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CASE STUDY

WILEY

Adapting compassion focused therapy for an adult with a learning disability—A case study

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Accessible summary

- Compassion focused therapy is a talking therapy.
- It helps people be kind to themselves.
- We do not know whether this therapy can help people with learning disabilities.
- Here, we talk about what happened when a man with a learning disability had the therapy.
- We hope that other people will use the therapy too.
- This will improve therapy for people with learning disabilities.

Abstract

Background: Joe was referred to the Community Learning Disabilities Team (CLDT) for support around low mood and overeating. Initial formulation suggested compassion focused therapy (CFT) as an intervention. The evidence base for using CFT with people with learning disabilities is currently limited.

Materials and Methods: Adaptations were made to the CFT framework, accounting for Joe's learning disability. A case study design was used to investigate the effectiveness of intervention. Joe attended 13 sessions of assessment, formulation and intervention. Client feedback was incorporated to assess suitability of the CFT approach and adaptations made.

Results and Conclusions: Changes in scores on outcome measures were limited. However, findings from this exploratory study suggest that CFT can be meaningfully adapted for use within the field of learning disabilities. Implications for clinical practice and directions for future research are discussed.

KEYWORDS

adaptation, community learning disabilities team, compassion focused therapy, mental health, psychological therapy

All names used in the report have been changed in order to preserve confidentiality. Client consent was sought and obtained, free from coercion. The client was deemed to have capacity and understood that taking part in the study did not affect services received. The case presented is an evaluation of treatment rather than research, therefore ethical approval was not necessary.

1 | INTRODUCTION AND REVIEW OF LITERATURE

With our thoughts we make the world
(Buddha, as cited in Dima, 2014, p. 60).

1.1 | Compassion focused therapy

Compassion focused therapy (CFT) integrates concepts from evolutionary, social and developmental psychology alongside neuroscience findings and Buddhist teachings (Gilbert, 2009). The primary aim of CFT was to work with individuals to move from an internalised, critical narrative to a stance of self-compassion and care.

CFT draws on evolutionary psychology to propose that humans possess three emotional regulation systems: threat, drive and safety (Gilbert, 2014; see Figure 1). The dominant system is threat, which results in "negativity bias"—preferential processing of negative information. The threat system activates in response to external or internal triggers, resulting in negative moods and emotion. Internal triggers include a person's own anger or anxiety (Gilbert, 2014). The drive system motivates a person to fulfil basic needs and seek rewards. In contrast, the safety system produces states of calm, contentment and rest (Depue & Morrone-Strupinsky, 2005) and activates in the absence of threat or drive (Gilbert, 2014).

In addition to these three systems, the model on which CFT is based suggests that humans have both an "old" and a "new" brain (Gilbert, 2002). The old brain contains our basic drives and automated responses to threat, while our new brain has evolved complex cognitive capacities. At times, maladaptive interplay between these two brain parts can result in difficulties, so the old brain threat system can be stimulated by new brain thoughts, maintaining and exacerbating a state of threat in the absence of it. For example, a new brain thought that is evaluated as threatening, such as "I must have said something stupid in that meeting," may lead to a stress response from the old brain, producing physical symptoms of anxiety in the absence of actual threat. This is referred to as the "tricky brain" phenomenon (Gilbert, 2002).

A crucial tenet of the CFT model is that the relationships people have with themselves are a lynchpin for a range of mental health problems (Gilbert, 2014). These relationships include self-criticism (Kannan & Levitt, 2013) and shame (Kim, Thibodeau, & Jorgensen, 2011). Processes such as self-criticism involve new brain mechanisms but stimulate the threat system (Longe et al., 2010). Self-criticism has been proposed as a barrier to therapy success in some individuals, despite engagement and skill shown in the processes (Rector, Bagby, Segal, Joffe, & Levitt, 2000).

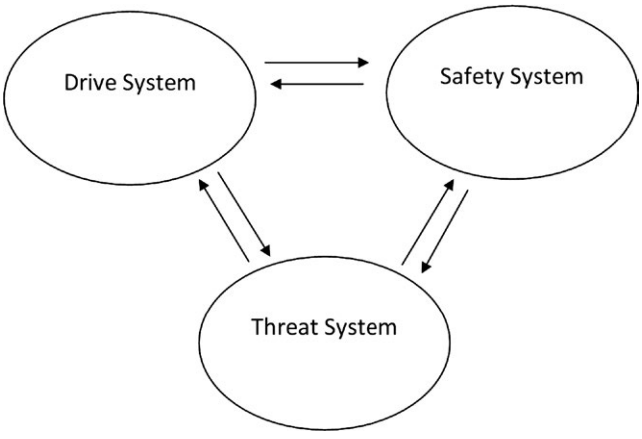

FIGURE 1 The emotional regulation systems

CFT aims to cultivate self-compassion to strengthen the safety system, thereby creating greater balance between the three emotional regulation systems (Gilbert, 2014). Developing a greater sense of self-compassion has been shown to have psychological and therapeutic benefits (Hofmann, Grossman, & Hinton, 2011; Weng et al., 2013). The evidence base for CFT is growing (Barnard & Curry, 2011; Gilbert, 2010a,b), with successful outcomes demonstrated in use with eating disorders (Webb & Forman, 2013), personality disorders (Lucre & Corten, 2013) and psychosis (Mayhew & Gilbert, 2008).

1.2 | CFT and learning disabilities

A scoping review of the literature suggests that the number of studies looking at the use of CFT with people who have learning disabilities is limited. Traditionally, psychological interventions for people with learning disabilities have focused on skills training, behavioural management and medication (Royal College of Psychiatrists, 2004). Recently, an increasingly wide range of therapies have become available and acknowledged, with new approaches adapted and established at a greater speed than in the past (Beail, 2016). These include cognitive analytic therapy, solution focused therapy and psychodynamic psychotherapy. There is also emerging evidence that components used within CFT can be successfully adapted for people with learning disabilities, such as cognitive behavioural therapy (CBT; Taylor, Lindsay, & Willner, 2008; Prout & Browning, 2011) which utilises many similar approaches, methods and techniques as CFT (Ashworth, Gracey, & Gilbert, 2011). In addition, mindfulness-based approaches have been successfully tailored for use with people with learning disabilities, with resulting improvements in compassion for self and others (Idusohan-Moizer, Sawicka, Dendle, & Albany, 2015; Miodrag, Lense, & Dykens, 2013), and have been positively evaluated as an approach by people who received the intervention (Chapman & Mitchell, 2013). Mindfulness techniques are incorporated into CFT within compassionate mind training (Gilbert, 2009).

Many of the concepts within the CFT model are highly relevant to people with learning disabilities. For example, negative and critical self-concepts are common among people with learning disabilities (Shessel & Reiff, 1999), along with external hostility from others (Reiff, Gerber, & Ginsberg, 1997). Pert et al. (2013) suggest that the use of compassion-based approaches within the field of learning disabilities should be explored, due to the relevance of this approach when working with clients who are likely to have experienced a high level of disruption to caregiving relationships throughout their lives. This disruption can compromise self-compassion, indicating the potential relevance of CFT for this population (Pert et al., 2013).

It is also suggested that CFT may be less reliant on cognitive skills than traditional models of CBT (Ashworth et al., 2011), indicating that a CFT approach may be particularly suited to adaptation for this client group. In support of this, a case study in the field of traumatic brain injury reports on the successful adaptation of CFT with a client

where traditional CBT was unsuccessful (Ashworth et al., 2011). This suggests that adapted CFT can be an effective approach to use with people who have cognitive impairments.

The current case study illustrates an adaptation of CFT to work with a man who has a learning disability. To our knowledge, this is the first case study which has investigated this adaptation. Practice-based case studies are of particular importance within the field of learning disability, due to the diversity of these clients and the limited quantity of current research (Beail, 2016). It is therefore hoped that the case will help inform the clinical work and research around using CFT with this client group.

2 | INTRODUCTION TO THE CASE

Joe is a white British male in his mid 40s, referred to the Community Learning Disabilities Team (CLDT) by his GP. Joe had attended his GP appointment accompanied by his key support worker Pam. Pam had asked for support regarding Joe's current eating patterns. Following an initial assessment by the CLDT, Joe was placed on the waiting list for psychology.

2.1 | Assessment

Three "getting to know you" assessment sessions took place. This followed a semi-structured CBT format to refine the presenting problem.

2.1.1 | Current situation

Joe lived in a supported flat attached to a residential care home. He received 9 hr of 1:1 support a week and 10 hr of shared support with the other residents. Joe described having a difficult relationship with several of his support workers, but this was positive with three of them, particularly Anna, who Joe asked to sit in on psychology sessions with him. Joe had a moderate learning disability and was deemed to be more independent than the other residents. Joe was able to carry out many activities of daily living alone, such as cooking, cleaning, shopping and using the local transport system. However, he required support around finances, planning and initiating activities, along with assistance in emotional and social areas of his life. Joe had a moderately high level of receptive and expressive communication skills and was able to participate in sustained conversation, provided concepts and language were clearly presented.

Joe had several physical health conditions, including diverticulitis, for which he had been fitted with a stoma.

2.1.2 | Presenting problem

Joe described feeling "down in the dumps" over the last 6 months. He described "eating too much chocolate" as his main coping strategy for these feelings. However, Joe's stoma had frequently been bursting as a result. Joe said that he felt distressed and embarrassed when this happened. He also explained conflicting with his support staff on a regular basis, which contributed to his low mood.

2.1.3 | History of presenting problem

Joe reported having used "comfort eating" as a coping strategy since he was a child. This had created significant issues for him during the past few years, due to the consequential medical complications for his stoma and his reduced physical activity. This had caused concern within the home 2 years previously, but had been managed to a degree with support from staff.

The comfort eating had increased over the last 6 months. Around this time, Joe had ended a relationship and had lost his previous key worker, who he described feeling close to. There had also been changes to the support structure of the home where Joe lived, with decreases in the amount of 1:1 support Joe received.

2.1.4 | Emotional and behavioural factors

Joe described going to cafes to eat cake and eating chocolate at home helped him feel calm, which distracted him from feeling upset or frustrated. Anna explained that Joe would typically buy around £4 worth of chocolate and eat this in one sitting. At times, this could occur daily. Joe described this as "comfort eating." Following the comfort eating, Joe described feeling guilty and thinking "why did I do that?" This could then lead to Joe becoming upset, which would result in further comfort eating.

2.1.5 | Physical factors

Joe had a stoma fitted 2 years previously, which resulted in increased medical preoccupation with his diet. If he ate a certain amount of food, the stoma would burst. This would result in an increase in Joe's self-critical thoughts and guilty feelings.

2.1.6 | Cognitive factors

Joe reported becoming very frustrated with himself when "things go wrong," such as losing something or after comfort eating. This would lead to self-critical thoughts, where he would curse himself in a derogatory manner, sometimes internally and sometimes by shouting aloud. This would occur several times a day.

2.1.7 | Systemic factors

The following systemic factors were identified in assessment as contributing factors:

1. Reduction in support hours, which lead to an increased sense of isolation, lowering his mood
2. Feeling blamed by some staff for the comfort eating, increasing Joe's self-critical thoughts and lowering his mood
3. Not feeling heard by all members of staff, decreasing the likelihood Joe would talk about his feelings and therefore increasing comfort eating as an alternative coping strategy
4. Joe had experienced the death of two grandparents over the past couple of years. Although Joe's immediate family lived within a mile

of him, Joe reported having felt closer to these grandparents and of often confiding in them. The loss of these important relationships further contributed to Joe's sense of loneliness.

3 | STANDARDISED MEASURES

In addition to open-guided questions, Joe completed the following measures at the start of assessment sessions:

The CORE-LD (Clinical Outcomes in Routine Evaluation—Learning Disability) is a valid and reliable 14-item tool designed to assess the effectiveness of therapy for people with learning disabilities (Brooks, Davies, & Twigg, 2013). It does not have a clinical cut-off, but a decrease in scores is indicative of change. This was completed with Joe three times prior to intervention and once post-intervention.

The FSCRS (Forms of Self-Criticising/Attacking and Self-Reassuring Scale) is a 22-item valid and reliable scale (Cronbach's alphas 0.90 and 0.86) designed to measure self-criticism and self-reassurance (Gilbert, Clarke, Hempel, Miles, & Irons, 2004; see Table 1 for details of subscales). Joe completed this measure with support from Anna, once prior to intervention and once post. This support was required as the FSCRS has yet to be adapted for people with learning disabilities.

4 | IDIOSYNCRATIC MEASURE

A "mood monitoring" scale was developed in conjunction with Joe. This was represented in pictorial form as a thermometer, with ratings from 0 to 100. It was decided that 0 would symbolise an extremely low mood and 100 an extremely positive mood. This was completed weekly.

5 | INITIAL FORMULATION

Together with Joe and Anna, an initial formulation of the comfort eating was developed (see Figure 2). It was agreed that both individual and systemic factors contributed to the maintenance of the comfort eating.

In relation to individual maintenance factors, the initial formulation suggested that Joe's self-critical thoughts were crucial to his low mood and comfort eating. Joe's self-critical stance and comfort eating appeared to have been present since childhood. It was hypothesised with Joe that these originated from bullying at school and the response from others concerning his reactions to this. It was hypothesised that Joe's heightened self-criticism resulted in a highly activated threat system (Longe et al., 2010). In addition, Joe's experience of critical caregiving and loss of confiding relationships suggested that CFT's stance of compassion and empathy could help to foster his sense of feeling cared for and validated. It was hoped that this would equip Joe with a self-nurturing approach to regulate his own distress. CFT was therefore chosen as an approach, with the aim of strengthening Joe's safety system and consequently decreasing self-criticism.

Alongside individual CFT, interventions were explored with the staffing team to address the maintenance of the systemic factors outlined in the formulation (see the Discussion section below for more on this approach).

6 | METHOD

A single-case two-phased (AB) design was used. Phase A consisted of assessment over three sessions, with measures taken at three points in time. Phase B comprised intervention (including developing a CFT formulation; see Table 2). Measures were taken 1-week post-intervention.

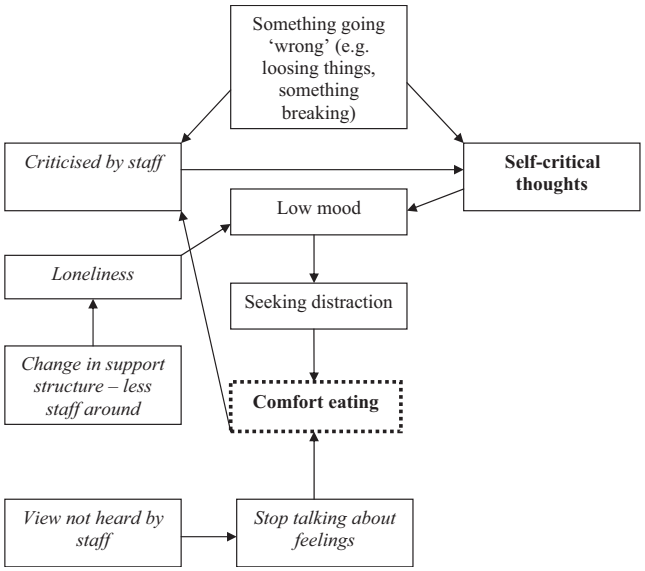

FIGURE 2 Formulation developed with Joe and Anna (italic text = systemic factors, bold text = relevant to the CFT model)

TABLE 1 Subscales of FSCRS

Name of subscale	What subscale measures	Direction expected to see in scores if change occurs due to a successful intervention
Inadequate self	Self-criticism focused on personal inadequacy	Decrease
Hated self	Self-criticism focused on desire to persecute self	Decrease
Reassure self	Ability to self-reassure	Increase

TABLE 2 CFT formulation developed with Joe during Phase B

Key fears	Safety strategies	Consequences	Unintended consequences
Feeling low Feeling upset Having critical thoughts about self	Comfort eating Avoiding people Not talking	Distraction from negative feelings Keep safe as the other person cannot do or say anything else to upset me	Have critical thoughts about self (e.g., "why did I eat that?", calling self names) Let out feelings by throwing things or comfort eating instead—then feel upset by actions and have critical thoughts about self

Dependent variables were assessed with both standardised and idiosyncratic measures (as described in the assessment section). Idiosyncratic low-/high-mood ratings were completed on a weekly basis, while the CORE-LD standardised assessment was completed four times prior to Phase B and at the end of therapy.

6.1 | Aim

The design aimed to test whether formulation and intervention using a CFT approach could be adapted for individual therapy with a person who has a learning disability to treat low mood and improve self-compassion.

Hypothesis 1: Joe's mood and self-compassion would improve over the course of the intervention. This was measured by comparing outcome measures taken at Phase A with those recorded post-therapy, alongside feedback from the client.

TABLE 3 Summary of sessions

Session 1–7	Engagement, assessment and initial formulation (Phase A)
Session 8–13	Intervention and CFT formulation (Phase B)

Hypothesis 2: Joe's comfort eating would be reduced post-intervention. It was decided that this should be measured indirectly due to the formulation that this was a coping strategy in response to low mood. Additionally, it was regarded that measuring this could reinforce the unhelpful narratives held by the staff that reduction of comfort eating should be the primary focus of intervention.

Joe received a total of 13 1-hr sessions (see Table 3).

Table 4 illustrates how the intervention sessions mapped onto the CFT approach.

The following general adaptations were additionally made throughout assessment, formulation and intervention:

1. Use of colourful, visual diagrams (see Figure 3).
2. Repetition of verbal summaries
3. Joe was asked to summarise frequently to check understanding
4. Visual prompts given as homework to build a physical "toolbox" of strategies
5. Reduced speed and content of sessions
6. Reduced depth and complexity of psychoeducation around CFT concepts

TABLE 4 Overview of sessions in relation to traditional CFT approach

Recommended CFT phases (Gilbert, 2014)	Sessions with Joe
Psychoeducation • De-shaming and de-personalising—tricky brain rationale, social construction of self • Explanation of three emotion regulation systems	• Tricky brain, old brain/new brain, it's not your fault, everyone has a tricky brain • Multiple selves. We drew out Joe's personalised selves to represent how much space each occupied • Introduced two emotion regulation systems—safety versus threat. Joe drew out how much space each appeared to have for him
Formulation • Developing insight into how early life experiences created safety strategies, drive-based strategies and soothing strategies • How each strategy is externally and internally directed • Formation of sense of self based on core memories	• Discussed Joe's current safety strategies—comfort eating and avoidance • Explored origins of the comfort eating • Explored function of comfort eating and positives of it • Session based on consequences of Joe's safety strategies and unintended consequences (see Table 4).
Exercises • Imagery and breathing based to build compassionate capacities	Exercises • Soothing rhythm breathing, Safe place visualisation, body scan exercise, compassionate colour exercise, compassionate image exercise • Chair work around multiple selves—Joe recalled the incident above and described his thoughts, feelings and behaviours from the perspective of his angry, critical and kind self
Behavioural practices • Building sense of compassionate self with behavioural practices	Behavioural practices • Breathing exercises set each week as homework
Working with specific problems • Engaging the compassionate self to work with anxiety/depression/self-criticism	Working with specific problems • Engaging the compassionate self to work with self-criticism by developing a compassionate image

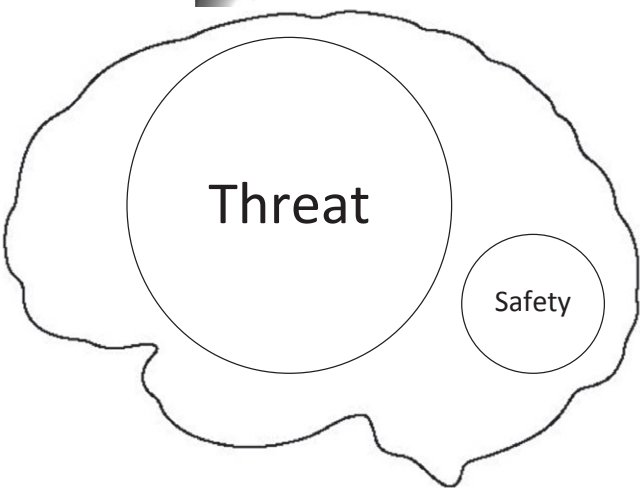

FIGURE 3 Example of a diagram used in the intervention. Colour was used by Joe to symbolise how much space his threat and safety systems appeared to occupy

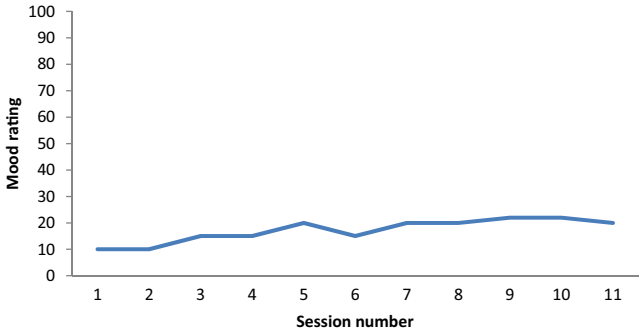

FIGURE 4 Joe's idiosyncratic mood ratings through baseline, intervention and follow-up

These are in line with the adaptations to therapy which are recommended when working with people who have a learning disability (Beail, 2016).

7 | RESULTS

7.1 | Outcome measures

Joe's weekly scores on the idiosyncratic mood measure increased gradually from pre- to post-intervention (see Figure 4). However, these continued to remain relatively low.

Scores on the CORE-LD increased overall post-intervention compared to baseline, indicative of an increase in distress (note—the CORE-LD does not have a clinical cut-off (Brooks et al., 2013)). One of the three subset scores on the FSCRS increased post-intervention, with two subset scores ("hated self" and "reassure self") decreasing by two and five points, respectively (see Table 5). These changes suggest a decrease in Joe's self-hatred, but an increase in self-inadequacy and a decrease in ability to reassure.

7.2 | Client feedback and reflections

A criticism of current intervention studies in learning disabilities is that they rarely explore which components of therapy are deemed by clients to be most meaningful and effective (Idusohan-Moizer et al., 2015), although service user views are increasingly important in research (Beail, 2016). Joe was asked for his feedback post-intervention, to address these points directly. It seemed particularly important in this exploratory adaptation of CFT, with limited current guidance as to what components may be most helpful and significant. This feedback was requested informally, through open-ended questions at the follow-up session, 1 week post-intervention. Joe's responses to the questions were written down verbatim during the session. These were then informally analysed for themes by Dr Julia Frearson (supervisor) and myself.

7.2.1 | What has been helpful

Joe rated learning about the "kind self" as the most helpful part of therapy:

> *I didn't know anything about the kind self – didn't even know it existed.*

In addition, Joe highlighted discussing multiple selves as important for him:

> *Before I started I couldn't break the feelings up…now I know them I can start working on them.*

Finally, Joe said that understanding the tricky brain as a rationale for experiencing difficult feelings had been helpful.

7.2.2 | Content recalled post-intervention

Joe recalled the rationale for CFT well, including the concept of old brain/new brain, fight or flight, the threat system (and its link with the critical self) and the safety system (and its link with the kind self). Joe remembered the safe place and compassionate image exercises. Joe also remembered that the chair exercise was designed to help him practice being more like the kind self.

TABLE 5 Scores on the CORE-LD and FSCRS standardised outcome measures

Phase measure completed	CORE-LD	FSCRS
Baseline (pre-intervention)		
1	64	Inadequate self = 25 Reassure self = 15 Hated self = 8
2	71	
3	64	
4	64	
1 week post	78	Inadequate self = 27 Reassure self = 10 Hated self = 6

7.2.3 | General feedback

Joe highlighted that the comfort eating continued to remain an issue, in line with the outcome measure data:

> *Haven't broken the circle of chocolate or my mood yet – still trying to break it – I just haven't broken it yet.*

He said that the following factors would be needed to help him do this:

1. Frequent review of strategies in box and file.
2. Support from staff with daily breathing exercises.

However, he emphasised that the therapy had been useful to him:

> *I've really enjoyed talking and it's helped me out.*

Joe also made reference to the importance of acknowledging the maintaining systemic factors discussed in the initial formulation (relating to concern raised about a critical comment made to Joe by a member of staff):

> *It was good of you to ring me up yesterday and say that what happened to me the other day – it wasn't good enough – that's the way to learn is to question things.*

8 | DISCUSSION

Comparison of Joe's outcome measures pre- and post-therapy suggests that little change occurred using the CFT approach in terms of his overall psychological well-being (as measured by the CORE-LD) and self-compassion (as measured by the FSCRS). However, Joe's self-rated mood increased, as indicated by weekly idiosyncratic measurements. In addition, there are various issues with the outcomes used, along with several extraneous variables, which may have impacted on the results. These factors will now be discussed.

Although Joe's score on the CORE-LD appeared to increase following intervention, analysis of his responses shows that this occurred over question 4 (have you found it hard to say how you feel?) and question 10 (have you felt people are getting at you?). Notably, Anna was present during these baseline measures and absent post-intervention. It is therefore possible that Joe felt constrained from rating these questions high at baseline due to the bias of the presence of Anna. As Joe completed the FSCRS with Anna, this bias may also apply to these responses, along with the reliance on Anna to translate the FSCRS into language which was accessible to Joe.

As noted in Joe's initial formulation, there were many systemic factors that appeared to contribute to his presentation. Although attempts were made to address these alongside Joe's individual therapy, little progress was made due to organisational issues within the residential home (such as staff change and shortage). This became increasingly problematic throughout the intervention—for example, Anna was no longer available to sit in for the final five sessions and Joe's 1:1 staff support hours were cut from 9 to 2 hr a week. Joe also reported that he was given little support with his practice outside of the sessions, despite numerous requests from us for this. It has been suggested that carer involvement and support with therapy greatly influence engagement and outcomes for people who have a learning disability (Idusohan-Moizer et al., 2015) in addition to the importance of reviewing materials between sessions (Lindsay, Jahoda, Willner, & Taylor, 2013). This is likely to therefore have been an important contributing factor to the lack of overall change that Joe experienced. In hindsight, it would have been useful to draw up a contract between Joe, his staff and myself to outline each person's commitments and responsibilities during the therapeutic processes, and reinforce this with the care home's management team if necessary. This could have ensured that the systemic conditions within which the therapy was delivered had a higher level of effectiveness. Despite this, therapeutic involvement with Joe ensured that these staff changes were noted and reported, widening the usefulness of psychology's involvement from delivering CFT specifically to noticing and intervening with these systemically maintaining factors.

Despite these problems, CFT appeared to be an appropriate approach to use with Joe as evidenced by his personal feedback. Joe was able to retain the key concepts discussed during the intervention. In addition, Joe appeared to find the theory and exercises useful, particularly in relation to the kind self, multiple selves and safe space exercise. This suggests that CFT may be a helpful approach to take when working with people with learning disabilities who have critical thoughts.

8.1 | Limitations

There were several limitations with the outcome measures used. On the idiosyncratic measure, Joe's scores fluctuated within a limited range—it is therefore possible that the scope of scores developed were insensitive to changes in Joe's mood. The reliability of this measure could have been increased by asking Joe to rate himself at an agreed time point during the week, rather than reflecting back on mood in sessions. Additionally, a behaviour measure (such as use of breathing exercises or amount of chocolate eaten) could have been included, which would not have involved self-monitoring and rating of emotions. In hindsight, it would have been useful if additional concepts were similarly measured, such as level of self-criticism, low mood and anxiety, particularly given the difficulties with the FSCRS. Furthermore, the validity of this measure is questionable—Anna frequently commented that Joe's scores did not appear to be an accurate reflection of his mood during the week, with Joe scoring himself far lower than she would imagine. It is possible that Joe found it difficult to differentiate between changes in his emotions and therefore gave a fairly consistent rating despite experiencing different moods. This idea is supported by Joe's post-therapy feedback: *'Before I started I couldn't break the feelings up'*. On the other hand, Anna's observation

may have been due to a mismatch between Joe's internal mood and external behaviour.

The CORE-LD is within early stages of use, and the authors acknowledge that it may be more relevant to some groups of people with learning disabilities than others (although the classification of such groups is not defined; Brooks et al., 2013). It is therefore possible that this was not a suitable measure to use with Joe. Additionally, the FSCRS has not been developed or validated for use with people who have learning disabilities. The reliability and validity of Joe's scores on these standardised measures are therefore questionable. To our knowledge, there are currently no compassion-based outcome measures for use within this population.

Due to time constraints, it was required that baseline data were collected over the assessment period. However, as the assessment process can be perceived as an intervention in itself, this method weakens the likelihood of collecting a valid baseline measure. Additionally, it was only possible to follow up with Joe 1 week post-intervention. This is limited in duration and weakens the conclusions that can be drawn in terms of long-term outcomes, and is particularly relevant given the long duration of Joe's self-critical stance. It is therefore possible that follow-up would need to occur over a far greater time period for changes in Joe's self-compassion (and subsequent further improvement in mood and well-being) to be seen. Further research should explore outcomes over a longer delay between intervention and follow-up.

9 | REFLECTIONS

Working with Joe highlighted to me the importance of accounting for systemic factors within formulation. This seemed to be particularly important in the context of Joe's referral, where Joe was centred very much as the "problem." This has also demonstrated to me the crucial role of drawing of systemic factors within formulation. Even within individual factors, this case showed me the importance of taking a meta view of the situation. It would have been easy to become focused on "treating" Joe for his "eating problems," potentially losing the importance of his maintaining thoughts and feelings. On the other hand, giving greater focus to the eating behaviours may have improved staff engagement and consequently improved outcomes for Joe. It may have also resulted in quicker benefits to Joe in terms of improved health outcomes. It is a challenging balancing act to consider what intervention may result in the greatest overall benefit, especially in the context of learning disability where the voice of the client could potentially be lost.

I found using CFT with Joe interesting and engaging. The emphasis on practical exercises facilitated its adaptation, and its nonjudgemental stance felt refreshing to explore with Joe. Creating visual materials and the use of vivid stories (such as relating the concept of "old brain" to the Flintstones) appeared particularly effective. Although at times it was frustrating to experience the lack of support that Joe received to practice the skills discussed, this challenge was not specific to the therapy.

10 | CONCLUSION

CFT appears to be an approach that can be adapted meaningfully for use within the field of learning disabilities. It was rated by the client as a helpful approach, with key concepts remembered well. Although the outcome data suggest that little active change occurred pre- and post-intervention in regard to general mental health, there are numerous limitations with the measures used which may explain the lack of demonstrated change. Additionally, the changes to Joe's care package may have contributed to the maintenance of his difficulties.

It would be useful for future research to replicate this approach with a case series design, accounting for the current limitations above. If possible, systemic factors should be addressed prior to the intervention, to reduce the impact of these as a confounding variable on outcomes. It would also be helpful for both clinical and academic purposes if a compassion-based outcome measure was developed for use within the learning disabilities field.

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