staff.

I: Sure.

P: I think when they come here, this is often the first time they've really had somebody sit and listen, because they don't have friendships in the same way as you and I have. They certainly don't often pick up the phone to somebody who can sit and listen.

I: Mmm. What's that client for you as a clinician? How does it feel like developing a relationship with these individuals?

P: Umm. What does it feel like? Goodness me. Umm … I think, if I think about it, it feels like, it's a special place to be. That … I know people's secrets and … that feels really nice that they've felt they can trust me with that, that feels really special that they can trust me with those feelings umm. On the other side though, it makes me, its sad, that there isn't anybody else there for the clients and I just kind of think, I don't see all the people with a learning disability here, what about the rest of the population who aren't having that opportunity. And my god no wonder there are so many mess ups that happen, you know, we hear on the grapevine that client x has done such and such and you just kind of think, 'oh dear that's probably because you know there not having that opportunity'. And often the relationship I have the clients, the clients give me permission to act as almost a go between, between them and staff to help try and resolve those issues. Umm. If the staff team, seem to be a staff team that will take on board ideas. Yeah. So I think, I think it's a very privileged position that we are in.

I: You mentioned a couple of examples there of how your work might be different than in adult mental health.

P: Yeah.

I: I was wondering whether you could tell me anymore about how the therapeutic relationship with people with learning disabilities is different to other settings?

Appendix 11. Initial List of Themes from Example Transcript

Therapist's positive experience of working in learning disabilities

Enjoyment of variety

Dissatisfaction with other settings

Familiarity

Multiple relationships encountered during therapeutic work

Difficulties in the therapeutic relationship

Time consuming

Influence of client's previous relationships

Inaccurate expectations belonging to the client

Putting the client at ease

Significance of the therapeutic relationship for the client

Significance of the therapeutic relationship for the therapist too

Fundamental to outcome

Compensatory strategies developed by the therapist

Uncertainty of the therapist

Limited research

Comfort & relief for the client

Problem of the referring person

Flexible boundaries

Therapist's frustration with their lack of insight into client's experiences

Therapist hypothesising

Therapist's directiveness

Appendix 12. Master & Sub-themes table from Example Transcript

TRANSPARENCY TRAIL

Master Theme	
	Variety of relationships within the therapeutic work
Sub-themes	
	Multidisciplinary Relationships
	External Relationships
	Problem of the referring person
Master Theme	
	Significance of the therapeutic relationship
Sub-themes	
	For the client
	For the therapist
	Fundamental to outcome
Master Theme	
	Putting the client at ease
Sub-themes	
	Relief
	Comfort
	Flexible boundaries
	Acceptance of help
Master Theme	
	Difficulties in the therapeutic relationship
Sub-themes	
	Influence of other relationships
	Good e.g. experience of therapy before
	Bad
	Inexperience & Uncertainty
	Time
Master Theme	
	Therapist's experience
Sub-themes	
	Satisfaction & Variety
	Dissatisfaction with other settings
	Therapist's uncertainty
	Limited research
	Lack of insight into client's experiences
Master Theme	
	Compensatory Strategies
Sub-themes	
	Hypothesising
	Directiveness
	Structure

Appendix 13 a. Further Examples of Annotated Transcripts

TRANSPARENCY TRAIL

Kevin

disabilities and normal living, and umm, in those days that wasn't around. And umm, I guess at that time as well, a lot of people were coming out with psychology degrees, and going into support work, it was, it was something a lot of people did. In the team, where I worked, there was only five people, and three of them had degress, and three of them, you know, myself included and were going onto to do masters and looking you know. So we were good, as a staff team, and I think that was beneficial for the people and that we worked for. The thing is that doesn't apply now. And, umm, and, umm, part of that is that the salaries haven't kept pace. And when I started, the salaries weren't great, but looking at them now, they were a lot better than they are now.

I: Mmm.

P: And so staff groups, tend not to be like that. And what you tend to find is that staff groups haven't got the skills or the experience or the enthusiasm to work with people, without a real network of support from, from, umm, professionals. And its constant and ongoing. We find it really difficult, for people to, umm, generalise what we are talking about. So we might be talking about something really specific, and I would hope that when I was in a staff team, the staff team worked in would take that specific and then generalise it to other situations, but we find that's much more difficult now.

I: Right.

P: Umm. But as I say it galvanised me and when , after umm, my masters, I applied for two jobs and both were in learning disabilities. And umm, I got the second one I applied for and umm, I haven't really regretted it. I think, partly as I say its because of that wide range of client group. Which, I have worked in mental health, because my placement in my training was in mental health. The difference is really quite staggering, you know, in mental health I always worked with the person that had the mental health problem, in isolation, one person. Where as here we work across the board, we can even, go into schools and day centres and so on and so forth, which is much better because you're having to see people in their environment, you can then help in a much more hands on way if you like. Whereas in mental health your just

restricted to talking to somebody in the room, which has much less effect. So, umm, and also I find that a lot of people don't appreciate that. You know, they don't understand. Because I remember when I was going for chartership, I put my plan together, because I went through the independent route. And umm, of, of how, of how, the, the job was split and, umm, and the case studies I was going to do and dah de dah. And umm, I got back from the chair, who I won't mention his name, 'as learning disabilities is such as narrow field we feel you may need to have a placement elsewhere'. You know. And I just thought that that was so, so ignorant of learning disabilities. You know. But I wasn't able to argue the point, you know so, I did a days placement in primary care. And in primary care, I saw one client in a room, one person, you know, but, (laughs) there you go, so … I don't

I: Mmm.

P: I don't think that a lot of people have a umm, very, very enlightened view of learning disabilities. They don't appreciate what it is. They may see someone with Down 's syndrome, and think 'that's learning disabilities', but of course its much, much more broader than that. Sometimes you are working with people, who many people, wouldn't even consider had a learning disability, because of the way they can articulate. But what they do have is some processing difficulties, and although they are very articulate, and they can talk, perhaps they are not always, following or understanding or appreciating or being able to conceptualise or being able to think in an abstract way. Or they maybe on the autistic spectrum, and people, find, that, that's not an easy way to work with people, because on one had they seem that they are able to understand but on another hand they don't, and if you don't compensate and don't accept that and work with that, then you don't get anywhere, it means, working with people, is, is a challenge. Because, you cannot come into a room with somebody and think 'ok I'll just work the way I did last time'. You know. 'oh this referral, it's the same as the last one I had, I'll just do the same'. Well it doesn't work that way at all (laughs).

I: Its interesting, you've mentioned, you've used the word challenge and difficult. And umm, my next question is, umm, is, is concerned about, whether you can tell me

a bit about, your own experience of what it is like, you know, to developing a therapeutic relationship, with somebody who has a learning disability?

P: Yeah. Well I think I've said its different with everyone. But I think the underlying thing is, is patience … not expecting too much too soon. But I think it's the same whether you work in learning disabilities, I think it's the same as in every situation, but, it's just more of something. You know. You take, it takes a bit longer. … You try as much as possible to get rid of err, jargon, to be as normal as possible, to be as open as possible. And by, by that I mean, I try not to be a therapist in the room and a blank canvass, because that's what people face all the time. People who won't give and won't share and won't belong and umm ... What I try to do as much as I can is to find a language that we both understand. And, and that, that takes quite a long time depending on the situation. And people can be quite verbal, and umm, articulate and use words but they sometimes don't know what they mean. So I spend quite a time err, finding out what somebody understands by the language that they use and the language I use. And when we have a mutual language, then that's how the relationship begins to develop. If you use a words people don't understand that's a bridge, that's a gap rather than a bridge, between you. And sometimes they're simple words, everyday words that we use all the time, and in therapy we use all the time, like imagine. You know. Its pointless using the word imagine if somebody doesn't know what imagine is. And often people don't. So we do a little exercise and a bit of role playing and try to simplify things by making it more concrete (cough). And, then we find a word that they use for imagine and understand, which is often something like pretend. You know, people who are really non-verbal will know what pretend is (cough). But, but that's something that, that I devised and the literature holds up on that. And that's, that's something I always tell trainees, and so on.

I: Mmm.

P: Umm, the other thing I always use, it may not be evident, from, from this conversation, is humour. People appreciate engaging in, in that way because it's a very warm relationship then, if you can have a laugh and you can joke about and things. And also, some people's lives, if they have been full of loss and, and so on, if

rediscovery laughter for people with LD.

you can't laugh about some things, it makes it more difficult for them to talk about those things.

I: Ok.

inexperience in relationships

P: Because, … often they've experienced people not wanting to talk about things that are really difficult. Because there is nothing that can be done about a learning disability. There is nothing that can be done about the fact that you might not have children or the fact you might never get married or might never leave home or you might never have a house of your own and so on. So people don't talk about those things, but I you can find a way of engaging with them and maybe even having a laugh and sharing a joke about things that are really quite taboo, then that can help people feel ok about talking about it.

Role of previous relationships

futility

tackling in depth

meaning

relaxing the client so they talk + share with you. Assess this t.r. is the first relationship of its kind for this reason.

I: Yeah.

P: So humour is, is a really big part of the work.

Relaxing the client

I: I am wondering what its like, umm, as well, you know you mentioned about needing patience and it can be difficult, what it feels like to you, engaging in a relationship with a learning disability? You know, what, what, what it actually feels like for you? What it conjurors up for you as a, as a psychologist?

perceptions of others

P: Well, … I think that's a difficult one, because err, I spoke to somebody the other day and they were saying, how umm, how it must be difficult and umm, you know … do you take it home, you know, is it, does it hang on you, does it stay with you. And I said 'well no'. Because if it did I wouldn't be able to do it. You know. And umm, I guess difficult, … the word difficult is, is, is a misnomer, because it's a word that we use, you know 'its difficult'. Its not that its difficult. Its that its demanding, in a way. That you can't float. You can't just breeze through it. You can't pretend. You have to be in it. And umm, I'm not saying that, in some relationships in other settings that, that necessarily people do that.

Complexity of the therapeutic work.

necessary additional skill level

1 complexity – extra energy / extra push.

I: Mmm. Mmm.

Therapists' need to concentrate/focus

P: But there are situations where people can breeze a little, they can just sit back and allow the client to do the work, and maybe take a bit of a breather, you know. Then come back into it when, when they've finished, what they are going to buy in a supermarket (laughs).

I: (laughs)

P: You know. I know that sounds cynical, but I've been around a long time and I know that people do that from time to time and it is hard to focus and concentrate on fifty minutes or sixty minutes or however long people spend but. If you work with somebody who finds it difficult to communicate, if you, if your not focused and thinking and being there, then your going to loose them. Because its incumbent on you, to try and help them to make that connection.

Responsibility on the therapists — they are responsible for the work to develop. Greater responsibility.

Therapists' skill level ↓ energy consuming

I: Right.

P: See … their not just going to open up, they're not just going to go with the flow of consciousness, they're not just going to start thinking about, you know, what happened yesterday and it might be something to do with what happened the week before and so on. In a way you have to help them make those sorts of connections, so you have to be with them all the time. So I guess that's what I mean by difficult. The actual work, the actual process of it, is no different to any other setting but I think it, it just means being there as much as you possibly can, which can be quite tiring. And I guess the way I deal with that is, I always try to have a laugh out of the session with somebody. And umm, I always try to write something down straight away and I find that really useful. Although in the NHS they are trying to stop us from doing that, we have to start using bloody electronic records (laughs).

Therapists' tiring — energy consuming

Therapists' needs ↓ self care / techniques developed to manage

I: (laughs)

Methods adapted to support oneself.

P: At the moment I try to write stuff down. If, if, if there are things that I'm feeling, then I prefer to write that down straight away. Some people let things go round a little bit before they write stuff down, but I try to write stuff down straight away. I guess I

Appendix 13 b. Further Examples of Annotated Transcripts

TRANSPARENCY TRAIL

Joanna

P: Yeah. I think its equally crucial really. Yeah.

I: Ok. Great Umm. You umm mentioned a little bit about your theoretical orientation umm and your interest in psychoanalytic work umm, do you think that influences your interest in the relationship, your, your, emphasis upon it?

P: Yeah, yeah, definitely, definitely. Because it, the psychoanalytic approach you know its all about the relationship, I was going to say its all about the mother but it kind of is in a way (laughs). Yeah, heavily influences my view of the therapeutic alliance. I've got friends who are excellent therapists, really excellent therapist who are pure CBT therapists and their view of the therapeutic relationship is a completely different one. It's a teaching role, its an instructing role, which is fine umm, and there, there, there is room for that I think its important, I think it depends on your client group and what your trying to achieve. Umm, it depends on the problems. You know there is no point in doing CBT with someone who has been sexually abused for fifteen years you know. Its just not, its not going to hit the mark. Umm. So yeah, because it heavily influences. I think my main, main model my main theoretical model I would turn to would be Klein, Winnicott, Bowby, Bion and its all about you know, essentially what your doing as a therapist is, is umm what the person hasn't had in that early, in early childhood, which is a person receiving all their crap processing it for them and giving it back to them in a manageable for so that they don't have to tolerate unmanageable anxiety. So, its, its absolutely fundamental in my view, the therapeutic alliance and this model.

I: Ok, great. Umm. Do you think there are any issues important in furthering our understanding of delivering psychological therapy to people with learning disabilities and also the therapeutic relationship?

P: Umm. Say that again? (laughs)

I: Umm, the questions about our further understanding, areas which you think we could understand better as counselling psychologist working with people with learning disabilities?

limited research

P: Umm. … areas we need to understand better. I think there is a real need for research. I think this goes across the board with the psychodynamic stuff but, there is a real need for research in this area, there is not very much. Pat Franksih and Nigel Beail have done a bit, Nigel Beail in particular, but there is not a great deal about psychotherapy and learning disabilities I don't think. Certainly not my model anyway. Well there isn't in general is there, there is some CBT stuff as well, there is that book that Biza-Kreose edited that had some stuff in it but no, there is not that much. I think, I think that's because of the history because it all used to be institutions and behavioural theory its only been in the last fifteen years that, that there has been more of a trend towards offering psychological therapy or even recognising that people with learning disabilities have emotional lives. So there is definitely a need for research, because without the research you can never argue with the commissioners why there should be resources.

uncertainty - isolation?

search for knowledge

current knowledge influenced by historical position

recency of psychological therapy

link between research + funding

I: You mentioned there about how umm, the history of people with learning disabilities in terms of the dominant behavioural approaches until maybe more recently, do you think that's influenced your work or your experience of your work in anyway.

P: That there is that history?

I: Yeah.

therapist's motivation derived from historical treatment

P: Umm, I think yeah, I think it makes me want to champion it even more, you know, because I think its really important and I think, deep down I think its disgraceful how people with learning disabilities have been treated I don't know whether you've ever seen footage from the old institutions, because its before my time and obviously before your time, there old shut down now. But its hideous. People used to have to share false teeth and be sat on buckets to go to the toilet and share clothes and … just outrageous really and that was going on really up until the eighties. I saw one footage of one institution that was filmed in the eighties. Umm and that was just unbelievable. So I think I feel very strongly about human rights in that regard and people who, a group of people who have a history of being so neglected and abused even more so need the opportunity to, to talk about their lives and their feelings and try and link up

emotionality emphasised in her use of language

disbelief outrage

therapist's motivation + values

passionate

rationalising need for t.r.

alliance with the disempowered.

what they think and feel more. Umm. So I think it, it makes me feel more committed to it I'd say. Yeah.

I: Umm. Is there anything else you feel is relevant to your experience and understanding of the therapeutic relationship with people with learning disabilities?

therapist's expectations. caution regarding achievements in therapy + sustaining gains.

P: Umm, anything else I haven't talked about … umm … … I suppose the one thing I haven't mentioned is that its really key as well is umm, your looking for baby steps (laughs). Don't expect somebody whose been abused for years, whose not been, not had any kind of emotional nourishing in order to develop, don't expect them to be able to, to make great leaps and bounds and be leaving therapy a year later you know with having advanced tremendously, I think you have to be focused on baby steps forward and you know, and treat those achievements for the person as enormous actually. Our client group tend to be, tend to have gone through a lot, you know. Umm. So I think the idea about sustaining gain you know, how difficult that can be for somebody. You might work on a whole series of loss and traumas but then they are going off back to continued loss and trauma. So you know, sustaining gain can be difficult as well. There are issues around, sometimes there are issues around then memory and so on that I think can effect what a person can hold onto to.

realistic expectations

difficulties in maintaining achievements

fragility of the work - due to LD + systems.

I: (coughs) Is there anything else that you want to add to our discussion at all?

limitations

P: … I don't think so … I think I've probably given you all might thoughts on psychotherapy and learning disabilities. (laughs) All the thoughts available to me right now anyway.

I: Sure. Sure. Can I got back to one point, from before my coughing fit. Umm, you mentioned about people with learning disabilities may come to you, into the relationship and the work that you do and then return back to umm, situations of rejection and things. How do you think that, that influences your relationship if at all, the knowledge that may be returning to that.

limitations of the work + possibilities for the work.

P: I think, someone once likened working in LD to working in palliative care. I can kind of see why. There is a sense of futility I think. Things aren't going to get better

"futility"

for a lot of people, their not going to wake up tomorrow and their learning disability is going to be gone, you can't give them a magic pill or a course of therapy that's going to mean that they can go and get a job, get married have children you know. And I think you are, you are just a bit subject to that. I think its quite a burden, not only, obviously for the individual clearly it is, but I think for services and individual clinicians. There is a sense of burden a lot of the time. Umm. Yeah.

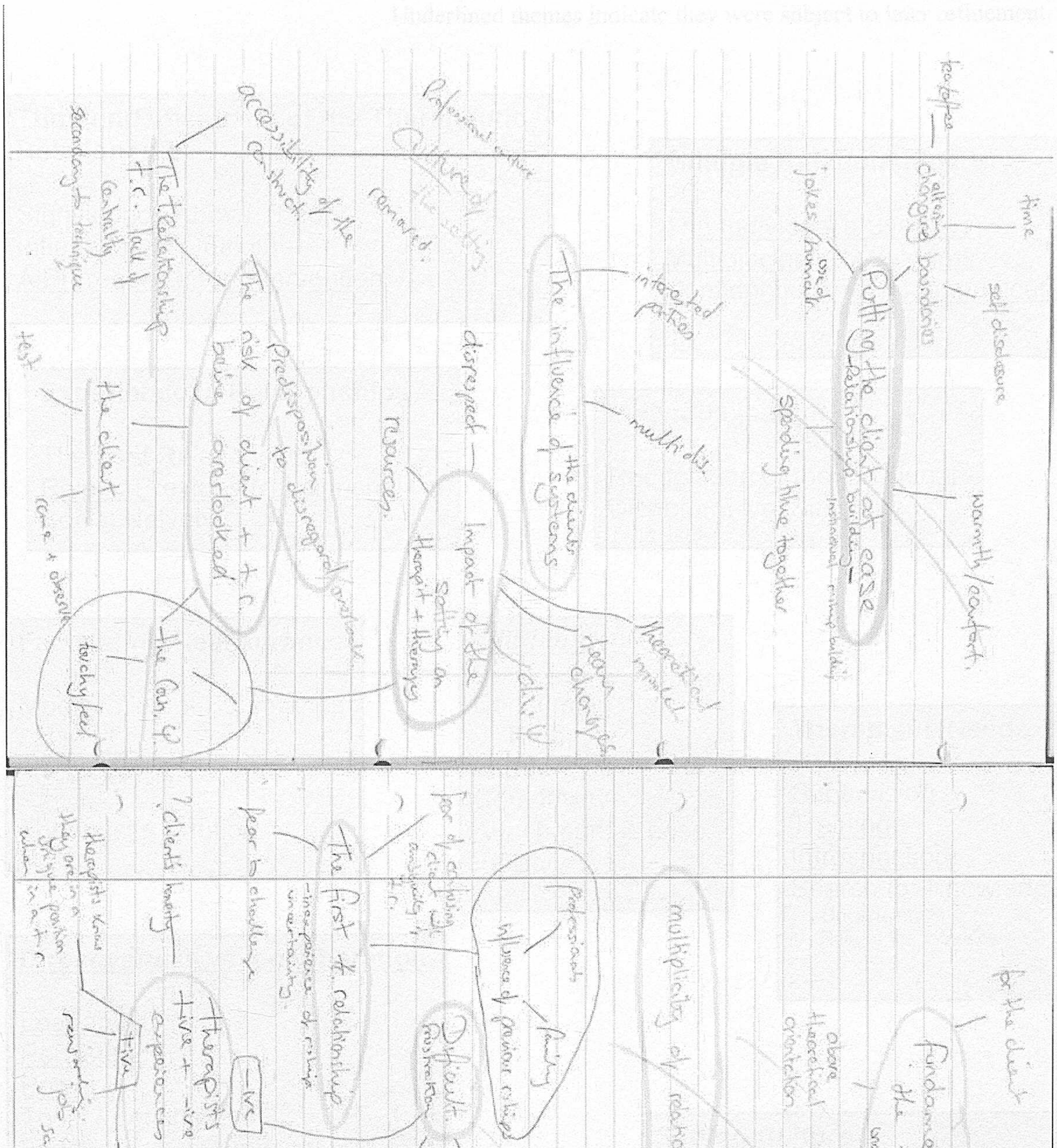
I: Ok. Brilliant. Is there anything else you wan to add?

P: That's it.

I: Ok great thank you.

Appendix 14. Central Table of Themes for all Transcripts – Initial

TRANSPARENCY TRAIL



Appendix 15. Central Table of Themes for all Transcripts – Refined

TRANSPARENCY TRAIL

Underlined themes indicate they were subject to later refinement.

The Fundamentality of the Therapeutic Relationship

Significance Above Theory
Influential on Outcome
A Prerequisite for Intervention

Multiple Relationships

The Individual's Systems
Multidisciplinary Systems
Confidentiality vs. Communication

Experience in Relationships

The First Relationship
Role in Previous Relationships
Social Naivety

Individualisation

Recognition of the Individual
Dichotomy vs. Similarity

Facilitating Reassurance

Modification of Boundaries
- Humour
- Refreshments
- Self-disclosure
- Praise

Therapist's Caution

"*difficult*"

Consuming
- Time
- Energy

Complexity
Attachment & Loss
Futility

Therapist's Needs

Supervision
Training
Introspection
Search for Knowledge
- Uncertainty
- Role of the Interview

Directiveness vs. collaboration

Leadership
Persistence
Power
Tools / Techniques
Language / Communication

Setting Culture

Removed from the person
Disregard
- Counselling Psychology
- The Therapeutic Relationship

Resources

Therapist's Motivations & Values

Emotionally Provocative History
Satisfaction
Familiarity

Appendix 16. Final Table of Themes

TRANSPARENCY TRAIL

The Fundamentality of the Therapeutic Relationship

Fundamental
Influential on Outcome
Significant Above Theory

Multiple Relationships

Triadic Relationships
Systemic Relationships
Confidentiality

Experience in Relationships

Role in Previous Relationships
- Negative
- Lacking Depth
- Inconsistent

The First Relationship
Social Naivety

Facilitating Reassurance

Praise & Comfort
Modification of Boundaries
- Humour
- Refreshments
- Self-disclosure

Therapist's Caution

Individualisation

Recognition of the Individual
Dichotomy vs. Similarity

Therapist's Needs

Supervision
Reflection
Search for Knowledge
- Uncertainty & Research
- Role of the Interview

Difficult

Consuming
- Time
- Energy

Complexity
Attachment & Loss
Futility

Therapeutic Approaches

Directive
Collaborative
Tools & Techniques
Language

Therapist's Motivations & Values

Historical Context
- Emotionally Provocative
- Evolving Services

Satisfaction
Familiarity

Setting Culture

Removed from the Person
The Position of Counselling Psychology
Disregard for the Therapeutic Relationship
Resources

Appendix 17. Table of themes with identifiers

A table of master themes and sub themes with identifiers for the supporting examples from each participant's transcript, for example, Abby 421= quotation can be found on line number 421 Abby's transcript

Master Theme 1: The Fundamentality of the Therapeutic Relationship	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Fundamental	421,	735	301, 522	403		421, 354		269, 420
Influential on Outcome			302	401		429	456, 548 588	
Significant Above Theory			307	451	630	272, 431	530	635

Master Theme 2: Multiple Relationships	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Triadic Relationships						111, 369	318, 395 403	
Systemic Relationships		538	220, 234 471	82	165, 32 485, 510	103, 436	309, 79 363	
Confidentiality		563, 547	225, 237	127				

Master Theme 3: Facilitating Reassurance	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Praise & Comfort	313, 320	610				543, 377 390	447	
Modification of Boundaries								

Refreshments						395		187, 485 506, 510 520
Humour					233, 253	400		
Self disclosure						408		
Therapist's Caution	327, 333, 343, 425	480				357, 369		85

Master Theme 4: Experience of Relationships	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
The First Relationship			310	337	418, 430 456, 527 460	158, 193 242, 215	103, 181	652
Social Naivety	105, 382, 389, 397 105, 170, 176	299				203	720	141
Role of Previous Relationships								
Negative			170, 188 210		413		103	465
Lacking depth					451, 242			
Inconsistent				111				124, 129 117

Master Theme 5: Therapeutic Approaches	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Directive		443, 271		217		283, 314 340, 465, 288, 320 334		
Collaborative	333						110, 115 191, 560 220, 612 639, 211	271, 195 220, 228
Tools & Techniques	58, 130	349, 514		117			444	
Language	330	737, 37 480	146, 164 269	228	214, 620	355	138, 141 600	201, 205

Master Theme 6: Difficult	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Consuming								
Time			452, 459 469	110, 259 271, 485	207	294		98, 452
Energy		202, 264			263, 281 292			
Complexity	49	261, 329 322	471	301, 312 358,	102, 143 304		249	168

				105 241				
Attachment & Loss		113		110, 135 144, 154 167	94	251, 262 172	733	692, 699 737
Futility		211	498	509, 491 184	387, 480 376	521		330, 136 281

Master Theme 7: Individualisation	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Recognition of the Individual	249 290	206, 291 586	259, 275 278, 290		606	197	462, 101 491, 479 241, 289	246, 123
Similarity vs. Dichotomy	149	225, 735 748, 764		98, 203 80	208, 406	490	351, 657	

Master Theme 8: Therapist's Motivations & Values	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
History Context								
Emotionally Provocative				466, 68	129, 580		773, 690 755	
Evolving Services							61, 704 713, 793 777	

Satisfaction		105	475	334, 344		65, 75	250	330, 737
Familiarity		15, 20, 85 97		31, 270		165, 149	46, 51	

Master Theme 9: Therapist's Needs	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Supervision	506, 517, 524			180, 191 277				173, 371
Reflection	485			324,3 62	294, 322 332, 649 665		550, 557	410
Search for Knowledge								
Uncertainty & Lack of Research	86, 180	237	409	443		478, 459		497
Role of the Interview	140, 148, 266, 300 373, 432, 557	721	384 389					639

Master Theme 10: Setting Culture	**Abby**	**Bill**	**Grace**	**Joanna**	**Kevin**	**Kirsty**	**Mac**	**Nehla**
Sub-themes:								
Removed from the person	73, 66	410, 402 361, 680	98, 378			183, 190 185	122	
Disregard for the Therapeutic	482,	424,	81,	86,	452		674	

Relationship	495, 455, 461	36 384	116 512	90				
The Position of Counselling Psychology	49, 105, 143, 156 208, 214, 227, 500 300, 234, 255, 468 475,		483					
Resources	447, 465	146, 419		82	150	141		353, 553 569, 727

Appendix 18. Respondent Validation Letter

Address / Email / Telephone

Dear .....

Further to your participation in my research:

How do Counselling Psychologists experience and understand the nature and role of the therapeutic relationship when providing psychological therapy to individuals with a learning disability?

You may recall expressing an interest in commenting on the analysis.

Please find attached to this email an overview of themes and a draft summary of themes and sub themes that were identified during analysis of the interview data from the eight participants that were interviewed for this study. The summary initially provides a more generalist overview of each theme; this is then followed by a description of how the analysis of your interview data contributed to the development of these themes. This includes specific illustrations from the transcript.

It would be highly valuable to my research if you would provide me with your thoughts and reactions concerning the draft themes. I am interested in ensuring congruence between my analysis as a researcher and your experience as my participant, in order to avoid misrepresentation of data.

In order for me to incorporate your views in my analysis, I would be grateful if you would respond to me within three weeks if at all possible. If I do not hear from you within this time I will assume you are happy with the analysis and do not have any particular comments to make.

Once again thank you for your participation and interest in my research.

Rachel Ann Jones
Researcher

Appendix 19. Example Respondent Validation Summary

PARTICIPANT 7.

How do Counselling Psychologists experience and understand the nature and role of the therapeutic relationship when providing psychological therapy to individuals with a learning disability?

2. The Fundamentality of the Therapeutic Relationship

a. **Fundamental**
b. **Influential on Outcome**
c. **Significant Above Theory**

One of the main themes that was identified from the data was that of the fundamentality of the therapeutic relationship when providing psychological therapy to individuals with learning disabilities. In particular participant's experienced the therapeutic relationship as central to their work, influential on the outcome of therapy and significant above theoretical approaches.

Within your interview you identified the therapeutic relationship as being powerful and essentially the vehicle for change. You described flexibility in your approach to the development and use of the therapeutic relationship depending on the client and the theoretical framework you are working within at the time. You additionally described a need to be respectful of the relationship.

3. Multiple Relationships

a. **Triadic Relationships**
b. **Systemic Relationships**
c. **Confidentiality**

Participants identified that their therapeutic work often involved additional relationships to that which they developed with their client. In particular the following were identified. The sub theme 'triadic relationships' refers to when a third individual, such as a residential staff member accompanies the individual during therapy sessions. 'Systemic relationships' refer to the therapist's involvement with the individual's systems, such as carers and staff, as an addition to the therapeutic work with the individual. The third sub theme, 'confidentiality', emphasises the questions raised by participants concerning maintaining confidentiality when working with the individual's systems and in a multidisciplinary setting.

"...a client can often ask a carer to come into a session. I have no objections to that ..."

You identified a variety of relationships that you develop when delivering psychological therapy to individuals with learning disabilities in addition to that which you develop with the client. You described work that you have completed with

key workers and home managers and a need to be flexible when working with these additional systems. Within your interview you identified that this, more systemic approach, provides greater support to your work and the client themselves. You also described a feeling that it is easier to work with individuals with learning disabilities who often have available to them more 'systemic support', unlike your experience in mental health services.

4. **Facilitating Reassurance**

    a. **Praise & Comfort**
    b. **Modification of Boundaries**
        i. **Refreshments**
        ii. **Humour**
        iii. **Self disclosure**
    c. **Therapist's Caution**

Facilitating reassurance summarises a desire by participants to put individuals with learning disabilities at ease when establishing the therapeutic relationship. Participants described achieving thing through offering individuals praise and the modification of therapeutic boundaries such as using humour, offering refreshments and self disclosure by the therapist. Participant's also described caution with regards to challenging or confusing individuals with learning disabilities during therapeutic work.

This theme was perhaps more evident in the data from the other participants. However, you did identify in your interview an interest in facilitating a good environment for therapeutic work, for example you described work you had completed with a client at their home as opposed to you place of work in order to better meet their needs.

5. **Experience of Relationships**

    a. **Role of Previous Relationships**
        i. **Negative**
        ii. **Lacking depth**
        iii. **Inconsistent**
    b. **The First Relationship**
    c. **Social Naivety**

Participants identified that the therapeutic relationship with individuals with learning disabilities was influenced by their client's previous experience within other relationships. There was an emphasis from participants that individuals with learning disabilities have limited experience of a relationship like the therapeutic relationship. It was identified that the therapeutic relationship was a novel experience for the individuals and often the first relationship of this nature, where they are given time and were central to the process. Participants spoke of a sense of social naivety in the form of honesty and openness when developing therapeutic relationships with individuals with a learning disability. In addition, participant's highlighted how previous relationships that have been negative, lacked depth and consistency have impacted individuals when engaging in therapeutic relationships.

Whilst you seemed able to identify clients who had experience of good relationships, you described frequently working with individuals who find the therapeutic relationship 'unusual' or a new experience. You described a sense that it was 'rare' for individuals with learning disabilities to have one to one time for an hour, to sit and talk about themselves. You identified that clients predominately value this experience in addition to finding it daunting. You also touched on the subject of stigma and how the relationships individuals with learning disabilities have had with others have subsequently shaped them.

6. **Therapeutic Approaches**

    a. **Directive**
    b. **Collaborative**
    c. **Tools & Techniques**
    d. **Language**

Participant's spoke of a number of therapeutic approaches and techniques within the data. Some participants described a need to be directive within the therapeutic relationship, such as taking the lead and being persistent. Whilst conflictingly, other participants reported being heavily client led and developing an interdependent relationship with the client to overcome power issues. Participants also identified particular tools and techniques, such as drawings, to aid the relationship and therapeutic work. In addition appropriately accessible language and alternative communication methods were also described as important.

"And I strive to make that quite valuing in so far that I am always interested in what the client wants to achieve rather than what I want to achieve initially."

You described a predominately person centred approach to psychological therapy with individuals with learning disabilities and a desire to be non-directive as far as possible. Your expressed a belief that it is important for the client to feel they have contributed to an interdependent relationship and that is meaningful for them. One of the techniques you identified for achieving this is using a language that the client has an affinity with or that is part of their repertoire.

7. **Difficult**

    a. **Consuming**
        i. **Time**
        ii. **Energy**
    b. **Complexity**
    c. **Attachment & Loss**
    d. **Futility**

Participants experience the therapeutic relationship with individuals with learning disabilities as difficult. In particular, the therapeutic relationship is experienced as both time and energy consuming. It was also described as complex. Theoretical concepts such as transference, countertransference and secondary handicap were used by participants to explain some of the complexities. Participants identified that

individuals with learning disabilities' experience of attachment and loss in the lives also influenced the development of the therapeutic relationship considerably. Participants also spoke of a sense of futility with regards to the therapeutic work and relationship, due to perceived limitations in achievement.

"... if your responding empathically enough and genuinely enough in that therapeutic relationship I think you often feel echoes of what the client is feeling, you often feel echoes of what's the clients experienced."

Overall your interview data did not emphasise particular difficulties within the therapeutic relationship when delivering psychological therapy to individuals with learning disabilities. However, you alluded to some complexities that might arise, such as experiencing echoes of what the client has experienced. You also described the role and significance of loss for people with learning disabilities, such a client striving to meet the expectations of their family and society.

8. Individualisation

- **a. Recognition of the Individual**
- **b. Similarity vs. Dichotomy**

Throughout participants' accounts there was an explicit need to recognise the individuality of the therapeutic relationships they had formed with people with learning disabilities. There was an emphasis on each individual and their therapeutic relationship being distinct from all others, there was a sense of a tailored approach. There was also reluctance from participants to generalise. Participant also emphasised a conflict between acknowledging the dichotomy of learning disabilities versus the similarity and comparability with the non-disabled population.

"Umm, but I, I think a one size fits all approach doesn't work ..."

Throughout your interview you recognised the variety of individuals that you have developed a therapeutic relationships with. You described finding each client different from the last and a need, as a practitioner, to work flexibly with each individual client's strengths. At times you found it difficult to generalise your experiences during the interview. In addition, you presented a belief that there is no dichotomy or delineation between people with learning disabilities and those without. You also acknowledged a desire for integration with other services for people without learning disabilities.

9. Therapist's Motivations & Values

- **a. History Context**
  - **i. Emotionally Provocative**
  - **ii. Evolving Services**
- **b. Satisfaction**
- **c. Familiarity**

Participants identified a variety of motivations and values that have contributed towards working therapeutically with people with learning disabilities. At an

interpretative level there is a sense that these motivations and values ultimately impact the therapeutic relationship. In particular, the historical position of individuals with learning disabilities was identified as significant for participants. They identified the historical treatment of individuals with learning disabilities as a motivation to work in the field. This was combined with a belief that services were evolving and developing continually, making it an exciting place to work. Participants reported a great deal of satisfaction and reward for working therapeutically with individuals with learning disabilities, something that had not been experienced necessarily in other settings. Participant's experience and familiarity within the field of learning disabilities is also attributed as significant in their work, many having worked in the field since training.

Within your interview data there exists references to the historical context of individuals with learning disabilities. This included references to institutionalisation, Nazi Germany gas chambers and prolific abuse, all of which you described as "horrific". You were able to reflect on the developments within services and society over the last fifty years particularly and identified this as a contributing factor to your motivation to work within the field. You described the evolving nature of the field as keeping you "excited" as you identified the need for continued growth and development.

"Umm, and, and, its interesting you know, more that I think about it maybe that's also what attracts me to this area of work. Because I think there is so much to discover, there is so much to, that, that there's so much, there's so much, there's so much good practice yet to be discovered."

A further motivation for your work appeared to be your experience and familiarity in working with people with learning disabilities; you referred back to your experience as a care worker during you teenage years resulting in a foundation knowledge in the field.

10. Therapist's Needs

- **a. Supervision**
- **b. Reflection**
- **c. Search for Knowledge**
  - **i. Uncertainty & Lack of Research**
  - **ii. Role of the Interview**

Participant's identified a number of needs for themselves whilst engaged within therapeutic relationships with individuals with learning disabilities. In particular, supervision, training and reflection and introspection were identified. In addition, participant's described a search for knowledge due to feelings of uncertainty as to their approaches to the therapeutic relationship and a lack of guidance from research. The interview provided an opportunity for some participants to reflect on this and their uncertainty about theory and practice.

You highlighted a need to be respectful of yourself within the therapeutic relationship, for example, you described boundaries with regards to client's becoming abusive. You also alluded to a belief that therapists should additionally experience the therapeutic relationship as validating and valuing experience.

11. Setting Culture

a. **Removed from the person**
b. **Disregard for the Therapeutic Relationship**
c. **The Position of Counselling Psychology**
d. **Resources**

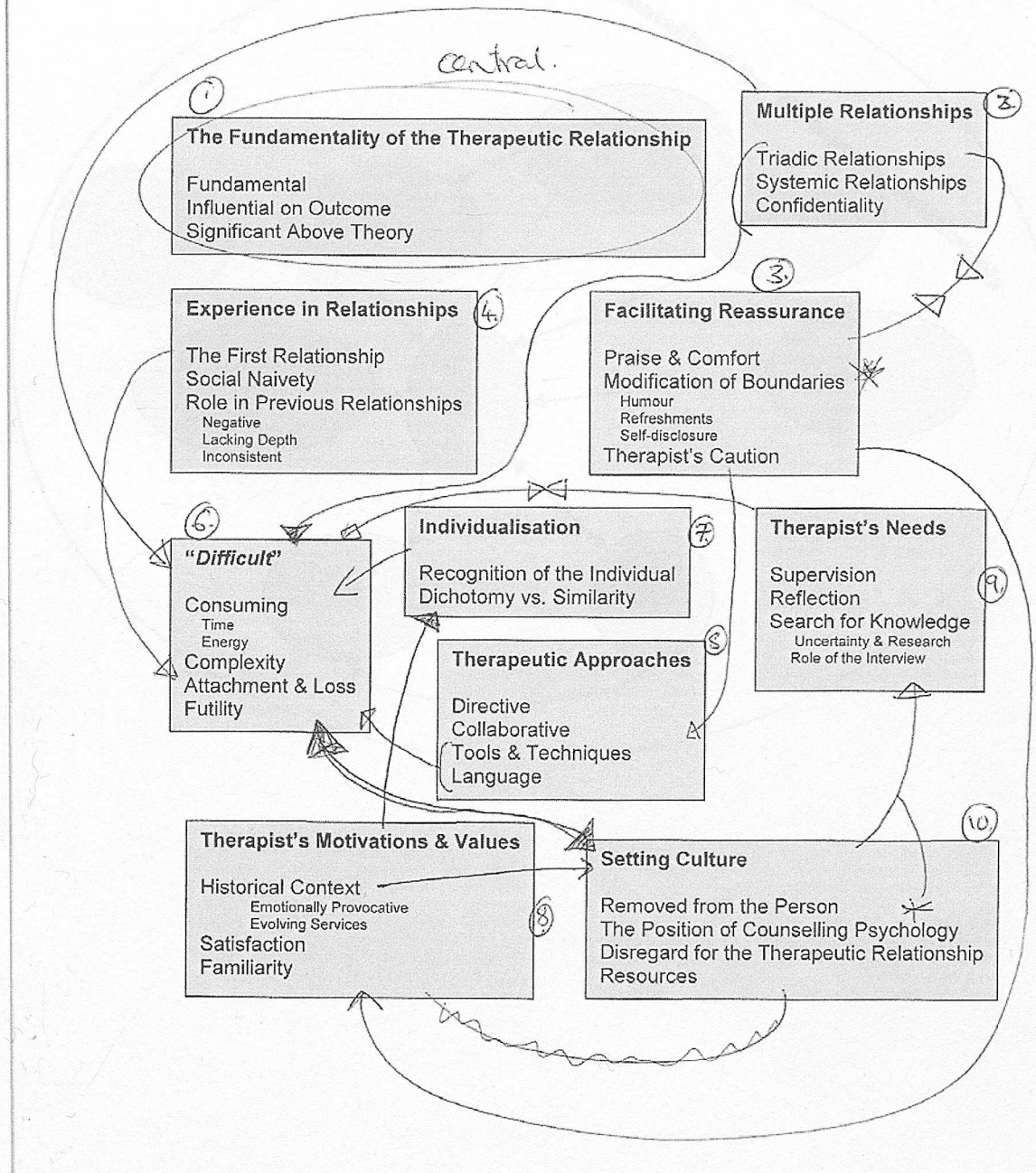
Participants reported a particular culture in the learning disabilities setting, a professional culture, concerning attitudes and approaches to psychological therapy and the therapeutic relationship. Participants identified that the discipline is predisposed to the removal of the individual from psychological work. Some participants also identified that the setting has disregard for the therapeutic relationship as a concept. In addition, participants reflected on their role as a Counselling Psychologist within the setting and their own experience and treatment. The setting culture was also identified as impacting upon resources; environments, theoretical models and attitudes that are not always conducive to therapy.

"I don't think therapy for people with learning disabilities is, is, is that available."

Not only did you highlight the limited availability of therapy to people with learning disabilities you described the therapeutic needs in this client group as frequently overlooked. You also acknowledged your self as being the only counselling psychologist in your part of the trust.

You identified difficulties with the referral process when delivering psychological therapy to individuals with learning disabilities and how this subsequently impacts upon the therapeutic relationship. For example, you described how the referring person, such as a home manager may refer on the basis of their belief as opposed to the wishes of the client. You highlighted how often the clients you work with have not come on their own volition.

Appendix 20. Model Development Sketch



Appendix 21. Model Diagram

Tentative Model of themes associated with the therapeutic relationship when delivering psychological therapy to individuals with learning disabilities