A QUALITATIVE INVESTIGATION OF THE THERAPEUTIC RELATIONSHIP IN THE FACILITATION OF EMPOWERMENT IN PSYCHOLOGICAL THERAPY FOR ADULTS WITH LEARNING DISABILITIES

PHOEBE ALONSO

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This work or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for any express acknowledgements, references cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and no other person.

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ABSTRACT

Background

Many authors in the field of adult learning disabilities have described the challenges experienced by clinicians in obtaining evidence regarding the effectiveness of psychological therapies for this particular client group (e.g. it can be a costly, lengthy, time-consuming process) (Taylor, Lindsay, Hastings & Hatton, 2013). Gaps also exist in the area of social justice and empowerment in relation to this population, which has historically experienced significant inequalities.

This research intended to contribute to the current information available for researchers and psychological practitioners and to focus upon particular practical issues highlighted as important to the service-users, therapists and support workers within a single UK NHS service. The aims of this research project were:

1. To investigate what factors clients with learning disabilities find most helpful and empowering in the psychological therapy received from psychological therapists.

2. To ascertain how the therapeutic relationship affects psychological well-being within a learning disabled population, as facilitated by their therapists and support workers.

3. To explore the importance of support workers' involvement in providing support with psychotherapeutic work for PWLD.

4. To consider how empowerment is experienced and conceptualised by the main stakeholders in the therapeutic encounter, between PWLD, their therapist and their support worker.

Method

Five triads were interviewed, each consisting of a person with learning disabilities, a psychological therapist and a support worker. Qualitative methodology was used to analyse the data obtained, via Interpretative Phenomenological Analysis (IPA).

Findings

The resulting research findings highlighted the importance of four super-ordinate themes:

i) Values, Stigma & Social Equity;
ii) Building Relationships, Collaboration & Trust;
iii) Coping & Adaptations and
iv) Positive Outcomes.

Implications for various key groups including counselling psychologists, were considered and findings were contextualised with prior research findings.

Conclusions

The researcher's original contribution to knowledge relates to the inclusion and exploration of the experiences and perspectives of three related stakeholder groups, including previously under-represented participants with learning disabilities, in order to voice what was important to them in terms of the therapeutic relationship and the facilitation of empowerment through psychological therapy.

1. INTRODUCTION

In this first chapter a brief overview of the area under study, the structure of thesis and definition of key terms is provided to give necessary contextualisation information and to orient the reader to the focus of the thesis. The research work presented in this thesis is a qualitative exploration of empowerment, as facilitated by the psychotherapeutic relationship, for people with learning disabilities, in a UK NHS service. For many years this has been an under-researched minority group, experiencing significant inequalities, which have existed throughout history. Chapter 2 (Literature Review) explores these issues in further detail. The therapeutic relationship has particular relevance within the discipline of counselling psychology (Clarkson, 2003; Parritt, 2016) and has been explored in terms of a variety of population groups in several studies (Clarkson, 1995; Fletcher-Tomenius & Vossler, 2009; Knox & Cooper, 2015). Increasing interest has become apparent in looking at this relationship in people with learning disabilities (PWLD), since this has been a somewhat neglected and less researched area within both counselling psychology and the field of psychotherapy in general (Willner, 2005a; Rizq, 2005). Currently however there is minimal research focussing upon the area of empowerment, as facilitated by the therapeutic relationship. Section 2.6 explores the area of social justice in relation to empowerment research for PWLD.

Although some studies have started to investigate the views of PWLD in terms of their therapeutic support (Lewis, Lewis & Davies, 2016), most existing studies have examined psychological therapy from the viewpoint of the therapists involved (Sinason, 1992; Strauser, Lustig & Darnell, 2004). Still fewer have contrasted the involvement and experiences of support workers, therapists and service-users together, a gap that has been identified in recent studies (Jones & Donati, 2009; Jones, 2013). The researcher had previously conducted an exploration of issues affecting therapists and their use of particular therapeutic approaches in an Adult Learning Disabilities Service, as part of an MSc in Counselling and

Psychology, and so wanted to build upon this interest in working therapeutically with PWLD, in order to highlight key areas of improvement which PWLD and the people and services working with them, could benefit from.

By increasing understanding and awareness of important elements of the therapeutic relationship and by highlighting key therapeutic interactions conducive to empowering positive outcomes, it was anticipated that practitioners of psychological therapy and support workers may be further equipped to work effectively when conducting and supporting therapy with PWLD. It was hoped that this in turn may encourage continued improvements in psychological wellbeing, as well as informing further developments in services offering this kind of support.

1.1 Structure of the thesis

This thesis consists of five main chapters. The introductory chapter (*Chapter 1*), which presents an overview of the study, the structure of the thesis and definition of key terms. Following this, *Chapter 2: The Literature Review* examines the existing research, knowledge and background information in the area of study for PWLD and their needs for psychological therapeutic support, including previous ‘therapeutic disdain’ (Bender, 1993) and research in the area of social justice. An exploration of conceptions of empowerment is presented, as well as a summary of the importance of the therapeutic relationship within counselling psychology in particular. The Literature Review also examines gaps in the existing literature, culminating in the rationale for carrying out this particular study and leading to the Research Aims and Research Questions.

Chapter 3: Methodology explores the researcher’s choice of qualitative methodological approach (IPA) and outlines the stages involved in carrying out the research, including the development of the study, recruitment, sampling and participants, procedures, materials, data analysis, consent and ethical considerations. The chapter aims to provide sufficient detail to enable replication of the study.

The findings for the study are presented in *Chapter 4: Findings*. This chapter includes a main section outlining the four main super-ordinate and sub-themes which emerged from the data analysis, with a cross-comparison of themes. This chapter also includes a section summarising each participant's conceptions of empowerment and how it specifically related to their experience of receiving or providing therapeutic support, as well as a discussion of empowerment overlaps and differences per triad.

Chapter 5: Discussion provides an overview of the results and outlines the degree to which the research aims and questions were addressed. The implications of the findings are also presented and contextualised with existing research. Finally, it contains the key conclusions for the study.

The Appendices provide additional important background and planning information, relevant to the research and participants involved, with tables and illustrative examples of the data collection and analysis process. The Appendix also contains a Reflexive Account, outlining the researcher's own experience of the research process (Appendix B).

1.2 Definition of key terms

1.2.1 Definition of empowerment

Due to the frequency of abbreviated terms and phrases found by the researcher during this research, a Glossary of Abbreviated Terms used in this piece of work is included in Appendix A. However, as it is one of the main concepts throughout this research and to aid clarity and brevity, the following general working definition of 'empowerment' was used within the research work presented in this thesis: ***'providing an increase in freedom, self-reliance, choice and action, enabling people to act more independently to make decisions and reach desired goals'.***

1.2.2 Terminologies used regarding psychotherapeutic interventions

The following terminologies have been used interchangeably by the researcher, which represent the most generic, often used terms within this field: 'psychological therapies', 'psychotherapeutic interventions', 'talking therapies', 'psychotherapies' and 'counselling'. For the purpose of this particular research, a relatively broad view of psychotherapeutic interventions has been adopted, which includes short blocks of structured therapy and counselling, in addition to longer term, ongoing psychological input and psychotherapy. Previous related research has referred to the idiosyncratic nature of psychotherapeutic services for PWLD (Royal College of Psychiatrists, 2004). Chapter 2 explores this area in further detail.

In addition, the 'support worker' role is also a key term within this thesis and may be defined here as the role that people providing support take in the therapeutic process. Support workers for PWLD are generally people whose paid employment involves supporting PWLD in their daily lives, with the level of support dependent upon the level of learning disability, physical or other medical needs. The support could involve personal care, health, activities of daily living, maintenance of relationships, finances, appointments and engagement with the environment. Most of the support workers involved in this research were paid members of staff, apart from one, who was also the carer and husband of one of the PWLD participants.

1.2.3 Definitions and Terminology: Learning Disabilities

This research used one of the most widely used and currently accepted definitions of learning disability in England, derived from the White Paper 'Valuing People: A New Strategy for Learning Disability for the 21st Century' (Department of Health, 2001). This document outlines that the definition for learning disabilities encompasses people with a broad range of disabilities and is supported by the British Psychological Society (2001), which states that irrespective of the precise terminology or wording in the various definitions, there are three core criteria that must be satisfied in order for a person to be described as having a learning disability:

i) A significantly reduced ability to understand new or complex information, to learn new skills (significantly impaired intelligence).

Practically, this equates to having an IQ score of 69 and below and is consistent with ICD-10 criteria. Within this classification exist the following sub-categories:

a) Significant impairment of intellectual functioning (IQ 55-69).
b) Severe impairment of intellectual functioning (IQ below 55).

(BPS Guidelines, 2001).

ii) A reduced ability to cope independently (impaired social/adaptive functioning).

Since having a low IQ in itself is not sufficient for defining a learning disability, the assessment of social functioning also needs to be taken into consideration. BPS Guidelines (2001) suggest the following sub-classification of social functioning:

a) A significant impairment of social/adaptive functioning is indicated by a person requiring either intermittent support (support on an ‘as needed’ basis) or limited support (support characterised by consistency over time, or time-limited).

b) A severe impairment of social adaptive functioning is indicated by a person requiring either extensive support (characterised by regular involvement [e.g. daily] in at least some environments and is not time-limited) or pervasive support (support characterised by consistency, high intensity, to be provided across environments, and having a potential of life-sustaining nature).

iii) Starting before adulthood (onset before 18 years of age) and with a lasting effect on development.

Typically, PWLD are likely to need support with at least two of these areas. The American Association on Intellectual and Developmental Disabilities (AAIDD) definition similarly defines an Intellectual Disability as:

‘characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18’.

The AAIDD measures intellectual functioning using IQ tests with scores of below 70-75 indicating a limitation in functioning, whilst ‘adaptive behavior’ refers to the conceptual, social and practical skills learnt and practiced by people in everyday life. This definition also aligns with those in the DSM-V and the ICD 10 (see Appendix A for Glossary of Abbreviations).

The researcher was aware that by using the White Paper's definition of Learning Disability, some conflict was present both in terms of her own wish not to engage in labelling individuals and in adhering to the ethos of counselling psychology, but it was necessary to find a way of describing this group of people in order to structure the research. Tension frequently exists between needing to label people in order for them to access services, (which in turn provide therapy and make diagnoses) on the one hand, whilst knowing that the label can serve to stigmatise people on the other (Green, Davis, Karshmer, Marsh & Straight, 2005).

Only people with a mild learning disability were approached for inclusion within this research - **i)**a above - to allow maximum verbal communication and discussion during their interviews, which meant that people with more severe impairments of intellectual functioning were not included in this particular research. This issue has been explored further in sections 3.3.2 and 5.3.1.

1.2.3.1 Note about PWLD abbreviation

In order to help reduce the word count in this thesis, due to the large amount of qualitative data that resulted from the interviews involved, an abbreviation has been applied to the phrase 'People with Learning Disabilities': this is replaced throughout the thesis with 'PWLD'. The researcher would like to apologise for any unintended offence this may cause, as the fundamental aim of the research is to support and explore ways of empowering this group of the population. Chapter 2 discusses this term in more detail along with the historical inequalities that have been experienced by individuals with learning disabilities.

The terms 'service-users' and 'clients' have also been used throughout this thesis, to describe the PWLD accessing the NHS Adult Learning Disability service involved in this research. 'Service-users' and 'carers' are generic labels frequently used within the fields of health and social care. The term ‘service-user’ generally means anyone who is a patient, client or other user of health and/or social services, although the researcher acknowledges that this can still detract from feelings of inclusivity and may not be preferred by some PWLD themselves (Tilly, 2011; Cluley, 2018).

The word ‘client’ has been used rather than ‘patient’, which reflects the ideology on the part of the researcher, although many NHS services and psychology departments still use the word ‘patient’. The term ‘patient’ could be argued as portraying someone as damaged, impaired or deficient (Joseph, 2011), which is the opposite that this research is aiming for. The word ‘client’ was developed to signify a move away from medicalised approaches, to be replaced by more humanistic language of growth and change, with a focus on the person having the expertise about what is best for them and how they feel (see section 2.5).

2. LITERATURE REVIEW

This review examines the contextual background and existing research relating to the provision of psychological therapy for PWLD. It provides the historical context leading to the current modern-day situation for PWLD, in terms of their additional health and support needs and the lack of equality that has existed to the present day for this particular group in society. This includes examination of: (i) the overt or subtle therapeutic disdain that has prevailed for many decades (Bender, 1993); (ii) models of disability which seek to explore and explain the position of PWLD and society's impact on their experience of life; (iii) the presence of stigma and attempts of social justice research to readdress this balance. Also included is an exploration of conceptualisation of empowerment and the different kinds of empowerment related to research and PWLD.

The review will then consider the importance of offering PWLD psychotherapeutic interventions and services, specifically including the NHS, before exploring the therapeutic relationship, the discipline of counselling psychology and therapists' choice of therapeutic approach in their work with PWLD. A counselling psychology perspective will be adopted, with its emphasis upon the therapeutic relationship, which is essential in this field (Strawbridge & Wolfe, 2003). Lastly, this review examines previous research in the area of providing psychological therapy for PWLD from both therapists and clients' perspectives, with additional focus upon support workers. Gaps in the current literature will be identified throughout. The review will finally be drawn together into the rationale for this current piece of research, with associated Research Aims and Research Questions presented.

2.1 Historical overview

A history of inequality is evident when looking at the treatment of PWLD. Ferguson (2017) described the way that poor and disabled people have been treated in modern society, in terms of ‘psychiatry’s horrible histories’. An ongoing pattern throughout UK and world history has been the greater prevalence of disabled people in poorer households (Thompson, 2017). Engels’ ‘The Condition of the Working Class in England’ in1844, described this in terms of the terrible conditions and treatment of PWLD, which were experienced far more by these people than by the rest of society, with many families being unable to care for their unwell and disabled members. Unfortunately, this pattern persists to the present day.

The most *“shameful chapter”* of psychiatry’s history (Burns, 2013, p.201-3) was inarguably the extermination of 70,000 mentally ill and learning disabled people by the Nazis in 1940’s Germany (which rose to 200,000 by the end of the Second World War), highlighting a responsibility of psychological professionals, as Burns describes here: *“The terrible shame of the extermination of the mentally ill is compounded by several prominent psychiatrists leading it and none vigorously opposing it… The broad mass of the profession probably did not share the extreme views articulated, but they voiced no effective opposition. Psychiatry was no better than those around it and, arguably, in this instance, worse. There is no excuse.”* (p.202-3).

The need to prevent anything similar occurring again or the use of electric shock therapies and other brutal treatments which were employed from the time of the First World War - and which are still being used in some cases – (Collins, Halder & Chaudhry, 2012), eventually started to be overturned by psychiatrists requesting more humane responses, such as the use of ‘talking therapies’. Similarly, the gradual move away from institutionalisation of PWLD, into care in the community was partly due to a series of public scandals in the 1960s, which slowly led to societal changes in perceptions of PWLD (Emerson, McGill & Mansell, 1996; Nirje, 1985; Felce et al., 1999).

Goodley (2015) argued that the way the concept of learning disabilities is understood today may be quite different to how it was conceptualised in the early twentieth century, when the eugenics movement gained popularity - although eugenics principles have been practiced as early as ancient Greece (Barnett, 2004)**,** in part due to its link with Darwin's theory and the aim of improving the rate of desirable characteristics in the population through controlled breeding (McKenzie, 1976). These scientific foundations that eugenics was based upon contributed to its widespread acceptability. There have been big shifts however in the societal treatment of PWLD and mental health conditions since the last century, which have started to transform society, but there is still a need for further transformations (Scior & Werner, 2015).

Haegele and Hodges (2016) discussed the historical changes in perceptions of learning disabilities on a societal level over the past several hundred years, including changes from Western Judeo-Christian frameworks and perspectives on PWLD, where having a disability was seen as an act of a higher being, with disability being presented as an opportunity for healing or a miracle to occur. This view was eventually displaced as medical and scientific knowledge expanded, with religious leaders being replaced by doctors and scientists as *"cognitive authorities*" in societal values and curing procedures (Humpage, 2007). See 2.5 below for further information about models of disability and the movement away from the medical model to the social model of disability. The language used to define disability is very important because it influences peoples' expectations and social interactions (Barton, 2009).

Emerson, Barret, Bell, Cummings, McCool, Toogood and Mansell (1987) also looked at the rights of PWLD, particularly regarding the development of community care. This particular social population has in many ways been a misunderstood and devalued group, not even considered appropriate to use talking therapies with, for much of the twentieth century. Freud commented in 1905 that *"a certain degree of verbal ability was required for psychoanalysis",* a view which could be considered questionable today, as many therapists and researchers have successfully used adapted forms of psychoanalytic theory with PWLD (Beail, 1998; Berry, 2003). Counselling and psychological intervention for this client group is now fortunately considered viable and helpful in a large range of settings (Taylor et al., 2013;

Chin et al., 2014). Nevertheless, in comparison with other groups (such as generic mental health services), treatment and outcomes are still relatively under-researched and under-represented. It is hoped this thesis will contribute to the existing research to help address this imbalance.

2.2 The position in society of people with learning disabilities & the prevalence of mental health problems

Compared with the general population, research indicates that PWLD are at a greater risk of developing significant psychological problems, in addition to having added complications of reduced capacity for problem solving and limited ability to adopt appropriate and effective coping mechanisms (Royal College of Psychiatrists, 2004). Emotional problems are more widely experienced in this population group (Prosser, 1999; McClure, Halpern, Wolper & Donahue, 2009) and mental health problems have been found in 20-39% of populations of PWLD (Hatton & Taylor, 2005).

There is much variation in the literature regarding the prevalence of mental health problems in PWLD, with factors for this including biased sampling, lack of methodological information, small cohort sizes and issues relating to the poorer communication skills associated with having a learning disability (Cooper et al., 2007). Most clinicians rely upon third party reports and identification of signs through observation, as opposed to self-reported symptoms (Woodward & Halls, 2009). It is unfortunate that historically this group has been the least likely to be able to access psychological therapies - sometimes due to active exclusion (Willner, 2005b) - despite arguably having the greatest need for them, as they are more likely to be affected and in need of psychological support (NICE, 2018a).

There has also historically been less concern for the mental health needs of PWLD compared to the rest of the adult population, despite evidence of higher levels of unmet needs (Robinson, Escopri, Stenfert Kroese & Rose, 2016). Some of these needs may be attributed to the effect of the environment, including social exclusion, institutional rearing, neglect, rejection, attachments and personal experiences (Rutter, 2005). Factors typically associated with poor mental health for the general population are likely to be similar for PWLD, such as poverty, social isolation and having membership of disadvantaged ethnic minority group (Cumella, 2009). On the other hand, it could also be argued that by being brought up in more protected environments, there are fewer opportunities to develop coping skills for emotional self-management and challenging social situations (Lindsay, 2000). These needs have gradually started to be re-addressed by government policies and service frameworks, with recommendations highlighting the importance of issues such as access to appropriate services and reasonable adjustments for this client group (Department of Health, 2007, cited in Taylor & Knapp, 2013).

In terms of relevance for government spending/investment and recommendations, around one sixth of the UK population currently experiences mental health problems at any one time (such as anxiety or depression), which is the main source of disability and ill health in England, accounting for 40% of people in receipt of incapacity benefits. These rates are even greater for PWLD and who are often more likely to be overlooked (NICE, 2015). Psychosis, dementia, autism, attention deficit hyperactivity disorder, problem behaviours and conduct disorders are all more common amongst PWLD (Bertelli et al., 2015; WHO, 2018), than in the general population, as are more general needs for psychological counselling. There are a range of historical, cultural, economic and attitudinal reasons for this inequality (Taylor, Lindsay, Hastings & Hatton, 2013). Hence this is clearly an important area in terms of the balance of service provision and organisation within the NHS.

NICE Recommendations and recent research (Jones, 2013; Lewis, Lewis & Davies, 2016) have pointed to the importance of greater investment for new services and training, as well as highlighting the importance of psychological therapies as an alternative to medication. There has gradually been a move away from the dominance of the 'medical model' (see 2.5.1 below), psychopharmacology and applied behavioural models for treating the mental health of PWLD, towards an increased use of alternative psychological therapies such as CBT and a greater input from multi-disciplinary teams and IAPT services (NICE, 2018b), which reflects the complex and diverse needs of this population (Jones, 2013).

The STOMP initiative ('stopping over medication of people with a learning disability, autism or both with psychotropic medicines') is a UK national project that was set up as a health campaign in response to Public Health England's 2015 research. This research highlighted that at any time, between 30,000 and 35,000 PWLD (1 in 6 of whom are known to their GP) are prescribed antipsychotic, antidepressant (or both) medications by their GP without having the conditions for which the drugs were designed to treat and have been shown to be effective. There has been particularly concerning regarding side effects which can occur when taking psychotropic medicines inappropriately or for too long, such as weight gain, drowsiness and impact upon metabolic and cognitive functioning. This human rights issue was highlighted as having a considerable impact upon quality of life and as a health inequality, therefore NHS England has worked alongside health care providers to produce a pledge to work together, to stop this over medicating. This has more recently also been extended to paediatric services (STAMP – Supporting Treatment and Appropriate Medication in Paediatrics).

2.3 Therapy & historical 'therapeutic disdain' - changing attitudes

Bender (1993) highlighted an attitude of 'therapeutic disdain' which he found was held by many mental health professionals, in his critique of the history of the exclusion of PWLD from psychological therapy. This ‘disdain’ was found across theoretical perspectives, from early psychoanalysis, to patient centered counselling and cognitive behavioural therapy and in turn it arguably limited the availability of these talking therapies for this group of the population. Such an attitude was found in the early psychotherapeutic work of key figures including Freud, who stated that there may be limitations in providing psychotherapy for *‘those patients who do not possess a reasonable degree of education and a fairly reliable character’* (1953, p.263). This view has been attributed to psychoanalytic practitioners wanting to remove less attractive clients from seeking their help (Bender, 1993). Similarly, Bender highlighted that Carl Rogers also omitted any reference to this population group in any of his publications relating to the Client-Centered movement. Even by the 1980s some cognitive therapists could not see how their work could be used with PWLD, being *“very surprised if clients with grossly subnormal levels of intelligence could be readily approached through this modality*” (Hollon, 1984, p.126).

This view of therapeutic disdain fortunately began to be challenged (Hollins & Sinason, 2000; Stenfert Kroese, Dagnan & Loumidis, 1997), as the emotional needs and emotional distress of PWLD was demonstrated to be experienced in the same way as people without learning disabilities and as being equally accessible to support and therapy. A recent survey of UK IAPT practitioners by Shankland & Dagnan (2015) indicated that most therapists believed that psychological therapy can successfully be provided for PWLD, with positive experiences of doing so leading to increased levels of confidence in their clients, which in turn led to more positive attitudes about providing such therapy again in the future.

Until well into the 1980s however the preferred orientation of such work still involved a preference for behavioural and psychopharmacological approaches, rather than ‘talking therapies’ (Scotti, Evans, Meyer & Walker, 1991; Didden, Duker & Kovzilius, 1997). An emphasis upon cognitive assessment functioning, behaviour modification and service evaluation was more often found in work with PWLD, as opposed to exploring a person’s inner world and emotional functioning (Arthur, 1999). This focus was more about looking at differences than commonalities (Fredman, 2006). Since this time there has been a continued growth in published research supporting such a need and beneficial outcomes of therapy for this group (Cooper et al, 2007; Brown, Duff, Karatzias & Horsburgh, 2011), a trend which is continuing to escalate and which more widely reinforces the need for appropriate support, financial investment and services.

2.4 Access to services for people with learning disabilities

In their review of the literature relating to psychological interventions and PWLD, Brown, Duff, Karatazias & Horsburgh (2011), found that the evidence base regarding psychological interventions was still sparse, yet growing. They also asserted that if therapeutic approaches are modified and adapted to meet the specific needs of PWLD, these may be life enhancing, with a previous lack of access to psychotherapies having led to their exclusion from mainstream research. This exclusion contributed to a limited evidence base around effective treatment approaches and interventions, which has significant implications for research, policy, education and clinical practice: therefore being an area requiring both local and strategic attention and development in the future.

Similarly, Chadwick, Chapman and Davies (2017) highlighted the importance of strategic level service decisions, which can help the service delivery and physical (and psychological) health of PWLD. They also referred to the important role that multidisciplinary Community Learning Disability Teams (CLDT) can play, for example psychology helping with anxiety management when supporting oral care appointments, with Speech & Language Therapy (SALT) working alongside carers to assist with communication and guidance during dental procedures. On a more personal level, daily inequalities exist for PWLD in accessing other smaller services and important forms of modern communication, for example in accessing the internet (Chadwick, Wesson & Fullwood, 2013).

The movement towards supporting PWLD around a range of different diagnoses and in terms of treatment and management of psychological conditions may be partly due to an emphasis upon normalisation, subsequently termed ‘social role valorization’ (SRV) by Wolfensburger (1972). This involves the idea that society tends to identify certain groups of people as ‘different’ and of less value than the rest, ‘a concept for transacting human relationships and services’ (Osburn, 1998)**.** By creating socially valued roles for people in their society, SRV proposes that they are more likely to receive the desirable things that are available to all, or opportunities for obtaining them (the goal behind SRV). These things include acceptance, belonging, respect, being accorded dignity, education as well as the opportunity to participate in the affairs of one’s community and having a voice to do so. SRV holds that within the resources and norms of a society, these desirable things that other people can obtain, are most likely to be accorded to a person holding societally valued roles. This is relevant to PWLD, as they have arguably been part of a societally devalued group (perceived as ‘deviant’ due to their negatively valued differences – including functional impairments). Therefore, enhancing the perceived value of social roles for PWLD is important, as is the creation of opportunities in which to fulfil these roles.

The work of Durand and colleagues on challenging behaviour as ‘functional communication’ has also been very influential in the field of learning disabilities, largely in terms of children and education, but also for adults with learning disabilities in various environments. Durand’s work has shown that ‘challenging behaviours’ in PWLD can be significantly improved by replacing these behaviours with forms of communication that serve the same purpose – a procedure called ‘functional communication training’ (FCT). The effectiveness of this approach has been demonstrated in many publications over the last thirty years (Durand & Moskowitz, 2015). The idea is that much of the behaviours in PWLD can be viewed as a form of communication (a metaphor used by philosophers for centuries to explain why young children and babies cry and scream, but only relatively recently used within serious research to find out if this concept could be applied in order to improve ‘challenging’ behavior). The rationale behind FCT is that if we can determine the ‘messages’ of behavioural problems and teach PWLD to communicate the same messages more appropriately, their behaviour would not be necessary and would reduce.

Burton, Sanderson, Shortland and Lee (2006) in their review of service needs and developments, found major regional disparities in the comprehensiveness of the provision of UK services, with unmet needs likely to increase due to new diagnostic technologies, in addition to more effective treatments and advances in neonatal screening programmes. They concluded that specialist services should be developed and expanded, in order to provide a more equitable and comprehensive service for the UK population.

Publications such as the government’s White Paper ‘*Valuing People’* with its four key principles (civil rights, independence, choice and inclusion) have helped the situation for this group, as has other legislation, such as the Human Rights Act (1998), Disability Discrimination Act (1995) and The Equality Act (2010), in which disability was deemed a ‘protected characteristic’, applying equally to all PWLD. With a combination of legislative changes such as these and increasing societal awareness of and acceptance of the importance of psychological therapy for PWLD, it is likely to become more difficult to justify their lack or absence from psychotherapeutic services (Morgan, 2011).

2.5 Models of Disability

In writing about what actually constitutes a disability, it is clear that any definition depends very much upon the position of the researcher or person creating the definition. From a social model of disability, disability is not an individual condition, but is created as a result of physical and social barriers which exist in a world organised to meet the needs of able-bodied (and minded) people. An important distinction can be drawn between impairment as an ‘individual limitation’ and disability as a ‘socially imposed restriction’ (Oliver 1983). In support of this, Finkelstein and French (1993) refer to the ‘Union of the Physically Impaired Against Segregation’ - where impairment is contrasted, by referring to *‘the lack of part of or all of a limb…organ or mechanism of the body’,* with disability: *‘the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal level, due to physical and social barriers’ (p.29)*.

2.5.1 The Medical Model of Disability

The medical model has its focus upon the role of the ‘scientist practitioner’ (a description that indeed most applied psychologists would identify with and endorse for themselves) and places an emphasis on the expertise of the professional, whilst the position of the patient (traditional medical terminology) or client, tends to be passive. This generally fails to allow for much value of the client’s internal, subjective experiences, or the importance of the relationship between the helper and client in dealing with the client’s identified problems (Wolfe, 2016). Such a model can be particularly problematic when applied to mental health, as it has tended to categorise and diagnose psychological problems in terms of symptom clusters, rather than engaging with the phenomenological experience of the client (Larsson, Brooks & Loewenthal, 2014).

In the medical model, disability is seen as residing within the individual, who then needs help from others to become as close to the norm as possible. Since the medical model may be argued in terms of viewing impairment as akin to a tragedy (Oliver 1990), with disabled people sometimes being viewed as having lower status than someone with an incurable illness, this can affect how disabled people experience disability (French-Gilson & Depoy, 2003). There has also been a significant focus upon the differentiation between mind and brain in the medical model, which is not always helpful (Szasz, 2007) and which more recent neuro-psychological research has started to question (Ruff, 2003). A need for a more empowering, collaborative approach in health-care is widely viewed as preferable, where the individual has greater understanding, responsibility and sharing in decisions about his or her health and well-being (Oldknow, Cornish & Newman, 2012).

2.5.2 The Social Model of Disability

The social model of disability became influential in the UK in the late 1980s-90s and contributed to some anti-discrimination legislation as well as the foundation of the academic field of Disability Studies. The social model of disability directly challenged the idea favoured by the predominant ‘medical model’ of Western society. Any segregation of disabled people as a minority group means that they may be denied access to ‘normal’ experiences and therefore forced to interact differently with the world. Partly as a result of continued research and increased awareness of disability and empowerment issues, Acts of Parliament have been passed such as the Disability Discrimination Act (1995) and the Special Educational Needs & Disability Act (2001).

In Oliver’s (1990) ‘The Politics of Disablement’ he outlined how, if disability

> *‘is seen as a tragedy, then disabled people will be treated as if they are the victims of some tragic happening or circumstance. This treatment will… be translated into social policies which will attempt to compensate these victims for the tragedies that have befallen them… [If] disability is defined as social oppression, then disabled people will be seen as the collective victims of an uncaring or unknowing society… such a view will be translated into social policies geared towards alleviating oppression rather than compensating individuals.’* (p.2).

Slorach (2016) raised the issue of definitions of disability going further than just being a matter of policy: exploring also the financial cost to individuals and governments. The

Economist in 2013 reported on a WHO World Report on Disability (2011), where over one billion people were categorised as having some form of disability (1 in 7 people). The 2006 census in Ireland found a disability rate of 9.3%, with the following 2011 census reporting a rate at over 13%. Also mentioned in the WHO report was disagreement about what counts as a disability, with dyslexia and autism sometimes counted, whereas many people with these conditions may contest what they perceive as a negative label. The effects of disability can also depend on the means available to cope with it, with devices and aids being less accessible in poorer countries, such as Zambia for example.

The above WHO survey (2011) also reported that 20% of the world's poorest people are disabled, with about 80% living in low-income countries. In addition, the 2008 WHO Report highlighted mental "disorders" as among the 20 leading causes of disability worldwide (with depression affecting over 120 million people), yet fewer than 25% having access to adequate treatment and health care. Slorach concluded (2016, p.22) from these WHO statistics that: (i) a large proportion of the world's population is disabled; (ii) many of these social impairments are socially caused; and (iii) a large majority of disabled people are poor.

The Union of Physically Impaired Against Segregation (UPIAS) group formed in the 1970s 'to challenge the traditional 'tragedy' view of disability' (p.19). One member of this group, Paul Hunt, who was a Leonard Cheshire resident (a UK health and welfare charity) at the time, contributed to the 1966 book 'Stigma: The Experience of Disability', in which he referred to disabled people experiencing social rejection and being less able to enjoy the 'goods' that most British people can enjoy (such as in restaurants and lodgings). This book was itself inspired by Goffman's (1963) book 'Stigma', which was also a survey of the unequal and unpleasant experience of 'handicapped' people in modern society at that time (1960s). Many of the complaints about stigma-related inequalities, raised by physically disabled people, have also applied historically to PWLD.

The social model of disability can equally be applied to the area of mental health in terms of the costs of mental distress – in recent years there has been an explosion in policy initiatives (in business and politics), as well as comments in social media and public domains. Slorach (2016) commented however that it is *"much harder to find such concern about [its] social and economic causes"*, describing DSM categories *as "neutral with respect to theories of aetiology"* (p.23) - in other words, "silent on causes"' – there is still arguably an emphasis on using medication as the preferred method of treatment for conditions that are seen as diseases of the brain. Slorach argued that psychologists (in comparison to psychiatrists) are more likely to attribute mental distress to "intolerable stress" (p.176), therefore being more likely to advocate mainly psychological treatments in response. A social model of mental health has been proposed by many researchers and writers, such as Beresford (2010), as opposed to medical model approaches towards mental distress, which may be viewed rather as focusing on changing the brain's chemistry or a person's behaviour – prioritising instead the voices of service-users and putting 'survivors' views into a wider context.

Critique of the social model of disability has been provided by researchers such as Shakespeare (2013), a leading disability academic and activist, who advocates a pluralist, nuanced approach to disability. He focusses on the interaction between impairment and disability, arguing that disability research would benefit from a firmer conceptual and empirical grounding, as polarisations of the medical versus social model can be dangerous; instead a complex multi-factorial account of disability identity is needed.

2.5.3 Other Models of Disability

Other important models of disability include the psychological model and the bio-psycho-social model. The psychological model, as with the medical model, takes an individual pathology view of the person, with disability being routed within the individual, although it aims to use strategies to enable people to attain their full potential (Rioux, 1997) and the model helped in the creation of the concept of ‘individual differences’. The psychological model links a person’s level of impairment with particular emotional and cognitive characteristics (Supple, 2005).

Many theories have developed from the psychological model, such as Applied Behaviour Analysis, which views disability in terms of a behaviour, which is subject to the same explanations as other behaviours and can thereby benefit from interactions which can help reduce the disability, but without a reduction in the underlying impairment (Johnston, 1996). The Transactional Model (Sameroff, 1991) also emerged from the psychological model, where disability is viewed as being created and maintained by many interacting variables, including social relationships and the environment (Llewellyn & Hogan, 2000), thus providing a fuller picture.

The bio-psycho-social model was developed originally by Engel (1980) in order to overcome missing elements from the previous singular focussed models. Its application was encouraged within the medical field to encourage a more holistic analysis towards health treatments, since it presented an integrated model which when applied to disability, can explain the interaction between impairment, environmental influences, behavioural intentions and resulting behavioural expression, which is interpreted as disability (Johnston, 1996). Advocates of this model included the World Health Organisation (2002), due to diagnosis alone not predicting service needs and consideration being included of the complexity of disability at different levels. This model has helped to shape the way that learning disability services think about the needs of PWLD, especially in terms of multi-disciplinary teams (MDTs), with multiple people or teams working on different aspects of life and using different approaches (Ingham, Clarke & James, 2008).

2.5.4 Preferred theoretical approach for the present research

The underpinning theoretical framework of this particular research is phenomenological (see Chapter 3), which embraces elements of the social model of disability, but the investigator was aware, due to her own clinical practice experience, that there are nevertheless criticisms of the social model for PWLD, as firstly, it tends not to account for people with more severe learning disabilities (Chappell, Goodley & Lawthom, 2001). Secondly, the social model sometimes ignores or forgets about PWLD altogether, being primarily focused towards people with physical disabilities (Shakespeare, 2013).

The researcher of this thesis considered that the theoretical position which most aligned closely with prizing the voices of PWLD and other stakeholders, was an interactionist view of the social model of disability. The bio-psycho-social model was also found to be favourable and a dominant hegemony within psychology currently (in terms of practice-based working), due to the amount of emphasis placed upon the individual, but the researcher felt that this model still placed insufficient focus on societal and policy elements influencing PWLD.

2.6 Stigma & Social Justice Research – attempting to readdress the balance

At the present time, it would be difficult to deny that in this current society there still exists considerable stigma (Goffman,1963), '*where shame and contamination run as a cultural undercurrent and therefore need to be openly discussed and confronted within the therapeutic space, as well as in a wider work context'* (Parritt, 2016, p.204, in Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016). One British study showed that *'[both] disabled and non-disabled people regard those with a learning disability or a mental illness as the least desirable groups'* (Deal, 2003). Indeed, many people with disabilities (including PWLD), do not consider themselves to be disabled: resisting labelling (Ho, 2004). This can be for a variety of reasons, including that having a diagnosis of learning disability is not always morally neutral, especially given the historical oppression on disabled people (see Section 2.1 above). There may be benefits to being labelled as disabled, such as legal protection, but for some having a label is akin to being part of a ‘deviant’, as opposed to ‘normal’ group (Minow, 1990, p.31), the costs outweighing the benefits.

Various definitions of ‘social justice’ exist in the literature, with some emphasising equality and others emphasising equity, such as in Kagan’s (2002) summary:

> *‘If we are serious about social justice as a value, we are serious about people’s rights to self-determination; to a fair allocation of resources; to live in peace, with freedom from constraint; and to be treated fairly and equitably.’ (Inaugural professorial lecture – Manchester Metropolitan University, Jan 30th, 2002)*

Counselling itself has been described as being a power and socio-political act (Katz, 1985) - in terms of certain more privileged groups and members in society engaging in the practise being in a unique position where they can intentionally think about their cultural socialisation and perception of less privileged members (Chen et al., 2015) - although arguably counselling and psychotherapy have been slower to encompass disability within the social model compared with other groups such as feminist, ethnic and cultural minorities (Parritt, 2016). Reasons for this include the suggestion that disability is harder to ‘celebrate’ than being black, or gay, or a woman, for example: being more difficult to recuperate and usually tending to be linked to limitation, incapacity or oppression (Shakespeare, 2013). There is also perhaps greater diversity within disability, compared to some other minority groups and the link away from the medical healthcare model has been a slow process.

2.7 Empowerment – its importance in research and for people with learning disabilities

The word ‘empowerment’ derives from the Latin root ‘passe’, involving both the words ‘power’ and ‘freedom’. It may be broadly defined in terms of being an enabling process, allowing individuals, groups or communities to take control of their lives and the environment around them. By exercising choice over one’s life, an increase in control is a likely result (Oladipo, 2009). Zimmerman (1995) referred to this *as ‘enabling people to act on their own in order to reach their self-defined goals’.* The Community Psychology approach has relevance here due to its’ emphasis on understanding and working with people in their wider social context. The work of Orford (2008) has been influential and involves a multi-level approach, as distinguished from primarily individualistic approaches to psychology. The origins of Community Psychology are drawn from the ecology of human development (Bronfenbrenner, 1979), with models and theories relating to empowerment (Rappaport, 1987) and liberation psychology (Montero, 1998).

2.7.1 Personal empowerment

Empowerment as a concept is diverse, covering psychological, social, economic, organisational, political and community contexts (Cyril, Smith, & Renzaho, 2015). It generally relates to the giving of some form of power, status or ability. Theory development and testing of the concept has so far been most extensive in the area of personal, psychological empowerment – which Zimmerman has also described as a process of change relating to intrapersonal, interactional and behavioural elements (Zimmerman, 1995).

Cattaneo and Chapman (2010) proposed a model of personal empowerment that focused on not only the subjective feeling of being empowered, but also upon actual physical evidence that empowerment has created an impact upon relationships and one's social surroundings. They described an interactive dynamic process, where it is necessary to apply the feelings of empowerment in the real world and seeing results; they emphasised the importance of concrete actions taken and their effect upon social relationships. Taking action was not considered to be sufficient in and of itself, as failures can create setbacks, so goal planning can be important to ensure a higher likelihood of success.

Cattaneo and Chapman (2010) define personal empowerment as *"...a process in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action toward that goal, and observes and reflects on the impact of this action, drawing on his or her evolving self-efficacy, knowledge, and competence related to the goal"* (p. 647). This model of empowerment views the process not as a linear drive toward stronger feelings of internal power, but instead as a dynamic process involving the acquisition of knowledge, taking action, assessing impact and refinement of efforts.

This model includes six steps for attaining personal empowerment:

1) Identification of a power-oriented goal: increasing one's level of influence at any level of social interaction, either with another person, a group or a system.
2) Knowledge: this involves an understanding of the system involved, the power dynamics which could be encountered, the resources required and a plan of action.
3) Self-efficacy: in order to take action, there must first be the belief that it is possible to achieve the goal, which may involve development of confidence or utilisation of a certain set of skills.
4) Competence: the better one's skill set the greater one's competence. Putting a newly acquired skill set into action provides information about strengths and areas to develop.
5) Action: the process of empowerment is a dynamic one involving action, reflection, assessment, and acting again.

6) Impact: personal empowerment can be hard work which may be necessary in order to feel genuine progress. Not all efforts yield results right away and the process of empowerment may be exactly that: a process, rather than an instant manifestation.

Also inherent is the suggestion that the more meaningful one's social influence, the more empowerment will be felt.

2.7.2 Community & patient empowerment

The World Health Organization (WHO) distinguishes between individual and community empowerment, with individual empowerment referring to an individual's ability to make decisions and have control over their own life, whereas community empowerment refers to the collective action of a group of individuals, to gain greater influence and control over the quality of their lives, health and wellbeing within their community (WHO, 1999). Community empowerment may be of more relevance in terms of affecting policy and decision-making on a wider level. An informed stance is needed and important in terms of personal responsibility, participation and making informed choices – this may be more complicated but particularly important in services geared towards supporting people with learning disabilities. Some countries have drawn up patient empowerment acts in order to ensure that people have the right to self-determination and power over their own health decisions, for example.

In the general context of healthcare, empowerment involves the promotion of autonomous self-regulation, to maximise a person's potential for health and wellbeing, which may include providing information and active participation in health treatments. Oladipo (2009) developed a Psychological Empowerment Model, in which he argued that any economic and or social empowerment of the masses may not be possible without psychological empowerment (PE), which he differentiated from other forms of empowerment and also related to Maslow's

Hierarchy of Needs (Maslow, 1943). Therefore, individual and collective empowerment can be interconnected. Oladipo proposed that PE allows changes in people's attitudes, cognition and behaviour, which in turn lead to changes in value orientation, deferred gratification, as well as improvements in self-esteem, self-efficacy, self-consciousness and psychological wellbeing: all of which arguably promote a peaceful and developing society.

In terms of patient empowerment, this movement started in the 1970s and advocated the rights of the patient, with the goal being to build the capacity of patients in order to allow them to become active partners in their own care, capable of sharing in clinical decision making. Many studies have shown that patients involved in their own care and the management of their conditions have better outcomes than those who are not (Wagner et al., 2001). Previously in the UK, a greater emphasis on the biomedical model by health care providers required patients to surrender control in important decisions regarding their health treatments, including coercive communication strategies which were more likely to involve persuasion and manipulation. This was generally not found to be efficient however, especially for people with chronic diseases, those ambivalent about changes that they needed to make and those without the confidence or intellectual ability to make such changes (Lau, 2002).

A more empowering model has been found to replace the above with a more relational form of patient autonomy, an emphasis on joint responsibility and mutual collaboration between service-users and healthcare providers. Better outcomes have been found when service-users are helped to understand any treatment processes involved (Lau, 2002).

The provision of information relevant to patients' needs has been found to be very important – suitable adaptations such as Easy-Read versions of leaflets and other formats for people with sensory and intellectual impairments can help promote accessibility of information, although creating these alongside input from the target audience is preferable (Ward &

Townsley, 2005). They can therefore help promote empowerment at various stages of a person’s health treatment and avoiding the potential imposition of a professional’s point of view should also be considered in order to help promote an empowering approach. This applies equally if not more so, to psychological therapies, as physical health treatments. Similarly, an empowering focus on prevention rather than cure and health rather than disease, can be applied to the use of relapse-prevention strategies within talking therapies (Willner, 2005c). By (i) encouraging and allowing patients to be experts of their own illness or condition and (ii) health care professionals being experts about medical or psychological conditions and of resource management; a combined sharing of expertise could provide a very empowering approach for people accessing health services (Cavet & Sloper, 2004).

2.7.3. Empowerment in the research context

Systematic reviews of empowerment measures in the area of health promotion have tended to focus on quantitative measurement scales (Cyril, Smith & Renzaho, 2015), whilst qualitative approaches to researching the area of empowerment can arguably provide more detail from the perspective of an individual person or participant’s point of view about what exactly is important to them and how empowerment can be facilitated. Beail and Williams (2014) looked at the development of qualitative methods and their application in the field of intellectual disability and found this approach to play an important role in terms of bringing previously unknown information to the forefront of current knowledge. Qualitative methods were found to play a valuable role by providing information about the lives of this population group. The participatory paradigm was highlighted as more established in qualitative approaches, due to lending itself to participation in the generation of research questions, developing interview questions, conducting interviews and sometimes also the analysis. Statham and Beail (2018) also explored how accessible, acceptable and effective psychodynamic psychotherapy (PP) is perceived by PWLD, using thematic analysis obtained via transcribed interviews. After PP participants reported that problems being experienced had improved and that they felt listened to, although many were less happy about therapy ending and struggled to share what they had learnt. The study highlighted the importance of identifying clear goals and ensuring that service users understand the nature of PP before starting sessions.

Jahoda, Dagnan, Stenfert Kroese, Pert and Trower (2009) conducted a review which identified a limited but promising evidence base supporting the use of CBT to address emotional and interpersonal problems in PWLD. They found particular adversities having implications for the adaptation of the approach, whilst also finding it important to consider the interpersonal context of therapy, in order to ensure effective work within sessions and to allow change in clients' daily lives. Jahoda et al. mentioned that a key reason for advocating the use of CBT for PWLD is an acknowledgement of their agency and a belief in their shared humanity to shape their lives, which can be assisted by collaborative involvement with family members, as discussed below in section 2.11.1. Jahoda et al. considered investigating the impact that therapy has on the lives of PWLD (not just self- or informant-reports of emotional difficulties and distress) of most importance as this would enable a more ecological model of CBT, where successful therapeutic interventions can reasonably be expected to lead to better lives and relationships and of particular relevance to this thesis, to evidence of greater self-determination.

MacMahon et al. (2015) gathered the views of PWLD who had recently taken part in a cluster randomised control trial of a staff-delivered CBT manualised anger management group intervention and found that PWLD were rarely asked about their experiences as users of psychological services. IPA was successfully used to gain an understanding of service-users' experiences of participation in the CBT group. Similarly, Stenfert Kroese et al. (2016) found in a pilot study, that IPA was a suitable approach for ascertaining service-users' experiences of attending a trauma-focussed CBT group for PWLD. Their findings indicated that a group intervention is acceptable to and feasible for PWLD, with participants expressing pleasure in being able to contribute constructive feedback regarding their experience and to promote improvements to a group manual.

Empowerment in the research context is generally seen as a process which is necessarily a good thing, with the participants benefitting from the research (Florin & Wandersman, 1990). Although some researchers may consider participants as ‘subjects’, who are researched upon, this may be more likely to be the case when quantitative approaches and methodologies are employed (Chalmers, 1999). This is linked to the idea that the researcher doing the researching may be a member of a more powerful group in society, researching a less powerful group. It is for reasons such as this that emancipatory and participatory research became more popular with some researchers, since they focus on involving and benefiting the people involved (Minkler, 2004).

The research in this thesis - although not participatory research in the sense of the participants being involved in developing the research questions and data collection methods, engaging in data collection, processing the data, organising the project and its findings, it still directly involves the participants, due to the immediacy of the interview methods used (a research paradigm working as transparently as possible, ‘with’ people rather than ‘on’ people) and it is hoped will prove beneficial in terms of supporting future therapeutic service provision and NHS policies for PWLD.

As previously mentioned, the field of ‘Learning Disabilities’ is a population in modern society where a lack of empowerment has historically been evident (Stainton, 2000). Cattaneo and Chapman’s (2010) aforementioned steps towards the attainment of personal empowerment still apply but may require adaptations, or at least simplification in terms of communication, explanation and support in putting the steps into practice, for people with lower intellectual and adaptive behavioural functioning. A gap exists in research exploring empowerment as facilitated by psychological therapeutic interventions for PWLD, which this thesis aims to address.

2.8 The importance of offering people with learning disabilities psychotherapeutic interventions & services

Increasingly research is showing that PWLD can provide reliable evidence to demonstrate the effectiveness and utility of psychological therapy for this group (MacDonald, Sinason & Hollins., 2003; Townson, 2004; Merriman & Beail, 2009; Pert et al., 2013). Adaptations can be made to override research obstacles affecting validity, such as memory and comprehension difficulties, recency-effects and acquiescence, by the use of: probes, self-report measures (such as open-ended questions) and visual materials to aid understanding (Whitehouse, Tudway, Look & Stenfert Kroese, 2006; Brewster, 2013).

It has become more accepted that provided general adaptations are implemented in the treatment techniques used by psychological therapists working with PWLD (Joyce, Globe & Moodey, 2006; Willner, Bailey, Parr, & Dymond, 2010; Jahoda, Stenfert Kroese & Pert, 2017), there is no reason why therapy cannot be effective and rewarding for this client group (Oathamshaw & Haddock, 2006; Lindsay, Jahoda, Willner, & Taylor, 2013). Such adaptations include adapting the process to ensure effective communication takes place and that the clients involved understand and can engage with the process as fully as possible, as well as the importance of making modifications to, but maintaining the integrity of a collaborative therapeutic approach (including setting an agenda, guided discovery and cognitive mediation for example) – in order to reduce the tendency towards acquiescence, of this client group in therapy (Jahoda et al., 2009).

The majority of the research impact in exploring therapeutic interventions (and adaptations) with PWLD has been targeted at cognitive-behavioural forms of therapy (CBT), although other forms of ‘talking therapies’ are also in use, as the findings in this thesis indicate. Key areas of focus and consideration for therapeutic adaptation include the importance of a strong knowledge of the client group and the development of technical expertise in the therapist (Keijsers, Schaap & Hoogduin, 2000; Lindsay, Jahoda & Willner, 2013). The development of the client-therapist relationship has been found to be particularly important (see Section 2.11). Allowing clients to produce their own material in the therapy sessions as opposed to relying solely on the therapist is a particular strength of the Socratic process, so often a part of the therapeutic process (Payne & Jahoda, 2004); Lindsay, Jahoda & Willner, 2013). Some researchers have even suggested that once adaptations are made, psychological therapy for PWLD can have an even *greater* impact as a form of therapeutic technique than may be seen in mainstream therapy, due to the prevailing lack of support often received in their lives and therefore a greater appreciation of the therapy (Lindsay, Jahoda & Willner, 2013).

See Section 3.2.1 for further information about the NHS in relation to this research and the use of psychological therapies with PWLD.

2.9 Counselling Psychology & the BPS

At the start of the Editorial of the ‘Power and Equality’ Special Edition of the 2013 Counselling Psychology Review, there was a request for a ‘call to action’ (Steffen & Hanley, 2013). This referred to changes in how society currently views power, powerlessness in the face of inequality and abuse of power, but also how these affect the discipline of counselling psychology. Further research around social justice was considered one step forward, although there is concern that this can also leave underlying power structures unchallenged.

Counselling psychology is a discipline in an ideal position to explore and highlight power inequalities in society, as well as to examine how aspects of the therapeutic approach can positively empower disempowered populations in modern society. Counselling psychology moreover *‘prides itself on a holistic view of clients, which includes an awareness of their contexts and thus societal structures and the operations of power within* them’ (Steffen & Hanley 2013). Sutherland (2007) also raises the importance of counselling psychologists using reflexive practice and having a responsibility to help reduce power imbalances, partly through awareness of societal imbalances and partly through consideration of how to empower the client. This necessarily also involves power dynamics between therapist and client and consideration of how power imbalances can be overcome or challenged (Harrison, 2013). As has been presented thus far, there is a need for further research around social justice.

Counselling psychologists are frequently placed *‘at the heart of ethical, moral and professional dilemmas and debates about the boundaries of the therapeutic relationship’* (Parritt 2016, p.204, in Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016). Within counselling psychology, calls for social justice have tended to emphasise the importance of working with and empowering oppressed groups in society in order to help address power imbalances and inequalities. The field of Adult Learning Disabilities is one such population in modern society where a lack of empowerment has been historically evident (see Section 2.7).

As a discipline, counselling psychology has been described as being in a position to offer a valuable contribution to understanding the therapeutic relationship when a person has a learning disability, due to its particular skill base and interest in understanding the therapeutic relationship (Jones, 2013). Rizq (2005) described this as being *‘pre-eminent’* to the discipline and *‘valued above any one theoretical model or doctrine’*. In addition, it is likely that any understanding about the therapeutic relationship within counselling psychology may also be applied and of value to other professionals (Jones, 2013).

2.10 The Therapeutic Relationship

The therapeutic relationship can be defined broadly as the collaborative and affective bond between therapist and client (Martin et al., 2000). Various different terms have been used, such as the therapeutic alliance, working alliance and the treatment alliance (Sander, 1992). A high positive correlation has been found to exist between the quality of the therapeutic relationship and the amount that a person gains from therapy (Orlinsky et al., 1994).

The importance of the therapeutic relationship in counselling psychology has been widely accepted in mainstream research for many years, with researchers generally agreeing that it is of universal importance as a component within psychological therapy (Clarkson, 2003) and a fundamental aspect in the outcome of therapy in the non-learning disabled population (Jones, 2013). However, researchers have also highlighted a need for further evidence of its effectiveness (Willner, 2005c) and as previously mentioned, there has been a relative sparsity of supportive research for PWLD, including a poor empirical and theoretical understanding of the role and potential complexities of the therapeutic relationship (Jones, & Donati, 2009).

The therapeutic relationship in psychological therapy for PWLD was overlooked for many years and research has only begun to address this imbalance in the last decade. The importance of the therapeutic relationship has in addition been found to span theoretical divisions, being more important than the type of therapy used and being one of the most important predictors of outcomes (Cowie, 1999). Suggestions have been made that the therapeutic relationship is even more important in complex and longer-term difficulties (Sanders & Willis, 2005).

Similarly, the working alliance between therapists and PWLD has been highlighted as an area lacking in research, although it is increasingly now being addressed (Strauser, Lustig & Darnell, 2004). Strauser et al. found that the therapeutic relationship was regarded by both clients and therapists equally as an important variable in psychological work with PWLD, as it was by non-learning disabled populations. Indeed, several therapies promote the therapeutic relationship as being a fundamental concept in the process and methods used in the treatment (for example, Beck, Rush, Shaw & Emery (1979), highlighting the focus of sharing and the therapist and client collaborating together on the development of the formulation). Jones and Donati (2009) reported that contributions to the literature came predominantly from clinical psychologists or psychodynamic orientated psychotherapists, with the latter focusing more on the theory of learning disabilities in terms of epidemiology, assessment and neurological aspects including executive functioning, whilst the psychodynamic literature was more focused upon exploration of the delivery of psychotherapy with PWLD and nature of the relationships involved (Sinason, 1992).

In terms of the nature of therapeutic relationships, limitations have been explored relating to a lack of experience (of emotional relationships in particular), on the part PWLD (Emerson, Hatton, Felce & Murphy, 2001) and having to develop friendships with those employed to help them, due to limited opportunities for intimate relationships and a lack of social networks (Hodges, 2003). Another significant limitation in the life of someone with a learning disability with regard to relationships, is the extent to which relationships may be formed and then broken – which is particularly likely for someone who has spent much of their life in care (Bungener & McCormack, 1994), with staff turnover being a particular problem (Hatton, Emerson & Rivers., 2001). This can cause or exacerbate insecure attachment problems (Hollins & Sinason, 2000). Other difficulties include a likelihood of confusion in PWLD around interpersonal boundaries and in differentiating between roles of the therapist as a professional or a friend (Caine & Hatton, 1998). These types of difficulties can contribute to adversely affecting therapeutic relationship formation in psychological treatment (Royal College of Psychiatrists, 2004).

Some psychoanalytic research has suggested that PWLD can evoke certain kinds of emotional counter-transference reactions on the part of the therapist, such as the urge to become an advocate for their client or a surrogate parent (Caine & Hatton, 1998). Other writers have referred to therapists experiencing tiredness, feeling drained of energy (Bender, 1993) or an inability to remain alert during sessions (Hodges, 2003), possibly due to finding it difficult to process hearing about situations which seem unbearable or impossible to understand. Jones and Donati (2009) in their review of existing literature about the therapeutic relationship for PWLD, even found reference to questions about the desirability of developing relationships with someone seen as unattractive and possibly creating unconscious unacknowledged feelings of contempt toward the PWLD that subtly affect practice – including a possible tendency to patronise, or feelings of unconscious contempt, despite at a conscious level having feelings of pity or sympathy. Symington (1992) related this to an instinctive animal impulse to attack and kill the weak.

Other studies have focused on the use of adaptations by therapists and an examination of positive ways that the above difficulties may be overcome, in developing therapeutic relationships: such as the need to be friendlier, to be less rigid about session times and to use more tactile interaction (Royal College of Psychiatrists, 2003). Other proactive suggestions include the need for therapists to be skilled at assimilating all sources of communication provided by PWLD, due to the frequency of impaired communication and language skills being a part of the therapy (Moss, 1998; Hutchinson, Anderson, Lang & MacMahon, 2017).

Until recently there was still very little research investigating the qualitative experiences of PWLD who have engaged in psychological therapy (Lewis, Lewis & Davies, 2016). Having a learning disability was even traditionally an exclusion criterion for good quality research about psychological treatments (Royal College of Psychiatrists, 2004). It is clear that PWLD are often in less powerful positions in relationships due to their disability, which can cause them to be less confident and expressive during therapy (Caine & Hatton 1998); this may manifest in them being less able to interrupt the therapist or feeling less able to clarify an issue. Research also suggests that PWLD are less experienced in or used to talking about their emotions in the context of a relationship (Hodges, 2003). They are therefore more likely to display greater passivity within therapy sessions, resulting in a loss of self-determination and possibly even simultaneous feelings of envy towards the therapist’s abilities and skills (Jones & Donati, 2009).

The concept of ‘secondary handicap’ has also been popular amongst psychoanalytic literature (Hodges, 2003), whereby the person’s original or primary disability is exaggerated as a way of defending oneself against painful feelings of difference. This exaggeration can provide a defense mechanism within the person receiving the therapy, as well as existing within the therapists themselves, who may experience a projection of ‘stupidity’ for not realising that this has taken place. Skill is required on the part of the therapist to be aware of such processes, identify and work through them.

This links to questions about what therapists can do to establish a collaborative, rather than an authoritarian relationship (Stenfert Kroese, 1997) and in turn highlights other important issues around motivation to engage and who makes the therapy referral in the first place, which in themselves can impact upon the therapeutic relationship (Oathamshaw & Haddock, 2006). This also resonates with the importance of empowerment for PWLD and the opportunity provided within psychological therapy for helping to encourage or facilitate feelings of personal empowerment.

2.10.2 The importance of service-users’ views of therapy, self-advocacy and the therapeutic relationship

The importance of consulting with service-users about their experience of psychological therapies has only relatively recently started to be emphasised (Johnson & Walmsley, 2003; Lewis & Porter, 2004; Nind, 2008). This is important in terms of equality, empowerment and in terms of improving services offered and helping to make sure people receive the best possible psychological care. Jones and Donati (2009) moreover suggested the use of qualitative methodologies such as semi-structured interviews being employed systematically, to explore practitioners’ views and the experiences of the nature and role of the therapeutic relationship, from the perspective of the PWLD.

Various studies have previously explored the link between self-advocacy and the effects of interventions to promote self-determination for PWLD (Algozzine, Browder, Karvonen, Test & Wood, 2001), with increased independence, physical and psychological well-being resulting from increased access to services and appropriate support. Self-advocacy has been described by its members as a civil rights movement through which PWLD seek to attain human, civil, and legal rights (Cone, 1994). Miller and Keys (1996) referred to the growth of a self-advocacy movement by and for PWLD in the United States which facilitated empowerment, in response to stigmatisation, exclusion from mainstream society and a lack of opportunities. As a result, Miller and Keys argued that some PWLD have been able to transform themselves from marginalised targets of discrimination, to respected citizens.

PWLD can clearly meaningfully engage in research and provide important feedback about their therapy – there is an increasing evidence base supporting that they should be included in research, rather than excluded just because of their label (Lewis, Lewis & Davies, 2016), so this is an area that still needs to be given more consideration.

2.11 Therapists' perspectives working with PWLD: what is important, what works best & what improvements do they see?

The BPS document 'Psychological therapies and people who have intellectual disabilities', edited by Beail (2016) provides a comprehensive overview of the talking therapies available to PWLD, with accessibility being an important (and successfully implemented) focus throughout, and discussed by a range of experts representing some of the main psychological therapy approaches currently being used within the area of learning disabilities. The importance of innovation, adaptation and reasonable adjustments for individual needs was highlighted as being essential to ensure equality of access to psychological therapies. Beail indicated that ID continues to be given as an exclusion criterion for some research focusing on psychological therapy involving the general population, but fortunately evidence continues to emerge from studies which include therapists' perspectives about providing psychological therapies to PWLD. These developments have highlighted a greater awareness of the value of these therapies in the alleviation of psychological distress in the whole population, including PWLD.

Jones (2013), exploring the therapeutic relationship between PWLD and their therapists, from the perspective of eight counselling psychologists using IPA, found the therapeutic relationship to be fundamental, yet difficult and influenced by a variety of different variables. Jones' study identified the following key themes to be important in terms of the therapeutic relationship, which emerged from the use of semi-structured interviews: clients' previous experience of relationships; the need for multiple relationships; the experience by the therapist of needing to facilitate the relationship and the necessary skills for therapeutic approaches. Themes also emerged relating to therapists' motivations, values and needs when working with this client group and conflicts concerning individualisation and the setting culture. The themes were discussed in relation to the existing literature and implications for theory and practice were explored.

In terms of the choice of therapeutic approach used by psychological therapists, questions continue to remain regarding ‘what works for whom’ (Roth & Fonagy, 2005) and which therapeutic approaches are best for particular clients and presenting problems. It is beyond the scope of this thesis to examine this specific area in great detail, which would present an interesting and worthy piece of research in itself, but the psychological therapists involved in the research did have questions about their choice of therapeutic approaches as part of their semi-structured interviews, as this was considered an important area to include.

Jones (2013) study above thus identified that the experiences of counselling psychologists working with PWLD is a lesser known area, worthy of greater research and it is therefore hoped that this present thesis will further expand upon the existing knowledge in this area. The therapists involved in this present research (this thesis) included two counselling psychologists and three counsellors (see Chapter 3 for more detail regarding methodology).

2.11.1 The importance of carers, support workers and the support role

The role of support workers and other professionals in the psychotherapeutic process has been commented upon but not systematically investigated as yet (Stenfert Kroese et al., 2014). The impact of the supporting role, in working alongside the therapist and encouraging positive therapeutic outcomes and goal attainment can usefully be obtained in a variety of ways including via reports from carers. The importance of a person’s social network can be very important generally in their psychological wellbeing, whilst the involvement of parents and carers in homework and relapse-prevention exercises, can be critical in the success of psychological therapy with this client group (Dagnan & Sandhu, 1999; Dagnan & Waring, 2004). This is an area identified as a further research need, since there is still a gap in the present available literature. Stenfert Kroese et al. (2014) found that for CBT to be effective in the longer term, a wider systemic approach including staff training and supervision, staff management and consultancy, as well as having a balance between confidentiality and the sharing of psychological formulations with ‘significant others’ to ensure maintenance and generalisation of improved psychological well-being, all needed to be considered by therapists in the therapy work they provided.

Jahoda, Stenfert Kroese and Pert (2017) reported that it is particularly important for therapists to liaise with others when working with PWLD, both for obtaining information and in terms of being helpful allies, who play influential and long-term roles in implementing and maintaining psychological and environmental change for PWLD. This should be balanced by a consideration of confidentiality and who to include or not include in the sharing of information, so that clients’ rights were still respected. Also reported was a need for families, carers and support workers to complement the therapeutic approach, and liaising with health and social services colleagues, which improved the chances of significant and enduring improvements in psychological well-being for PWLD. The importance of spending time delivering staff training around mental health and psychological issues was again raised as vital, as was helping to ensure all staff involved understand the psychological principles involved in the therapy and formulations being used.

People with disabilities more generally and PWLD in particular, demonstrate that minority groups can have distinct internal diversity, yet share key similarities with other oppressed groups, especially in the areas of power, oppression and discrimination. In terms of their support, some researchers have also argued that support workers can represent both a support and a barrier to accessing health services, as PWLD may have to rely upon them to identify their health issues and to negotiate their contact, which can limit their ability to make healthcare decisions for themselves (Carlson, Hames, English & Wills, 2004). Therefore, it is important to continue work which helps promote greater equality and awareness about

PWLD needs within society (Reynolds & Pope, 1991; Parritt, 2016). It is hoped that this thesis will help to further explore the internal and external diversity of this population group, including examination of the various overlapping differences involved and particularly the experiences of key participant groups involved in psychological therapy.

Woolfe (2016) outlined the wide variety of roles that encompass the description ‘helper’, with professionals and volunteers who work alongside therapists being just one sub-set. The definition of a professional helper is often based upon claims of technical expertise embedded in a body of specialised knowledge. In terms of therapeutic practice and psychotherapy, it has been suggested that there are a number of narrative accounts or ideologies of what the practice involves – often found within two tensely competing world views, which have been described as either ‘psychopathological’, or in terms of the ‘intersubjective world of client and therapist and the joint construction of meaning’, which emphasises agency and consciousness (Douglas & James, 2013).

Jones & Donati (2009) referred to the importance of other supporting relationships and a variety of helping professionals who may not directly be involved in providing psychological therapy, but who are nonetheless still psychologically meaningful support relationships. They also mentioned the potential of research in the field of learning disabilities and the therapeutic relationship to be relevant for informing theory, training and service provision for a range of other health professionals. Some of these relationships include day service staff, social workers, advocates, community nurses, as well as clinical and counselling psychologists, psychotherapists and psychiatrists (Hodges, 2003; Royal College of Psychiatrists, 2004; Brown & Marshall, 2006).

2.12 Gaps in existing LD research & rationale for current study

A small number of studies have been conducted in recent years (Jones, 2013; Lewis, Lewis & Davies, 2016) exploring the experiences in psychological therapeutic work, of counselling psychologists and of PWLD (as clients or service-users), but very little research has been carried out looking at the views of both the psychological therapists and their clients (PWLD). Even less exists specifically taking a social justice perspective by linking the area of empowerment to this therapeutic relationship. Prior research has identified a need for research containing interviews or focus groups with staff/families/professionals to explore their perspectives on the outcomes of psychological therapy for PWLD and what they consider helpful or unhelpful (Jones & Donati, 2009; Lewis, Lewis & Davies, 2016).

The current research will address some of the gaps outlined above, as it specifically focuses upon the factors important to PWLD, their therapists and support workers in the provision of psychological therapy, particularly in relation to the facilitation of empowerment via the therapeutic relationship. It was hoped to encourage PWLD as a sometimes oppressed group, the opportunity to make their voices heard. By including the voices of PWLD and using a phenomenological approach, it is anticipated that this research will provide a unique opportunity to find out more about the importance of therapeutic relationship for PWLD. This includes how empowerment is i) understood by the different parties described and ii) linked to the therapeutic relationship.

2.13 The Research Aims & Expected Outcomes of Study

2.13.1 The aims of this research project:

1. To investigate what factors clients with learning disabilities find most helpful and empowering in the psychological therapy received from psychological therapists.

2. To ascertain how the therapeutic relationship affects psychological well-being within a learning disabled population, as facilitated by their therapists.

3. To explore the importance of support workers' involvement in providing support with psychotherapeutic work for PWLD.

4. To consider how empowerment is conceptualised and experienced by the main stakeholders in the therapeutic encounter, between PWLD, their therapist and their support worker.

2.13.2 The research questions to be investigated:

1) How do **people with learning disabilities** experience empowerment from psychological therapy and the therapeutic relationship?

2) i) How do **psychological therapists and the support workers of people with learning disabilities** enable clients with learning disabilities to experience empowerment from the psychological therapy received within the NHS?

   ii) Does choice of therapeutic approaches & methods influence or facilitate positive outcomes and empowerment in people with learning disabilities?

3. METHODOLOGY

This qualitative investigation explored the key issues relating to the therapeutic relationship between PWLD and their therapists, in an NHS Adult Learning Disabilities Service. In particular, it focused on how the therapeutic relationship facilitates empowerment. Semi-structured interviews were carried out, which were analysed using interpretative phenomenological analysis (IPA), to identify the ideographic experiences of empowerment within therapy, of therapists, support workers and people with learning disabilities. Following the use of IPA methodology, key themes across the groups were identified. This chapter will outline: the research approach and epistemology involved; the research context and participant recruitment; the research procedure which was involved; ethical considerations and risk management; culminating with an exploration of the data analysis which was used to produce the findings in the next chapter.

3.1 Research Approach & Epistemology

Coyle (2007, p.11) describes how qualitative psychological research, at its most basic;

> *'may be regarded as involving the collection and analysis of non-numerical data through a psychological lens… in order to provide rich descriptions and possible explanations of people's meaning-making – how they make sense of the world and how they experience particular events*'.

Qualitative research is inextricably bound to epistemology, the branch of philosophy that is concerned with the theory of knowledge – how and what we can know (May, 2002). An epistemological position in any research study explains the approach taken and methods that are used in conducting the research. This is important when trying to ensure the study is carried out consistently and coherently, although there are times when a more flexible approach may be appropriate (Finlay, 2011).

Qualitative methodology was used in this project as the study focused on the direct, lived therapeutic experiences of people with learning disabilities, their support workers and the therapists involved in providing their psychological therapy. An interpretivist approach (Smith et al., 2009) was taken - as opposed to using a more positivist 'scientific method' - as the researcher was not striving for neutrality and objectivity in the data collection and analysis, but a more subjective exploration of the participants' own experiences.

Semi-structured interviews provided a means of obtaining the direct views and information from all parties involved in the therapeutic work and they also facilitated self-reflection – a crucial element within Counselling Psychology, which emphases developing the reflexive practitioner and the importance of the scientist-practitioner model (Woolfe, Dryden & Strawbridge, 2003). Counselling Psychology however has also furthered the idea of what is scientific beyond positivistic approaches and therefore frequently includes qualitative approaches, which are often arguably more relevant to practice than purely the generation of nomothetic information (Strawbridge & Woolfe, 2003).

3.1.1 Decision-making in applying qualitative rather than quantitative methods

It was expected that qualitative methodology would be helpful in this investigation: the researcher considered that by utilising an interpretative paradigm, it would allow hermeneutic knowledge to be examined (see below for an explanation of hermeneutics) and to enable the exploration of subjective understanding and meanings - of both the participants and researcher. This will be returned to in the Findings chapter and Reflexive Account (Appendix B).

One key qualitative methodological approach is that of phenomenology, which can be useful and drawn upon when trying to understand the nature of human experience. Finlay (2011, p.3) describes phenomenology as inviting us *‘to slow down, focus on, and dwell with the ‘phenomenon’ – the specific qualities of the lived world being investigated’*. This is contrary to the scientific approach which requires ordering, categorising and explaining (of behaviour or phenomena).

It can be difficult to get away from one’s own subjective filtering of experience and understanding, but this may be seen as actually an essential part of the qualitative research approach. This was referred to by Pring (2004, p.100) for example: ‘*To understand particular events one must see things from the point of view of the participants or of the people who are involved – how they interpret events and thereby constitute those events as events of a certain sort’.*

There are arguments for and against both qualitative and quantitative research approaches. Cohen et al. (2000) argued that both positivists and interpretivists have been criticised for presenting an incomplete account of social behaviour, by neglect of political and ideological contexts, which resonates with the importance given to addressing issues of social injustice raised earlier in this thesis (Chapter 2). It was considered that IPA could highlight such issues particularly well (for example educational, social or economic inequalities), by enabling close exploration of individuals’ own experiences of having a learning disability (or working with those who do) which may, due to their increased likelihood of social disadvantage and exclusion, lead to them to find themselves in a socially disempowered situation.

Other qualitative approaches were considered, including the use of focus groups and narrative approaches to collect information, with Thematic Analysis or Discourse Analysis to explore and analyse the subsequent data. Thematic Analysis had been considered originally alongside IPA, as it can be helpful when seeking to use qualitative information to test out hypotheses and to compare data to similar previous research (such as health professionals' experiences of conducting therapy with PWLD – e.g. Hutchinson, Anderson, Lang & MacMahon, 2017). The researcher had considered using Thematic Analysis as a first stage of analysis, to inform the second round of analysis via IPA. It has been argued that most qualitative research involves thematic analysis in a general sense, since researchers tend to look for themes, although it is mainly associated with phenomenology (Holloway, 2008). Thematic Analysis can be useful for identifying themes and patterns in interviews, when listening to recordings and reading transcripts and was the approach used by the researcher in her previous Master's degree research.

A Framework Analysis approach, which sits within the broad family of Thematic Analysis methods, was also considered initially since a larger number of participants than is typical in IPA studies was recruited into the study. Framework Analysis has been identified as an established and rigorous method of analysing qualitative data in health services research, found to be particularly useful as it allows teams of researchers to work together, following five distinct interlinked phases (Furber, 2010). The researcher considered this approach as it is well adapted to research that has specific questions, a pre-designed sample (e.g. professional participants) and a priori issues, (such as organisational issues), as well as being a dynamic approach that allows change or amendment if needed, throughout the process. Framework Analysis is also considered to provide a helpful tool for assessing policies and procedures from the very people that they affect (Srivastava & Thomson, 2009) – another compelling argument in favour of using this approach, which the researcher thought could be useful for subsequent work involving the NHS and other services. There is some overlap with IPA, including the immersion phase, where researchers familiarise themselves as fully as possible with the data obtained, whilst developing a theoretical framework, making notes (usually in the margins of the transcripts) of the main ideas that appeared to recur in the data (Richie, Spencer & O'Connor, 2003). There are also commonalities with the indexing, charting and synthesising of the data phases, which all help to facilitate transparency of the data analysis process and enhance rigour (Ezzy, 2002).

However, IPA was ultimately considered more suitable for this research project as it was hoped to collect data that reflected people's actual lived experiences and perspectives, with a more idiographic focus and where experiential-type questions could be asked (as opposed to obtaining information from focus groups or story completion tasks for example). The Framework Method arguably cannot accommodate highly heterogeneous data, as it requires data to cover similar topics or key issues (Gale, Heath, Cameron, Rashid & Redwood, 2013), in order to categorise it – which the present research arguably contains - although it is useful for the thematic analysis of semi-structured interview transcripts, which is one reason it was considered initially. The choice of methodology was largely driven by the research questions, which were intended to be centred upon the participants involved and their direct experiences. It was hoped that by using IPA a more in-depth view on what the therapeutic experiences were like could be gathered. One disadvantage of Framework Analysis is that due to the framework it imposes, it can constrain what can be studied and suppress complexity (Bowling & Ebrahim, 2005), both of which are strengths of IPA.

Discourse Analysis (DA) had also been considered initially, as it similarly has a strong constructionist position, where language is analysed and considered in terms of constructing versions of truth, as it occurs. Inherent within DA is the idea of (i) speakers having a stake and (ii) language promoting that within social discourse. This was therefore a contender as a methodological approach involving empowerment and valuing the opinions of the participants involved. In this case however, it was decided that a phenomenological focus on the meaning that participants made of their lived experiences was more critical than the actual words used, especially since many PWLD experienced various difficulties and challenges with expressive verbal communication, so articulation of experience may be more challenging and could be misinterpreted or used out of context. It was felt that the interpretive nature of Interpretative Phenomenological Analysis would help overcome this issue.

3.1.2 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was selected by the researcher as most appropriate, and was utilised in this study. This approach encompasses three key epistemological underpinnings: phenomenology, hermeneutics, and ideography.

Firstly, IPA is a qualitative research approach which is based upon the branch of philosophical thought known as ‘phenomenology’. It is ‘*committed to the examination of how people make sense of their major life experiences. IPA is phenomenological in that it is concerned with exploring experience in its own terms’* (Smith, Flowers & Larkin, 2009, p.1).

Alexander (2006), in an article explaining the position of phenomenology amongst differing paradigms and referring to Husserl as a key shaper of phenomenology, highlighted a strongly expressed dissatisfaction with the positivist approach in western thought, particularly in the mid-twentieth century, which constructivism and phenomenology in particular, sought to address:

> ‘*If ever there was a paradigm shift in the history of epistemology that sought to replace its predecessor it was this… Edmund Husserl may have offered the clearest account of the epistemological underpinnings of what later became known as constructivism… we can only know indubitably that which presents itself within consciousness…’* (p. 211).

Husserl felt that the only way to achieve knowledge that could not be doubted, would be by creating a new science, ‘phenomenology’, which focused on the internal experience of life.

He considered that nothing could be said with any certainty about life beyond our thoughts and experiences.

This is a very different view from the positivistic approach which wanted to do the opposite. Skinner for example, working from a positivist standpoint, wanted to disregard all ‘internal’ experiences as unmeasurable, unobservable, unobjective, and unquantifiable; whilst phenomenology prizes this subjectivity. Husserl described this method of reducing all elements of everyday life down to subjective experience as ‘*epoche’*, a method claiming to free people from pre-conceptions which were not part of their own experience.

This subjective meanings – or phenomenological – approach, was extended by Schultz, who linked Husserl’s ideas to sociology. According to Cohen (2000):

> *“The origins of meaning he (Schultz) thus sought in the ‘stream of consciousness’ – basically an unbroken stream of lived experiences which have no meaning in themselves. One can only impute meaning to them retrospectively, by the process of turning back on oneself and looking at what has been going on. In other words, meaning can be accounted for in this way by the concept of reflexivity”* (p.24).

Reflection here is seen as a crucial methodological tool, enabling people the maximisation of their subjective experiences and using them to contribute to an understanding of the social world.

Secondly, hermeneutics, the theory of interpretation, is also a major theoretical underpinning within IPA. Notable hermeneutic phenomenologists included Heidegger, Schleiermacher and Gadamer (Smith, Flowers & Larkin, 2009, p.21-2), who were keen to explore the methods and purposes of interpretation itself, including determining whether it can be possible to find out the original meanings and intentions of an author or source of information.

Heidegger was keen to label hermeneutic enterprise as a key part of phenomenology: finding out how, when and why a phenomenon occurs – which brings in the ‘hermeneutic circle’ idea referred to by many writers of hermeneutics, in exploring the relationship between the part and the whole and the need to move backwards and forwards between them when considering the meaning of things – which is the iterative process involved in IPA analysis (exploring a range of different ways of thinking about the data involved).

Thirdly, ideography is an important part of IPA, as it examines human behaviour on an individual, particular level, rather than on a nomothetic, group or population level, which is more often the case in psychological research. This can be subdivided further: it allows a focus on detail and as a result can allow for a deeper analysis, as well as enabling a very particular focus (which may involve a particular context, people, or events). Warnock (1987, in Smith, Flowers & Larkin, 2009, p.31) highlighted the fact that by focusing more closely on the individual, it takes us closer to the universal. IPA is able to move to general statements from single cases, whilst maintaining the potential to retrieve information back to individual participants if required.

IPA was therefore chosen because it allows the researcher to embrace the philosophy and practice involved in counselling psychology - as it is concerned with the meanings and beliefs that people construct from their experiences, as well as the context and processes involved which affect the psychological wellbeing of the individual (BPS, 2005).

It was decided that the most parsimonious way to gather this information from the participants using IPA involved would be through semi-structured interviews. IPA researchers often use an interview schedule to allow the researcher to approach the research question ‘sideways’, facilitating the discussion of relevant topics which allow the research question to be answered and analysed. It could be argued that interviews are at the heart of qualitative research, for it is through this vehicle that people's views and perspectives on the world are obtained (Lewis, 2002; 2004). Further, an IPA interview aims to encourage participants *'recall of selected events and to collect information about them as well as the connections made by the participants, with examination of their personal meaning and idiographic experience'* (Burgess, 1984). Smith, Flower & Larkin (2009, p.57) describe a qualitative research interview as '*a conversation with a purpose'* – the aim of which is to allow an interaction which encourages participants to be story-tellers of their own experience, using their own words (see section 3.1.3 below regarding the successful use of interviews with PWLD and adaptations which can facilitate and help the process).

3.1.3 The research process and the participatory role of the researcher

The role of the researcher is particularly relevant in IPA, as it involves the researcher actively participating alongside the interviewees. The researcher tries to get close to the participants' personal world and take an 'insider's role' (Conrad, 1987). Thus it is a dynamic process, but the process is still complicated by the researcher's own conceptions, which are needed in order to make sense of what sense the participants are making. The researcher cannot help but be influenced by their own preconceptions and assumptions, so the research and any new information will be seen in the light of the researcher's own prior experience. Smith and Osborn (2003) refer to this double hermeneutic process as an essential part of IPA and an essential combination of hermeneutics and theories of interpretation, they outline that an empathic hermeneutics is combined with a questioning hermeneutics, in IPA.

This combination of both empathic and critical elements allows for an active, but thorough approach, which highlights IPA's theoretical commitment to the cognitive, linguistic, as well as the affective and physical being aspects of a person (Smith & Eatough, 2008). These combined dynamic elements, alongside the philosophical roots of IPA appealed to the researcher, as she was keen to employ and experience the use of phenomenology, hermeneutics and ideography, although she was aware that the double hermeneutic involved can be challenging and entail a mixture of pros and cons.

Although it can always be questionable whether the researcher's understanding is a correct and accurate account of the participants' experience, this can in part be reconciled by acknowledging clearly how the interpretations have come about and where assumptions have been made. Checks can also be made afterwards with the participants, following the analysis. It was hoped that both important generic themes from the analysis and unique information relating to the individual lives of the participants, would emerge from the interview data.

Since an important part of qualitative research can be the quality of the researcher and participants' relationship and also because PWLD may be a vulnerable group (Walmsley, 2004), the researcher took care to sensitively clarify the nature of the research process and participatory relationship involved. One reason why this is important is because PWLD often tend to lack social networks, which are frequently made up of professionals and paid staff rather than friends (Pockney, 2006). Therefore, the investigator was aware of the importance of considering what the research relationship might mean from the perspective of the participants, clarifying that contact for the study was mainly limited to the interview.

3.1.4 Involving people with learning disabilities in qualitative research

In terms of their humanity PWLD are no different to any other person and the same concern and sensitivity needed for conducting research with any member of the population should be applied. Additionally, the cognitive impairments and functional and pragmatic challenges that characterise diagnosis of PWLD have an impact upon the research and interview process and require additional consideration.

One relevant communication strategy is to use augmented and alternative communication (AAC), which may be either low-tech or high tech (Brewster, 2004). The investigator therefore liaised with SALT colleagues around suitable symbols for the research materials and potentially for the interviews. This was one way that possible challenges were met, in line with Murphy's (1997) 'Talking Mats' low-tech recommendation, as a communication resource to help PWLD express their views and feelings. 'Talking Mats' were developed by Murphy, a Speech and Language Therapist and they have become a well-researched communication tool, involving the use of a mat, upon which Velcro symbols and picture cards can be placed, to facilitate discussion in therapeutic and educational environments, usually for PWLD.

Due to possible difficulties with articulation of information, richness of data may arguably be compromised when using qualitative interviewing approaches with PWLD, which could threaten meaningfulness or credibility of the research (Lloyd, Gatherer & Kalsy, 2006). It could alternatively be argued that such views however contribute to reasons for the limited amount of research carried out with this group of people and as contributing to the exclusion, disadvantage and 'deficit' as outlined in the social model of disability, discussed in Section 2.5.2.

Other potential challenges in carrying out research with PWLD can include poorer memory and temporal orientation (Hubbard, Downs & Tester, 2003; Biklen & Moseley, 1988), reduced insight and awareness (Patterson & Scott-Findlay, 2002) and difficulty responding to unfamiliar questions or abstract questions (Finlay & Lyons, 2002). The present study addressed some of these issues by utilising modifications such as pictures and easy-read formats of information, open-ended rather than closed-ended questions and the use of clarifying probes within the interviews to check understanding. Some researchers have argued that PWLD are not a homogenous group, making assumptions about how interviews are conducted, or questions constructed irrelevant and even the cause of greater obstacles in themselves, to carrying out qualitative research with PWLD (Goodley, 1998). However, the researcher of this thesis considered that such an argument ignores a wealth of research around the potential support needs of individual people and therefore proceeded with the adaptations described in this chapter, utilising the expertise of Speech and Language colleagues in the planning and implementation stages of the research.

Hastings, Hatton, Lindsay & Taylor (2014) highlighted the need for more direct research around the uptake of evidence-based approaches, in addition to advocating for more large-scale Random Controlled Trials (RCT), in measuring mental health and adaptations for the psychological therapy of PWLD from mainstream assessment measures. The present research may not be a large-scale RCT, but nevertheless it was anticipated that the data and findings obtained from a smaller-scale IPA study would be valuable in contributing to the existing research information available regarding psychological therapy for PWLD.

Nind (2008) carried out a systematic review of research issues arising from conducting qualitative research, with people where traditional methods of qualitative research can present challenges and found that many PWLD have expressive communication difficulties. Nind reported that one of the challenges faced by researchers with this participant group is considering whether the research is for, with or on, PWLD. The investigator in this thesis intended to avoid the warnings of Townson (2004, p.73) who wrote of the dangers in research of PWLD ‘being partly included, *which also means partly rejected,* by someone else’ (original italics). Although fully emancipatory research did not take place in this instance, contribution through participation was encouraged, particularly since the main focus related to empowerment. It was hoped to encourage PWLD as a sometimes oppressed group, the opportunity to make their voices heard.

3.2 Research Context & Participant Recruitment

The feasibility of qualitative approach was supported by the accessibility to relevant participants afforded by the NHS service involved and the researcher's existing role as a counselling psychologist. The researcher had regular contact with other psychologists, counsellors and psychotherapist colleagues, support workers and learning disabled service-users.

3.2.1 Setting

Clinical bases used by therapists and learning disabled service-users throughout North Derbyshire provided the setting for this project. Permission was achieved during the ethics approval stage, from NHS management and research advisors (Appendices D & E). Clearance was obtained regarding local health and safety procedures. Clinical rooms were used for interviewing, which were suitable and familiar to the participants involved. Two service-users also chose to be interviewed in their own homes, where they normally had their therapy sessions.

Psychological therapies have increasingly been advocated in the NHS (NICE 2018), although the efficacy of using them within learning disabilities services has been debated over the years, causing some resistance to their utilisation (Prout & Nowak-Drabik, 2003). This is partly due to a reduction in some services in recent years, community enterprises that have disestablished MDTs and the provision of the IAPT (Improving Access for Psychological Therapy) initiative, which although one of the largest expansions of mental health services in the world, has been argued by some as being a 'one size fits all' or 'cookie cutter' therapy, involving a 'McDonaldization' process, which may not be useful for all PWLD (Binnie, 2015).

It is likely that any helping professional working within an organisation such as the NHS will experience being influenced in some way by the culture of that organisation (Woolfe, 2016). Although cultures are dynamic and subject to change, the importance and narrative of the reflective practitioner is a central theme for counselling psychologists in the NHS, providing evidence-based practice and paying allegiance to the relationship between client and therapist.

3.2.2 Participants, Recruitment & Sampling

The study recruited a small-scale sample of five triads: five service users, their five psychological therapists, and five support staff who had worked directly with them (for at least one year) were recruited into the study. The sample was small enough to ensure detailed analysis of responses to the interview questions, yet large enough to encompass a sufficiently wide range of information and issues from the participants, so was considered ideal for IPA. The researcher was able to benefit from triangulating sources and including the voices of people not included previously in related research (i.e. support workers), as outlined in the Introduction. A similar approach was used by McGarry, Stenfert Kroese and Cox (2015), who used pairs of participants in their study, exploring the experience of women with an intellectual disability being supported by a birth doula during and after pregnancy. In their study both groups of participants were interviewed, with resulting interview transcripts being analysed using IPA, enabling themes to be identified from each separate interview, prior to an overall analysis of themes. Being able to utilise the perspectives of both groups of participants via IPA methodology strengthened the data obtained (in line with Yardley's 4 principles regarding Trustworthiness and quality in qualitative research, outlined in section 3.5.1.), with the doulas being considered helpful prenatally and a reliable source of information about pregnancy.

The possible benefits of triangulating sources (such as here including service-users, their support workers and therapists), included the emergence of multiple perspectives in the qualitative analysis of empirical data, the reinforcement of key findings and the overall resulting strengthening of the qualitative methodology (Mjosund et al., 2016). This novel use of triangulation involving three separate groups in conjunction with IPA, has been an important, beneficial component of this research facilitating new perspectives and understandings to be elicited and contrasted.

Participants recruited included NHS adult service-users with learning disabilities, their support staff and psychological therapists employed within the same service. All the participants except one (see below) had a mild learning disability with IQ scores ranging between 50-70 (Wechsler, 2008). The validity and reliability of IQ tests is well documented but has been much debated. For example, in Whitaker's 2008 study, where a meta-analysis was carried out on of the stability of low IQs (IQ<80). Using commonly used IQ tests he found that although the majority of Full-Scale IQ's changed by less than 6 points, 14% changed by 10 points or more in a mean period of 2.8 years. This indicates that the test retest reliability of IQ tests is less than ideal.

Whitaker listed three reasons to explain why an individuals' tested IQ may change over several years and therefore why it may be prudent to approach the use of IQ tests to obtain intelligence scores with a more critical eye. Firstly, random error caused by small changes in factors, including test administration and a person's state on the day of testing, could create variations in IQ. Secondly, systematic error whereby scores change consistently in one direction, due to factors such as practice effects or the Flynn effect (Flynn, 1999): whereby measured IQ has a tendency to increase by 0.3 points per year (more so in Performance IQ than Verbal IQ). Thirdly, an actual change in an individual's ability over time is another potential reason accounting for change in measured IQ. These factors have implications for the interpretation of IQ assessment results and diagnoses and decisions made on the basis of them. Therefore, the researcher of this present study considered it important to approach the results of IQ tests critically, in line with Whitaker's recommendations.

The researcher initially discussed the proposed study in departmental team meetings, with other psychological therapists working in the same service, in order to recruit willing participants. The majority of the department agreed to take part, although it was decided to target qualified, experienced psychological therapists rather than assistants or trainees, which slightly reduced the potential sample. The therapists were therefore the initial participants who received information sheets (Appendix H), invitation letters (Appendix E) and via a combination of reciprocal discussions with the researcher, they determined which of their clients would be appropriate candidates for the study. Firstly, the therapists considered which clients in their case-loads they thought could be suitable candidates for participating in a qualitative interview-based study, in terms of the likelihood of wanting to take part, who would enjoy being interviewed, as well as their level of cognitive ability and receptive communication skills, to enable ease of obtaining and processing data. They each identified one of their clients, selected others as potential alternative participants, in case the first decided not to participate.

Secondly, service-users were then told about the study by their therapists. They were asked if they would like to take part and told they would be sent an invitation letter (Appendix E) with an information sheet, to decide if they would like to be involved. Support workers were requested and therefore selected in the same way by the service-users, who also received invitation letters (Appendix E) and an information sheet (Appendix H). Some service-users had one main support worker or stated a preference, whereas others suggested more than one member of staff as possible participants, so in these cases the researcher spoke with the support worker and therapist regarding who knew the service-user best. All participants were able to choose pseudonyms to protect their identity (Appendix J), which have been used throughout this thesis. Information about PWLD has been presented in green, therapists in red and support workers in blue, in key tables within the thesis. The interviews were carried out one triad at a time, starting with the therapist, then the service-user and lastly the support worker: ensuring that all three participants were interviewed before moving onto the next triad.

The sampling approaches employed were purposive and convenience sampling, as the therapists worked in the same department as the researcher and they in turn were able to discuss the research with some of their clients who they thought might wish to be involved in or be suitable for the interviews. The sampling approach fits with IPA because of the individual nature of each participant and their responses to the questions asked (Smith, Flowers & Larkin, 2009). It also met a homogeneity requirement of IPA (Hopf, 2004) as all participants were in the same service (see 3.2.3 below).

3.2.3 Inclusion & Exclusion criteria

A small homogeneous sample is recommended for IPA; the three different participant samples were considered homogeneous and representative in terms of meeting job description roles and service user eligibility. However, one of the participants in the Learning Disability group had accessed the service despite not initially meeting the eligibility criteria of the service. This information was not obtained until towards the end of his sessions, due to his Pathological Demand Avoidance diagnosis (a form of Autism found on the Autistic Spectrum - O'Nions, Viding, Ronald & Happe, 2014), which had prevented assessment at an earlier stage. He was nevertheless included in the project as he fulfilled most of the research participant criteria and continued to access related services due to his support needs associated with Autistic Spectrum Disorders. Background information on each participant can be found in Tables 3.1-3.3 below and in Appendix F.

i) **Participants with Learning Disabilities**:

Inclusion criteria for participation in the study included the need for the service-users from the NHS Adult Learning Disability service chosen, to have known the therapists for over one month. There was also a requirement for psychological therapy to have been received for at least two sessions, to allow comment on the therapeutic experience and relationship with the therapist.

At the time of the interviews, only one participant lived with a family member (her husband), whilst all the others received support from paid carers and lived in their own homes. The geographical range spanned the region of North Derbyshire, UK, with three participants living near Chesterfield and two living near Buxton. The age range was 18-40s.

Participants with learning disabilities were selected with a mild learning disability who were able to communicate verbally, with or without the help of visual symbols. Consultation with SALT colleagues was carried out to help inform the use of appropriate visual aids. As mentioned, one participant was included who had accessed the Learning Disabilities service, although subsequent assessment proved his IQ exceeded that for normal eligibility.

The researcher was aware of possible disadvantages associated with using diagnostic labels pertaining to IQ (Mild, moderate, severe and profound cognitive impairment), although health care professionals often use diagnostic labels to classify individuals for both treatment and research purposes. Despite some possible benefits such as enabling eligibility for accessing services, labels such as ‘mild LD’ may also potentially serve as cues that activate stigma and stereotypes (Garand, Lingler, O’Conner & Dew, 2009). The researcher therefore attempted to ensure that all participants with learning disabilities were treated respectfully and as equal, valuable partners in the interview process. Although there may be limitations inherent with the use of IQ assessments and diagnostic labels, these were nevertheless the shared language, or common vernacular, of the therapists involved in the service, with ‘mild LD’ (IQ between 50-70) relating to an agreed understanding of higher levels of intellectual ability in their clients.

ii) **Therapist Participants:**

Therapists needed to have had at least one year’s professional working experience. They needed to have known the client for over a month having conducted at least two therapy sessions. The therapists had approached their clients and linked support workers themselves. The age range was late 40s-early 60s. Age, qualifications and background experience was requested from therapist and support worker participants. The therapists all lived in Derbyshire or South Yorkshire.

iii) Support Worker Participants:

Support workers needed to be well known to the clients (preferably for over three months) and able to comment on any involvement in the process and changes they noticed in the people they supported, following the therapeutic work. The age range was early 30s-early 60s. Most of the support workers were paid members of staff, although one was the husband and carer of one of the interviewees with a Learning Disability. All support staff participants also lived in North Derbyshire.

See Tables 3.1-3.3 of Participant Information below (for a full version with further background information details, see Appendix F):

Table 3.1 Participant Information (PWLD)

Pseudonym & Triad No.	**Age & Sex**	**Reason for Referral (presenting problems of client)**	**Diagnosis**	**Level of LD/Functional Needs**	**Duration of Interview**
Sid (PWLD#1)	Mid 40s/M	Counselling for Recurrent Depression due to past relationship/family issues & low self-esteem.	Recurrent Depression was reported.	Mild learning disability	19’23”
Jacky (PWLD#2)	Mid 40s/F	Counselling for past traumas from family issues & abuse, resulting in mental health concerns & self-harm.	PTSD & various physical health issues.	Mild learning disability	22’45”
Edward (PWLD#3)	Mid 30s/M	Counselling for past workplace bullying/abuse, relationship & behavioural issues	Had initially met the criteria for PTSD.	Mild learning disability	26’31”
Abbey (PWLD#4)	Mid 30s/F	Counselling for anger management and past relationship issues.	No prior formal diagnosis.	Mild learning disability	21’15”
Neil (PWLD#5)	Late Teens/M	Service screening assessment and counselling for mental health/behavioural concerns, struggling with transitional issues, PDA & OCD symptoms.	High functioning Autism, PDA & OCD	IQ exceeded service criteria specifications (above 100). Mental health and functional needs resulted in accessing service.	28’00”

Table 3.2 Participant Information (Therapists)

Pseudonym & Triad No.	Age & Sex	Job Title	Reason for Therapeutic Work	Therapeutic Model/ Approach Used	Length of Time Working with Client	Duration of Interview
Eve (T#1)	Late 40s/F	Senior Counselling Psychologist	Counselling for Recurrent Depression due to past relationship/ family issues & low self-esteem.	Compassion-Focused Therapy	6 months	36’02”
Nichole (T#2)	Early 50s/F	Senior Counselling Psychologist	Counselling for past traumas from family issues & abuse, resulting in mental health concerns & self-harm.	Integrative/ Mixed Therapeutic Approaches	10+ years	33’51”
Tim (T#3)	Late 40s/M	Therapeutic Counsellor	Counselling for past workplace bullying/abuse, relationship & behavioural issues.	Integrative/ Mixed Therapeutic Approaches	10+ years	39’10”
Penny (T#4)	Early 50s/F	Counsellor	Counselling for anger management and past relationship issues	Person-Centred Approach	12 months	41’14”
Janice (T#5)	Early 60s/F	Consultant Counsellor	Service screening assessment & counselling for mental health/behavioural concerns & PDA	Person-Centred Approach (& some Transactional Analysis)	2 years	39’45”

Table 3.3 Participant Information (Support Workers)

Pseudonym & Triad No.	Age & Sex	Job Title	Reason for Support Work	Type of Support Worker	Length of Time Working with Client	Duration of Interview
Robert (SW#1)	Early 60s/M	Support Worker (Previously also Social Worker)	Work-placement-based support. No joint work with therapist.	Voluntary Work Placement Support Worker	10+ years	13’36”
Malcolm (SW#2)	Early 60s/M	Technical Instructor/Support Worker	Support work involved travel/bus training and working with therapist to put into practise activities relating to social anxiety and overcoming past traumas.	Community Support	4 years	11’16”
Ray (SW#3)	Mid 30s/M	Support Worker	Supporting Edward in his own home and in the community or accessing appointments. Some joint therapy sessions.	Community Support	4-5 years	21’13”
Kevin (SW#4)	Late 30s/M	Carer/Support Worker	To support Abbey (wife) to appointments & to support her at home with domestic tasks.	Husband, Carer & “Supporter”	5+ years	24’04”
Paul (SW#5)	Early 40s/M	Technical Instructor/Support Worker	Support to access the community, liaise with other professionals involved working with Neil’s PDA & OCD related symptoms.	Community & In-patient Support	18 months	52’42”

[Notes: Person with a learning disability - PWLD; Therapist – T; Support Worker - SW]

3.3 Procedure

3.3.1 Interview Schedule Development

The topics for the interview schedule (Appendix G and Table 3.4 below) were considered, drafted, discussed with research supervisors and then redrafted, before being submitted to the University of Wolverhampton's ethics committee for approval. They were related to the research aims and questions. They were also explored with psychological therapy colleagues working alongside the researcher and informed by the researcher's own experience as a practitioner counselling psychologist working within an Adult Learning Disability service, to consider key issues in the area of working providing psychological therapy for PWLD. In addition, the topics were developed as a result of reviewing existing research in the area and identification of gaps. The researcher attempted to speak with other researchers also having recently undertaken research in related areas, such as a telephone discussion with Jones (2013) about her project and the experience of carrying out semi-structured interviews with counselling psychologists working within the NHS for PWLD.

The interview topics for therapists and support workers consisted of questions in the following key areas: 'background'; 'therapeutic approach & process'; 'outcomes'; the 'therapeutic relationship and learning disabilities'; 'empowerment'; 'additional questions'. The topics for participants with learning disabilities were adapted by changing 'therapeutic approach & process' to questions about the 'counselling experience', which also included reference to the therapeutic relationship and 'results' instead of 'outcomes'; other topic headings remained the same. Broad open-ended questions were used with prompts to be used where needed to elicit narratives. The initial 'easy' background questions were partly intended to enable PWLD to feel more comfortable with the interview process and as though they were 'performing well' as suggested by Maynard (1999), to build confidence and help develop rapport for the rest of the questions.

Adaptations were made to the research schedules for each of the three participant groups, in order to ask questions which specifically tapped their lived experience. Pilot interviews were carried out with Assistant Psychologist colleagues and their clients with learning disabilities and support workers, to identify and resolve any problems prior to the final research interviews. The research schedules coincided with the research aims outlined in Section 2.13. The researcher adhered to guidance provided by Smith, Flowers & Larkin (2009) regarding conducting semi-structured interviews using IPA**.**

Table 3.4: Summary of interview schedule topics per participant group

Question Topics per Participant Group	**Service-User Participants**	**Therapist Participants**	**Support Worker Participants**
	Background Questions	Background Questions	Background Questions
	Counselling Experience	Therapeutic Approach & Process	Therapeutic Approach & Process
	Results	Outcomes	Outcomes
		The Therapeutic Relationship & Learning Disabilities	The Therapeutic Relationship & Learning Disabilities
	Empowerment	Empowerment	Empowerment
	Additional Questions	Additional Questions	Additional Questions

3.3.2 Interview Procedure

Following confirmation of ethical approval for the study from the University of Wolverhampton and the NHS service involved, the study site organisation (NHS service) was contacted by letter. All participants received an invitation letter and an information sheet (Appendices E & H) prior to their interviews, to explain the purpose of the study and procedures involved, in three separate formats. The participants with learning disabilities were advised that they could choose to be accompanied by their support worker or an advocate if they wished. One participant chose for his support worker, family and therapist to be present and one chose for his therapist to be present during the interview. The rest chose to be interviewed on their own. The interviews were conducted on a face-to-face basis, at times and locations to suit the participants.

The duration of the interviews ranged between 11-53 minutes (see Tables 3.1-3.3). Despite two of the interviews with support staff being short, the information gathered was succinct and relevant to the study. The interviews started with a summary outline of the research project and an explanation about the kind of interview questions that would be involved, as well as the opportunity to any ask questions. The interviews also included the signing of consent forms (separate formats for PWLD and non-LD participants - see Appendix I and Table 3.4). Easy-read versions with pictures appropriate for the learning disabled participants and 'Talking Mats' communication-aid resources to aid service-user interviews was available if needed or desired (a mat and pictures/symbols, as recommended by an NHS SALT advisor). Participants were advised they would be able to choose a pseudonym to protect their anonymity. All participants were reminded that they could change their mind about taking part in the interview or research at any time. They were given the opportunity to ask any questions and told that they could ask for clarification if they did not understand any questions. Semi-structured interviews followed the interview schedule outlined above (Appendix G).

Advice was followed from previous research (Lloyd, Gatherer & Kalsy, 2006) regarding conducting research interviews with PWLD. Allowances were made therefore, by allowing greater flexibility in the schedules followed with each participant and carefully explaining any language terms not understood, to support the responses in cases where receptive language and cognitive deficits may have impeded the ability to comprehend and respond to questions. Audio recording equipment was borrowed from the NHS research department involved and all interviews were recorded to enable subsequent transcription and analysis of the data. After the interview, as part of the debriefing process, the opportunity was given to participants to reflect on their experience, ask questions and information was provided regarding what would happen with their recordings.

3.4 Ethical Considerations & Risk Management

3.4.1 Informing participants of the risks, benefits and rights to refuse or to withdraw

No health and safety issues arose from the conduct of the research. As participation was voluntary, participants were advised that they could withdraw from the study at any time without penalty. They were given information on how and when they would be debriefed about the results of the research. Had participation placed any individual at risk or caused undue stress, alternative clients may have been approached, in discussion with the therapists involved.

In terms of the ethical issue of researching within the researcher’s own service, attempts were made to ensure that coercion did not occur, by reminding the invited participants that they were not obliged to take part in the research, were free to withdraw at any time without penalty or change in relationship or situation. This was considered especially important as the study explored issues relating to empowerment.

3.4.2 The participants were recruited from a potentially vulnerable group

PWLD are considered to be a potentially vulnerable group due to the nature of their cognitive & mental health impairments. Therefore, the following ethical research principles from Wolverhampton University’s Research Policy Unit (RPU) were also considered in planning the research: *Excellence* (conducting and disseminating to as high a standard of research as possible), *Honesty, Integrity, Cooperation, Accountability, Training and Skills, Care, Safety and Respect.* These are important in conducting all research, but were particularly important in this study, due to the potential increased difficulties with understanding and communicating information.

The client group’s rights were respected and protected by including the mention of safeguarding in the information forms and letters of consent. It was planned that any specific safeguarding issues that could arise would be discussed promptly with the local safeguarding team or other suitable advisors (line manager or supervisor), although these did not arise.

3.4.3 Consent process & ethical approval

Ethical approval was obtained from other necessary ethics agencies including IRAS and the NHS (Appendix D). External ethics agency approval was sought after approval from an internal ethics committee at Wolverhampton University. Considerations involved in the project included obtaining the informed consent of all participants via forms provided (Appendix I) and optional additional explanatory meetings with support staff, for the participants with learning disabilities. Ongoing consent was monitored and checked at each episode of participant contact, as the Mental Capacity Act (2005) states that a person lacks capacity if they cannot do one or more of the following: i) understand the information relevant to the decision; ii) retain that information; iii) use or weigh that information as part of the process of making the decision; iv) communicate the decision, (whether by talking, using sign language or any other means). The researcher considered that all of the PWLD involved in this study could do all of these things and discussed these issues with their therapists and support workers during each phase of the research (continuous checking throughout).

Participants were questioned on several occasions about their understanding of the research project and their wishes regarding continued involvement with the research before and after being interviewed, whilst reviewing their transcripts and at any other possible occasions via their therapist as well as the researcher. As suggested in other related research (e.g. Hamilton et al., 2017), visual aids (in terms of symbols and simplified versions of invitation letters, information sheets, consent forms and interview schedule) and checking for reconfirmation of consent (and retention of understanding) at the end of the data collection, were utilised when assessing and supporting capacity to consent to the research, in as person-centred an approach as possible, whereby the researcher tried to help the participants feel at ease during each episode of contact and attempted to communicate simply, clearly and as genuinely as possible. As mentioned, the offer of having an Advocate to support the participants with learning disabilities during the interviews was available. The idea of using of a specific tool in future research to assess capacity to consent within this context is discussed further in the Discussion, in section 5.2. and in the Reflective Account, in Appendix B.

All participants were able to consent for themselves (specifically in terms of consenting to taking part in this study), as service-users with learning disabilities were selected with mild cognitive disabilities only. The researcher was aware of the requirements of the Mental Capacity Act and a) endeavoured to include participants who had the capacity to make the decision to participate in the study and b) explained that this could include involving an advocate where required, although none requested an advocate and only one chose to be accompanied by family members, his support worker and psychological therapist in the interview.

The researcher also took care to observe for positive indicators of consent at the time of the interviews, as suggested by Cameron & Murphy (2007), including a high level of engagement (e.g. eye contact, body language), relevant elaboration (e.g. verbal comments, willingness to take part), and positive non-verbal responses (e.g. nodding).

3.4.4 Protection of service users' identity and storage of data

Confidentiality was addressed by the signing of a written/pictorial declaration to anonymity and consent to all stages of the research (Appendix I) by both the researcher and the participants. Coding was used during the gathering and processing of the interview notes, taped recordings and transcripts to ensure confidentiality and anonymisation of data. A pseudo-anonymised key was used for organisation of raw data.

Care was taken that any participant profiles included would not provide sufficient information to allow identification of any individual. Locations, place names and others mentioned in the interviews were anonymised. See Appendix J for a list of pseudonyms per participant group.

Participant information was stored securely and solely for the execution of this study, remaining the property of the researcher for the appropriate period of time according to the requirements of the ethics committees. This was expected to be two years after completion of the work and submission of any associated publications.

As required by all registered counselling psychologists, the researcher adhered to the BPS Code of Human Research Ethics. Local NHS service policies on confidentiality and information governance were observed, including compliance with the Data Protection Act (1998), Caldicott (1997) guidance and the NHS confidentiality Code of Practice (2003).

3.5 Data Analysis

As mentioned, analysis in IPA is both phenomenological and interpretative, depending upon the participants' view of the world, as well as the researcher's own views and standpoint, which brings in the reflexivity valued within counselling psychology (Willig, 2008). IPA was thus used following a transcribing process of the raw data from the recorded interview information, to identify the primary experiences of the individual participants, the three groups and key themes within and across the accounts, via a cross case comparison.

The participants were given the opportunity to provide feedback when reading through their interview transcripts. This process was carried out in the same order as the interviews were carried out, upon completion of each triad group's interviews: PWLD, then therapist, then support worker. Any changes requested (which were minimal) or comments about the research process, were noted at this time. The Reflective Account in Appendix B includes further discussion about the researcher's learning in terms of the importance of participant feedback and issues related to the capacity of participants to consent to use of their interview data.

Smith, Flowers and Larkin's (2009) suggestions for data analysis were followed as in steps 1-3 below. In order to analyse the interview data, an idiographic approach was used: each case was individually analysed in order to explore accounts with sufficient detail of the participants and triad groups they comprised. Triangulation was available from the informants' information and different groups that comprised the participant interviewees, which added to the credibility of the research data. Further information about this may be found in the Findings section of this thesis. Box 1 below also shows the stages involved in the data analysis.

Semi-structured interviews
⇩
transcribing process
⇩
immersion, in-depth reading of transcripts & initial notes
⇩
coding of transcripts (line-by-line commentary; emerging themes)
⇩
compilation of cross-case comparisons between individual participants & participant groups (PWLD, therapists, support workers) & triads
⇩
creation of overall super-ordinate & sub-themes

Box 1 - The stages involved in IPA data analysis

The stages of analysis and data preparation followed the steps below:

1. <u>Transcription</u>

All participants were able to review their transcripts after completion and were able to withdraw their data if they wished to do so. The interviews were transcribed verbatim, in line with the NHS Trust policy and procedures in terms of privacy, confidentiality of data handling and storage. A sample transcript can be found in Appendix K.

2. <u>In-depth reading of transcripts</u>

Secondly, the researcher read and re-read the transcripts several times, to ensure the participants were the main focus of the analysis. This also allowed the researcher to immerse herself fully in the data.

3. <u>Coding</u>

The third stage involved initial coding of the data and recording of exploratory comments considering three main areas of focus: descriptive, linguistic and conceptual:

(i) a descriptive element (‘D’ in Appendix M) of the text, focusing and noting what the participants were describing;

(ii) a linguistic element (‘L’ in Appendix M), which took into account the language and imagery used, to produce a deeper meaning;

(iii) a conceptual element (‘C’ in Appendix M), which allowed a more interrogative level of engagement for the investigator and enabled her to include her own comments and interpretation of the data. This resulted in a set of comments with a clear phenomenological focus; it also allowed connections, interpretations and interlinking concepts to be identified throughout each transcript (Smith et al., 2009).

The notes that emerged provided the initial formation of 'emergent themes' (see Appendices L-R). The intention was that these would summarise the key elements and meanings of the participants’ accounts and would involve the reporting of both interpretation and understanding by the investigator. It was important that the transcript was re-read at the same time as the emerging themes, in order to make sure that they captured the essence of the participant's lived experience as fully as possible. The participants’ extracts could be considered as forming the phenomenological (P) aspect of IPA, whilst the analytical comments formed the interpretative (I) part of the process. IPA focuses on the lived experience of participants, so this was aimed for in the analysis and quotations selected.

Section 4.1 describes the four major themes which were found as a result of the process of data analysis (summarised in Table 4.1, with illustrative quotes). All of the themes related to the experiences of the 15 participants interviewed. A set of four super-ordinate themes was created for the 15 participants/five triads, each containing additional sub-themes. Appendix O includes initial lists of the main themes which began to emerge from the data and Appendix P shows a table of cross-case comparisons from the participant group themes. Research Supervisors DC and CW made additional credibility checks to confirm the analytical interpretations were clearly grounded within the data and to ensure that no other important emergent themes had been overlooked.

3.5.1. Trustworthiness & quality in qualitative research

As with any research process, it is important to assess quality and validity in conducting an IPA project. Yardley's (2000) 4 principles for assessing the quality of qualitative research were considered and are detailed below.

(i). Sensitivity to context

This was addressed by the choice of IPA methodology, which was anticipated as being one of the most suitable approaches for gathering meaningful phenomenological information, from this particular group of participants. It could be argued that the data itself produced in an IPA project is the strongest context that good research is sensitive to – including via immersion and detailed analysis of the transcripts produced following the semi-structured interviews. The researcher also tried to show sensitivity to context in the previous chapter through a review of relevant literature, which it was hoped would help to appropriately orient the study and then its findings.

(ii). Commitment and rigour

These considerations included the personal and professional commitment of the researcher, investing time and attention to each stage of data preparation, collection and analysis, as well as skills development and additional study/research training, as the study progressed. Rigour within the study included trialling pilot interviews with assistant psychologist staff in the same team, to check for any confounding variables, issues that needed to be addressed or changes made prior to carrying out the main interviews. For example, the pilots allowed re-examination of wording and phrases to make interview themes and questions easier to understand for the PWLD.

Supervision with research supervisors was another helpful way of encouraging rigour within the study, where ideas such as transferability were discussed. Although due to the ideographic nature of the research, the exact results would not be replicated or generalised as with more quantitatively orientated approaches, the methods used and overall themes were considered to be transferable and potentially representative of the kind of issues encountered by clients with learning disabilities, their support workers and therapists in the NHS service where the research took place.

(iii). Transparency and coherence

These were relevant in each stage of the writing about the research, including providing background (although anonymised) information about each service-user, how they were selected and their presenting therapeutic concerns. Drafting and re-drafting each section of the chapters was an essential part of aiming for a coherent piece of writing. It was hoped that the hermeneutic and phenomenological underpinnings of the approach chosen would also be apparent in the analysis (the reader trying to make sense of the researcher trying to make sense of the participants' experiences).

(iv). Impact and importance

These were elements that Smith, Flowers & Larkin (2009) stated all researchers should be aspiring to: to produce interesting, meaningful research, that is useful and important. It was hoped that this research would meet these criteria and contribute to addressing the gaps highlighted in the previous chapter, regarding raising awareness of the lives and experience of PWLD and helping to provide service recommendations to do so, for some of the issues raised.

The researcher referred to Kmet, Lee and Cook's (2004) quality assessment framework for qualitative research to check that the methodological approach taken in the current study was in line with their recommendations. By familiarising herself with Kmet et al.'s framework, she was able to check for a standard of reproducible criteria (specifically here within qualitative methods, including semi-structured interviews) and appraise the quality of the research carried out.

Kmet's checklist questions involved the following 10 criteria: was the research question sufficiently described?; was the study design evident and appropriate?; was the context for the study clear?; was there a connection to a theoretical framework/wider body of knowledge?; was the sampling strategy described, relevant and justified?; were data collection methods clearly described and systematic?; were verification procedures used to establish credibility?; were the conclusions supported by the results?; was reflexivity of the account addressed? The researcher completed Kmet's checklist and found that the scores for all criteria met the quality standards outlined. For example, in Q8, 'Use of verification procedure(s) to establish credibility of the study', the researcher ticked 'Yes', as triangulation had been used within the methodology via the analysis and comparison of the three groups of participants, as well as the five different triad groups interviewed, as a key method which helped to establish both the credibility and trustworthiness of the study.

Further information about trustworthiness and quality in qualitative research, as they relate to this particular study can be found in Appendix B, personal reflections (Reflective Account).

4. FINDINGS

This chapter is organised into two sections. Section 4.1 presents the emergent themes and cross-case comparisons which resulted from analysis of the data obtained (see Section 3.5 for details about how the data analysis was carried out). Section 4.2 summarises participants' conceptualisations and experience of empowerment from the psychological therapy they received (relating to Research Questions 1 & 2 in Section 2.13). An additional section in Appendix C contains the idiographic accounts and key themes per participant, with diagrams representing the key themes and experiences for each triad. These sections all contribute to addressing the research questions and aims of this study, outlined in Section 2.13.

The previous chapter explained the chosen methodological approach for this research (IPA), with Section 3.5 outlining the data analysis process, including the series of steps that were involved in analysing the resulting data from the original semi-structured interview transcripts (Smith, Flowers & Larkin, 2009; Larkin & Thompson, 2011). Originally, individual accounts were created - interpretive idiographic analyses - for each participant, with the intention of maintaining and adhering to the phenomenological underpinnings of IPA (Smith, Flowers & Larkin, 2009; Larkin & Thompson, 2011). These were obtained from the contextual and experiential data collected from each transcript, in order to produce short accounts exploring how the investigator reported each participant's responses to the questions and their individual lived experiences, with particular predisposing factors relating to the topics explored and the participants' interaction with the interview process.

However, as the study involved 15 participants in total, which is a larger number than would be typical for an IPA study, it was considered that idiographic accounts of the triads would be more suitable as a result of this more novel approach taken in the present study. It was considered permissible to have some flexibility in terms of how people are selected to be interviewed in an IPA study as the main objective in adhering to the inherent value in understanding and reflecting peoples' real, lived experiences, was still maintained; these are bound to be individualistic in nature and as described, the selection process was linked to the type of service and therapeutic groups in place at the NHS site where the investigator worked. Each of the three participants per triad group all had some involvement with the presenting problems requiring therapeutic support, so in discussion with the research supervisory team, it ultimately seemed most sensible to group the idiographic accounts in this way. This was also the most parsimonious option, given the large quantity of data involved and the word count allowance for this thesis, in order to enable all participants' accounts to be included and honoured.

Appendix C contains the full interpretive idiographic analysis accounts which were originally created for each of the five triads, which highlight the clients' problems requiring therapeutic support and the issues encountered by each triad. Quotes relating to the experiences of each participant are included within the thematic accounts, as are links to the Super-ordinate and sub-themes outlined below in Section 4.1. The accounts thus present the context and process of therapeutic engagement and interventions involving all three parties, for each triad; each triad account highlights and summarises the key findings and themes relating to empowerment for each of the three parties, in separate diagrams, as well as in the final paragraphs.

4.1 Emergent Themes & Cross-Case Comparisons

Section 4.1 describes the four major themes which were found as a result of the process of data analysis (summarised below in Table 4.1, with illustrative quotes). Appendix O shows the initial lists of main themes which emerged per participant group and Appendix P includes a table showing initial cross case comparison of the participant group themes.

An overview of each super-ordinate theme is provided in the following section, with interpretations of meanings and critical discussion. The key features of the data obtained from the participants' accounts have been analysed, selected and presented below with group similarities and individual divergences shown in the narratives. Line numbers are included next to each participant's quote throughout this chapter, for the purpose of tracking and evidencing the relevant information from each transcript.

Following IPA analysis, four super-ordinate themes, each with two to three sub-themes, emerged: these are summarised in Table 4.1 below. A split emerged between the issues linked to the processes and practicalities with facilitators (including the need for adapted materials and relational elements, such as building trust and developing rapport) and impedances (including struggles due to stigma, comprehension deficits and difficulties with literacy and numeracy) and conceptualisations/operationalisations of empowerment (summarised in Section 4.2). The construction of the themes involved much wrestling on the part of the researcher, as many issues and smaller themes emerged from the transcripts, which had to be reduced in number and decisions needed to be made about which themes to prioritise (see Reflective Account – Appendix B). Prior to the final draft, five super-ordinate themes, each containing three sub-themes, had been organised, which reflected the number of triads (five) and the number of participant groups (three). However, upon discussion with the supervisory team, it was agreed that organising the themes in terms of such patterns was less important than arriving at clear, solid and more concrete compartmentalisation.

Initially, five themes were identified in the data, consisting of: 'the influence of values, stigma and social equity on the therapeutic process'; 'building relationships and trust during therapy'; 'adapting and coping/managing'; 'the role of collaboration in therapy'; and 'positive outcomes from the therapeutic process name themes'. However, further consideration of the data following discussions with supervisors (which involved following the verification procedures used to establish credibility from Kmet's quality criteria, as outlined in section

3.5.1) led to the fourth theme relating to ‘the role of collaboration in therapy’, being integrated into the present Super-ordinate theme 2: ‘Building Relationships, Collaboration and Trust’. This was because there was considerable similarity and overlap between the two and it was considered more appropriate to reorganise them.

As discussed by Doody and Bailey (2016), defining research aims and constructing good research questions are particularly significant steps in research, as well as some of the most challenging aspects of any study; collaboration with supervisors and colleagues can be invaluable, which was found to be the case in this instance. The researcher of the present study found that a more fluid, interactive and inductive approach was required than initially anticipated, involving some refinement and re-phrasing of the research aims, rather than it being a static process. The investigator considered that the research aims and interview questions could possibly have been more general and non-directive, with a greater focus on the participants’ experiences, to follow the IPA approach even more closely. Nevertheless, although the structure of the interview questions may have had a somewhat top-down element imposed upon them, the investigator considered that she had still honoured the participants’ stories and experiences, which were central to the research and followed the processes for interview schedule construction identified in Smith, Flowers & Larkin (2009).

The themes identified in the analysis are presented below.

Table 4.1: Super-ordinate & sub-themes with illustrations and cross-case comparison for each triad group

Super-Ordinate Themes & Sub-Themes	Cross Case Comparison – presence of themes per triad					Illustrative Quotes
	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	
Super-ordinate Theme 1: **Values, Stigma & Social Equity**	✓	✓	✓	✓	✓	
-Sub-theme 1.1: **Experience of Stigma by PWLD**	✓	✓	✓	x	✓	*"Because I'm a crazy person!" (PWLD-Neil 1.6)* *"I've had some problems. I got bullied at school.." (PWLD-Sid 3.60)* *"they're looking around – I know they are, I can see their eyes moving around – I'm not that stupid…" (PWLD-Jacky 11.287)* *"And they said, 'if you can't keep up, we'll put you back in the disabled area' – it's like bullying" (PWLD-Edward 4.91)*
-Sub-theme 1.2: **Facilitators' awareness of limitations & challenge working with PWLD**	✓	✓	x	✓	✓	*"I was wary of suggesting something that would cost money… it was probably not attainable for him, in his social situation" (T-Eve 13.396)* *"a lot of our clients don't feel very empowered, they have very little control over much in their life, and that's not unusual at all" (T-Nichole 8.247)* *"I suppose, when you think about it, you've got individuals who've been labelled, segregated, you know… for sort of much of their life… they sort of cherish and welcome that one-to-one engagement" (T-Tim 8.361)* *"because people with learning disabilities tend to lack in confidence" (SW-Robert 4.119)* *"often you see perhaps a parent or carer disempowering somebody, not deliberately, but because they're talking down to them – talking to them like a child" (T-Janice 19.526)*
Super-ordinate Theme 2: **Building Relationships, Collaboration & Trust**	✓	✓	✓	✓	✓	
-Sub-theme 2.1: **The importance of trust &**	✓	✓	✓	✓	✓	*"I've had counsellors in the past… they didn't understand me… But Tim does I think" (PWLD-Edward 5.126)* *"I don't usually like working with men 'cos of what I've been through… but Malcolm seemed really nice, I knew he wouldn't do anything, so I thought, 'right, I'll work with him'" (PWLD-Jacky 4.95)* *"When I'm with Nichole I feel like I'm safe" (PWLD-Jacky 5.126)* *"you know, it's critical for the client to feel safe, comfortable within the environment, for them to know you, to*

rapport in the therapeutic relationship (experience of PWLD and client-led experience for therapists)						*warm to you, to trust you… you know… it's absolutely critical that that's right" (T-Tim 8.380)* *"I think rapport is really important, because if they don't have that rapport and trust with you, you're not likely to develop a therapeutic relationship that's going to be successful" (T-Nichole 7.222)* *"I think with some of the disclosures that she made, she took quite a long time to disclose them and I think that was about needing to trust me…" (T-Nichole 7.231)* *"to give someone a really safe space, so they're confident to..work therapeutically" (T-Janice 15.429)*
-Sub-theme 2.2: **Collaboration (MDT/joint working)**	x	✓	✓	x	✓	*"we've discussed them quite a bit [therapy sessions] And afterwards we'll say – d'you know when everyone's gone – we'll say "it went alright didn't' it?' you know and have another discussion ourselves about how it was, so that's good, and it keeps us all in the know" (SW-Ray 6.153)* *"In Learning Disability services there tend to be quite a large number of multi-disciplinary teams – so I felt like, I was working very much just with him, so there wasn't really any need to share, or to talk to carers… which suited the way we were working together…" (T-Eve13.417)* *"'I've engaged with Speech and Language… with Occupational Therapy and with Community Nursing.. which has all been beneficial – all beneficial to my client, you know" (T-Tim11.509)* *"it resulted in actually working with her support workers – how can we help her manage her finances better, or how could they?" (T-Nichole 5.149)* *"it's worked extremely well – by including everybody, in what we're doing" (T-Janice 17.467)*
-Sub-theme 2.3: **Therapeutic relationship was more important than type of therapeutic approach used**	✓	x	✓	x	✓	*"it's the core, it's absolutely core... and without the relationship you wouldn't be able to progress onto the other phases… so it's absolutely critical…" (T-Tim 8.376)* *"initially we started some counselling in a therapeutic way and then we used various different things really – kind of pulled a mixture of things together, in order for Jacky to be able to kind of understand and work with them…" (T-Nichole 3.80)* *"It had to be at his pace really, the whole therapeutic approach" (T - Janice 5.134)*
Super-ordinate Theme 3: **Coping & Adaptations**	✓	✓	✓	✓	✓	
-Sub-theme 3.1: **PWLD struggled without support**	✓	✓	✓	✓	✓	*"I thought, 'if I'm never going to get rid of this, I'm going to do something to myself – because I can't stand it'" (PWLD-Sid 4.91)* *"I used to cut my arms and … I was in a lot of pain, so I used to cut my arms, thinking it would release the pain – the pain 'd be coming out of me" (PWLD-Jacky 1.12)* *"it's really helped… made me release everything… realise what I couldn't see, and I felt so weak… I just didn't*

						know what to do and now I feel so much more stronger –"(PWLD-Abbey 4.101) *"and T… mainly broke the ice really… and helped me to get through it actually… and I'm a better person… to this day, thanks to him…" (PWLD-Edward 4.105)*
-Sub-theme 3.2: **Adaptations are essential for facilitators working with PWLD**	✓	x	✓	✓	✓	*"you really have to be as flexible as you can be" (T-Janice 21.616)* *"he came up with this compassionate owl, so I printed out a picture of that and he came up with some phrases about that that he could use when he was being self-critical" (T-Eve 9.269)* *"It's in stages, it's got to be monitored, that's what I've done for the past seven months: bit by bit" (T-Penny 14.438)* *"So long as you're mindful of applying reasonable adjustments throughout your session, being very open, very transparent, er… explaining everything as you go along, I think it's a right positive experience" (T-Tim 8.369)*
Super-ordinate Theme 4: **Positive Outcomes**	✓	✓	✓	✓	✓	
-Sub-theme 4.1: **Positive, empowering outcomes were experienced from therapy**	✓	✓	✓	✓	✓	*"Definitely, definitely, it's really helped me" (T-Abbey 3.69)* *"I never used to walk to the shops on me own… I never used to come down here on me own… But I do now" (T-Jacky 8.211)* *"I feel… I can do things more… And I've passed my chain-saw course, so that's made me feel better" (PWLD-Sid 6.159)* *"I'd say since the earlier sessions, my life has got more difficult… The difference is how I'm dealing with things" (PWLD-Neil 4.105)* *"and Tim… mainly broke the ice really… and helped me to get through it actually… and I'm a better person… to this day, thanks to him…" (PWLD-Edward 4.105)* *"It actually feels really positive, where I enjoy the sessions and I enjoy seeing him and hearing about his improved mood, and hearing about how well he's doing" (T-Eve 8.244)* *"There's nothing more fulfilling than, you know, than meeting with a client who's initially meek and mild and taking them along, you know with them – sort of walking in their footsteps, through that therapeutic journey –" (T-Tim 8.369)* *"it's nice seeing her transform in front of your eyes…" (T-Penny 6.184)*
-Sub-theme 4.2: **Therapeutic approach & presenting problem affected type of empowering**	✓	✓	✓	✓	✓	*"so we used a mixture of like CBT with you know, negative thoughts and automatic thoughts… we did some timeline work and story work… to try to build up a picture of the past and so on…and we used some neuro-linguistic programming, to do with some of the past traumas. And I used some energy therapies as well, to help decrease her state of arousal… We also used various kinds of relaxations techniques, so we tried out a selection of those… So yes, it was quite a mixture of different approaches really." (T -Nichole 3.83)* *"initially, on the onset I chose Person-Centred, Rogerian – primarily to build up the sort of therapeutic relationship between us… Which were great for the foundations you know… And then I brought into it er... Gestallt, Fritz Perls, er… and that were to help me with the therapeutic challenge/…. So in with that I also introduced Eric Berne's*

outcome						*Transactional Analysis, to help us to look more closely at how he does interact with others and to try to help R to become more self-aware of how he was presenting. It also helped me with me reports as well" (T -Tim 3.108)* *"it's the Person-Centred Approach – I find that by having that approach, I can build up that relationship and it works for me! (laughter)" (T -Penny 1.29)* *"I took a laid-back, Person-Centred approach, let him lead the session" (T -Janice 5.115)* *"I thought from the start that I had in my mind, from the referral information… that working in a compassion-focussed, erm, therapeutic model, would be helpful given his presentation, mood and his history, and as I met him over the first few sessions it was apparent that that did seem a good way of working with him" (T -Eve 1.23)* *"I had to do a lot of reflection… particularly as it was a new approach" (T -Eve 11.349)*

[Notes: Person with a learning disability - PWLD; Therapist – T; Support Worker - SW]

4.1.1 Super-ordinate Theme 1: Values, stigma & social equity

The first major emergent theme related to social values, stigma and social equity. Cross-case comparison of themes (Table 4.1) found this to be important across all the triads.

4.1.1.1 Sub-theme 1.1 – Experience of Stigma by PWLD

Most of the participants with learning disabilities referred to some aspect of social stigma, including bullying (see Table 4.1). For example, Sid described previous bullying at school: "*I've had some problems. I got bullied at school..."* (Sid – PWLD - Triad 1 - 3.60) and client 3 Edward, described his experience of bullying in the workplace: *"they said 'if you can't keep up, we'll put you back in the disabled area' – it's like bullying"* (Edward – PWLD -Triad 3 4.91). Concern about stigma and labelling by PWLD included worrying about not 'fitting in' or being 'normal', as well as other people's responses, treatment and attitudes towards them.

The participants with learning disabilities described feeling uncomfortable about other people's judgements of them, such as: *"Because I'm a crazy person!"* (Neil – PWLD– Triad 5 - 1.6). Neil appeared to use humour in his account partly as a defence-mechanism, as he did not like to be perceived as 'different' or not 'fitting in', and was reluctant to enter the LD centre, but other participants such as client 2 Jacky described finding others' attitudes towards them very painful, threatening and feeling sensitive towards potential criticism: *"they're looking around – I know they are, I can see their eyes moving around – I'm not that stupid…"* (Jacky – PWLD - Triad 2 - 11.287).

This awareness of 'difference' or not being 'normal' created frustration or even aggression in some participants, such as Neil: *"Every person – 'stop asking questions, fuck off! Oh, fucking leave me alone!'"* (Neil 3.83); whilst client 3 Edward felt (justified) indignation: *"and I was not getting… the right amount of money either… I was on less pay than the others… but I was doing a better job, than they were…"* (Edward – PWLD - Triad 3 - 4.91) and his victimisation led to a ‘nervous breakdown’, which his therapist Tim described, as well as having to leave his job. Jacky was aware that her situation (having a Learning Disability, with additional physical and mental health support needs) affected every part of her life, including her finances, which she also described: *“I get paid every 2 weeks… I get sick money every month…”* (11.297). Overall, it was evident in the accounts that stigma was experienced negatively, reducing the wellbeing of participants.

4.1.1.2 Sub-theme 1.2 – Challenges to therapeutic empowerment when working with people with learning disabilities

A second sub-theme related to the limitations, challenges and barriers experienced when working within a learning disabilities service, with PWLD, provided from the accounts of both the therapists and support workers interviewed. The cross-triad comparison in Table 4.1 shows that this sub-theme was emphasised in four out of five triads, hence they it was clearly an important consideration when working therapeutically with PWLD. These challenges were many and diverse but included i) communication or physical difficulties which sometimes created barriers or obstacles in understanding PWLD, as well as ii) the actions and expectations of others in society, iii) limitations of choice and control and iv) finances. Particular disempowering elements or manifestations included a lack of self-confidence in PWLD: summarised by support worker 1 Robert: *“because people with learning disabilities tend to lack in confidence”* (Robert – SW - Triad 1 - 4.119), as well as a lack of choice or control. This appeared to be largely as a result of their life experiences and was often due to power imbalances in relationships, with a lack of opportunity to experience life with the same autonomy as people without learning disabilities.

Communication barriers were raised by therapist 4 Penny: *“and you’re thinking, ‘yeah, you’re telling me all this, but where’s you, in all of this…?’ you know, and it’s sad because they’ve never learnt how to express themselves… not able to find that…”* (Penny –T - Triad 4 -

11.342). Penny was referring to a lack of confidence or experience with self-expression on the part of PWLD, although reasonable adjustments to counter this and to aid communication, was also mentioned several times during the interviews. A determination to address such communication challenges or other inequalities was therefore evident (linking with empowerment through therapy), such as in Penny's quote: *"With having a learning disability... and with my background as well* [being from an ethnic minority group] – *you can feel at a disadvantage, so I can relate to that and so I'm like 'yeah, come on, do it!'*[go for it]" (13.389).

Janice, the therapist in triad 5, described in further detail some of the problems frequently experienced relating to communication either with clients, or the people supporting them*: "often you see perhaps a parent or carer disempowering somebody, not deliberately, but because they're talking down to them, talking to them like a child"* (Janice - T – Triad 5 - 19.526). She added, *"I think that we have to unpick a lot more in learning disabilities than you would with the general population"* (16.435) and explained, *"Because they're not always able to express what's wrong really and what's happening in their life"* (16.438). Janice also explained that *"it's difficult, for anyone to talk about their innermost feelings, and I think it's generally more difficult for someone with a lower intellect who can't understand why you would want to talk to them about it in the first place!"* (16.450). Janice highlighted the importance of making extra effort to understand and communicate clearly with PWLD, when engaging in psychological therapy, as well as a greater need to investigate background influences and factors affecting them. Janice also referred to the importance of speaking respectfully and in an adult manner, to PWLD: *"it's helping them to understand on their level but without patronising them…"* (17.487), which has wider communication implications across society in general also.

In terms of barriers created by others or society, one key area mentioned several times was that of financial limitations. Therapist 1 Eve for example said, *"I was wary of suggesting* *something that would cost money… it was probably not attainable for him, in his social situation"* (Eve – T - Triad 1 - 13.396). A more sinister element, that of financial abuse by family members or employers, was also raised in two of the triads, as referred to here by therapist 2 Nichole: *"in a way she's not been able to move on and they still treat her the same way that they used to… financial abuse"* (Nichole – T -Triad 2 - 6.194). This shows how 'social support' can hinder, as well as help facilitate positive functioning by people. Nichole also mentioned that despite encouraging assertiveness and talking about different ways of relating to others, in practise this did not always happen: *"I think therapeutically you can teach someone to be assertive or something like that, but whether they actually act on it is a different matter"* (9.272).

Nichole elaborated upon limitations of choice and control frequently experienced by PWLD, which could impinge upon therapeutic progress: *"a lot of our clients don't feel very empowered, they have very little control over much in their life, and that's not unusual at all"* (8.247); indicating why empowerment may be a fundamental aspect of the therapeutic relationship.

Therapist 3 Tim summarised stigmatising and disempowering factors that more generally affected PWLD, and made psychological (and other forms of) therapeutic support even more important: *"I suppose, when you think about it, you've got individuals who've been labelled, segregated, you know… for sort of much of their life… they sort of cherish and welcome that one-to-one engagement"* (Tim – T - Triad 3 - 8.361). This last quote by Tim could be viewed with some hope, that despite often experiencing disempowerment in many areas of life, the provision of NHS support services significantly and positively supports the lives of many PWLD, as well as monitoring concerns and highlighting needs and changes that may be required in their support (although the reverse could also be argued, that less support would be needed in a more socially equitable society).

4.1.2 Super-ordinate Theme 2: Building Relationships, Collaboration & Trust

A second major theme to emerge was that relating to the importance of building relationships and trust, particularly in terms of developing and maintaining an effective therapeutic relationship, which was crucial for enabling positive outcomes in therapy.

4.1.2.1 Sub-theme 2.1 – The importance of trust & rapport in the therapeutic relationship

Being able to trust the therapist or support worker was found to be important for PWLD, in order to be able to feel safe and make disclosures. This was also noted as important in client-led experience for facilitators. All five triads emphasised this particular sub-theme, hence it appears to be of paramount importance when working therapeutically with PWLD. This was sometimes a new experience for PWLD (some even having past experiences of feeling patronised by non-LD therapists or other professionals). Client 2 Jacky stated this simply as *"When I'm with Nichole I feel like I'm safe" (5.126) and "She listens to me…"* (4.86). Jacky spoke about the importance of trust for her: *"See I can't trust people. I've got to try to trust people."* (12.325) and she was able to explain why this mattered to her, possibly due in part to the therapeutic processes she had explored during the work she had done with Nichole. Jacky experienced positive feelings of trust towards both her therapist Nichole and her support worker Malcolm*: "I don't usually like working with men 'cos of what I've been through… but Malcolm seemed really nice, I knew he wouldn't do anything, so I thought, 'right, I'll work with him'"* (4.95). Feeling safe with these professionals allowed Jacky to express hitherto hidden information, to process difficult life experiences and to explore her behaviours and feelings that she had as a result. Experiencing trust also appeared important in enabling Jacky to make changes and to increase her level of self-awareness.

Similarly, Edward (PWLD – Triad 3), spoke about the importance of feeling understood and trusting his counsellor Tim*, “I’ve had counsellors in the past… they didn’t understand me… But Tim does I think”* (5.126). Edward also spoke about the length of time this process had taken, indicating the degree of difficulty he had experienced, requiring time to feel safe enough to open up and feel he could trust Tim enough to talk about his feelings. Edward spoke about the process taking a long time to ‘break’ into him, suggesting to the researcher an image like a delicate egg, with a brittle shell around it (Edward exhibited behaviours that ‘challenge’ affecting others and his defence mechanisms), protecting the soft interior (Edward’s emotions, pain and traumatic memories): *“it took ages to break into me, really…it took a long time… me mum was at wits’ end”* (5.147). Edward spoke effusively with warmth and gratitude about Tim and the positive changes he had enabled him to make: *“he’s a good friend… he’s really helped me … I wouldn’t want anybody else”* (5.123).

From the point of view of the therapists interviewed, building trust and developing rapport was also extremely important, in relation to the therapeutic relationship and success from the therapeutic process. Penny spoke about the importance to her of the approach she used (PCA): *“it’s the Person-Centred Approach – I find that by having that approach, I can build up that relationship and it works for me!”* (Penny – T -Triad 4 - 1.29) and she explained that the three core conditions were crucial, such as empathy, mentioned here, for enabling productive outcomes: *“well there’s empathy, and I feel like I’ve been on the journey with her, I’ve shared her journey”* (3.76). Tim also spoke about using the PCA for the purpose of developing the therapeutic relationship: “*initially, on the onset I chose Person-Centred, Rogerian – primarily to build up the... therapeutic relationship between us”* (Tim – T - Triad 3 - 3.108), elaborating, *“building that trust and also, earning the right to be able to psychologically engage with that person and to later down the line, challenge… it was really nice…”* (6.272).

Several therapists including Tim stressed the importance of having a safe environment: *"it's critical for the client to feel safe, comfortable within the environment, for them to know you, to warm to you, to trust you... it's absolutely critical that that's right"* (Tim 8.380). This was supported by Janice: *"to give someone a really safe space, so they're confident to... work therapeutically"* (Janice 15.429). She explained the impact a safe, trusting therapeutic relationship had upon her client Neil: *"he said he didn't feel I imposed anything on him, I just made suggestions that I thought might be useful"* (10.264)

Comments were also made on the length of time it took to develop rapport, being possibly longer when working with PWLD, as explained by Nichole: "*it's evident that it takes so much longer, for people with an LD, to develop that kind of rapport…"* (Nichole – T -Triad 2 - 6.210). Nichole spoke specifically about her client Jacky*, "her learning disability is mild, so we could use... her language and everything, but it did take a while to build up trust and rapport…"* (3.78) and she reinforced the reasons for the need for therapeutic rapport: *"I think rapport is really important, because if they don't have that rapport and trust with you, you're not likely to develop a therapeutic relationship that's going to be successful"* (7.222). Nichole also added, "*I think with some of the disclosures that she made, she took quite a long time to disclose them and I think that was about needing to trust me…"* (7.231).

An active, dynamic process involved in developing rapport and building the therapeutic relationship was commented upon by therapist 1 Eve: *"I feel like I was gauging the pace all the time, because Sid was quite anxious to start with"* (Eve – T - Triad 1 - 9.279). She also added that the process involved change over time, *"I feel like the relationship – developed a lot over the course of working with him"* (2.64) and Eve explored some of the reasons for the success and necessity of rapport within therapy from the point of view of the client: *"he didn't feel like people really listened to him, so actually having somebody that would actually listen and validate what he had been through -"* (11.330). An adaptive process was also discussed by Janice, who explained: *“I changed the treatment plan to build a good relationship with him and help him trust me”* (Janice – T -Triad 5 - 3.64).

4.1.2.2 Sub-theme 2.2: Collaboration (MDT/joint working)

Collaboration was another major theme that emerged from the process of applying IPA to the data collected. Three out of the five triads emphasised the importance of using a shared, MDT approach. Working jointly with client-therapist-support worker was frequently expressed as important in creating positive changes and also frequently mentioned and appreciated by the clients with learning disabilities. Collaboration and liaison with other MDT colleagues was also often considered very helpful in the process, enabling success from psychological therapy.

Experiencing a collaborative approach was important for clients, in order to make therapeutic progress. Several participants with learning disabilities mentioned that they had experienced a helpful, collaborative kind of approach, from which therapeutic progress had been possible. Jacky referred to the importance of being able to work with therapist 2 Nichole about her problems: *“You see I know other people can listen to me, but I can say a lot to Nichole, and she’s got a lot of stuff out of me now, if you know what I mean…”* (Jacky - PWLD -Triad 2 - 4.86). She was not always able to specify exactly what it was that she liked or had helped, but it was clear she found talking and the relationship she had built up with Nichole was important for them both, allowing change to occur: *“with talking to her, I just shot up!”* (7.184).

Edward also spoke about the benefits of being able to work alongside and talk to his therapist Tim and his other support networks, which he had not been able to do in the past prior to his referral: *“If I’m in a mood over something, I kind of tell people… they hammer me, to say what’s wrong.. with me… and as soon as I’ve said what’s wrong with me, it’s all* *alright… it's no bother…"* (Edward – PWLD - Triad 3 - 3.62). Edward added details about some of the specific activities he had worked on with Tim, *"I came up with a chart...it's like a face… and you can either put a smiley, or an upside-down face to say how I'm feeling… So as soon as they come through the door they see, Edward's upset and … they know what's happening, staff would know… And if it's happy and joyful, then I'm in a good mood"* (6.162). This chart was a collaborative, joint initiative, with Tim having used and adapted or simplified charts with his clients previously. Here he involved Edward in this process, using a client-led approach: asking about suitable, meaningful symbols (which Edward later mentioned in his interview) that he would like to include in his chart and would be likely to respond well to when used with Tim and his support workers, as a result of the reciprocal roles in the therapy and taking part-ownership of the process (Reciprocal Roles and collaboration in therapy has been widely found to be important for therapeutic success when working with PWLD – Psaila & Crowley, 2006). Abbey also spoke enthusiastically about the collaborative work she had been involved in with Penny during and in between her sessions: *"she did ask me to keep a diary, at first I did… for my sleeping habits … to keep myself calm so I don't kick out at Kevin in my sleep. I tried out all different techniques before I went to bed"* (Abbey – PWLD - Triad 4 - 5.125).

A collaborative approach was also important for therapists in their work with PWLD. Collaborating with clients involved a shared, communicative approach towards the therapy, frequent questions, checks and mutual agreement about the methods and ways of working, as reported here by therapist 1 Eve: *"it was a case of checking with him you know, 'would it be helpful to talk a little bit more about that?'"* (Eve – T - Triad 1 - 2.42). She elaborated upon her approach which centred on placing Sid at the core of the therapy sessions and utilising a Compassion Focussed Approach, to ensure she was on the right track, *"I was trying to walk next to him… Not pushing him too far or lagging behind – making sure I was really there with him in the sessions"* (9.282). Similarly, Janice mentioned the importance of sensitivity to Neil's needs and not imposing upon him, *"he said he didn't feel I imposed anything on him, I* *just made suggestions that I thought might be useful"* (Janice – T -Triad 5 - 10.264). She *"gradually eased in topics that were difficult for him, such as his self-harm, his behaviour toward his mum, his family and his strategies and things like that"* (5.117). Nichole added to this theme of collaboration, tailoring every step to the issues and scenarios Jacky presented in her sessions: *"it was following her timeline, it depended on what we came up with, depended on what particular approach we might use for that particular scenario"* (Nichole –T - Triad 2 - 3.97).

Joint/MDT working and sharing information was helpful & important for facilitators. Joint and MDT working was agreed as helpful by both therapists and support workers, in terms of a) encouraging and sharing effective, consistent ways of working which would benefit the PWLD as well as their carers and wider support networks, although b) there may be times that MDT working is not the preferred approach and consideration of confidentiality, privacy and therapeutic boundaries may override some instances of sharing information and c) making use of multi-disciplinary teams and referrals can provide additional, client-focused services and specialist support, beneficial to the service-users and others involved.

Joint working was generally agreed as important, as therapist 5 Janice explained: *"it's trying to get everybody on board, trying to work with everybody in a similar way"* (Janice – T -Triad 5 - 19.537). Janice found sharing information helpful and commented, *"it's worked extremely well – by including everybody, in what we're doing"* (17.467). She spoke about the importance of educating and talking with carers, parents and others involved in the care and support of PWLD, because*: "But once carers and parents get it, the difference it makes is huge."* (19.530). Support worker 5 Paul commented that the work wasn't always easy, but discussions with other colleagues could be invaluable, in helping create lasting changes - *"it took a lot of hard work… and a lot of … teamwork, to get Neil how he is"* (Paul – SW - Triad 5 - 9.303). He also spoke about everyone learning from each other: *"we can always learn from each other... I think I learn a lot from the professionals I work with…"* (17.559).

Support worker 2 Malcolm also mentioned that checking with the client and obtaining their consent to share information could result in more productive sessions working jointly with the therapist: *"with a joint session… I could have, with Jacky's consent, to bring anything up that she might have forgot – to tell Nichole, and I'll just prompt and then Jacky'll just come out with it."* (Malcolm – SW - Triad 2 - 4.103). Support worker 3 Ray also agreed that joint discussions could be helpful and facilitate further post-therapy explorations and conversations: *"we've discussed them quite a bit [therapy sessions] And afterwards we'll say – when everyone's gone – we'll say "it went alright didn't' it?' and have another discussion ourselves about how it was, so that's good, and it keeps us all in the know"* (Ray – SW - Triad 3 - 6.153).

Although the majority of therapists and support workers agreed about the importance and usefulness of sharing information and working collaboratively in an MDT/team, Eve spoke about there being times when this may not be appropriate: *"In learning disability services there tend to be quite a large number of multi-disciplinary teams – so I felt like, I was working very much just with him, so there wasn't really any need to share, or to talk to carers… which suited the way we were working together…"* (Eve – T -Triad 1 - 13.417). Eve's adherence to confidential, ethically-bound agreements and ways of working seemed to have been reassuring for Sid: *"it made him feel like there was you know, that true sense of confidentiality, there wasn't any need to share anything…"* (13.430). Robert had also referred to not wishing to *"delve"* into Sid's private therapy sessions, indicating a shared understanding and respect for confidentiality, in their triad.

A significant benefit of working within an NHS service is having access to a range of health, adult care and other professionals, who can be contacted, and additional referrals made for PWLD, where such needs have been identified by members of the PCT. For example, therapist 2 Nichole referred to how *"the whole team are involved with her – 'cos she's had a lot of health issues as well"* (1.22) – by which she meant the health team of the CLDT involved. Nichole also explained that due to some of the financial concerns raised in her work with Jacky, Adult Care services and other support workers were contacted: *“it resulted in actually working with her support workers – how can we help her manage her finances better, or how could they?”* (5.149).

Therapist 3 Tim spoke about engaging with other health professionals which he and his client Edward also found useful: *“‘I’ve engaged with Speech and Language… with Occupational Therapy and with Community Nursing… which has all been beneficial – all beneficial to my client, you know – and I sort of initiate that by always arranging the first sessions where the people who are familiar with Edward can be there – so it’s not new”* (Tim - T– Triad 3 - 11.509). Referrals to wider agencies and services were also found to be useful, such as the Vulnerable Person’s Unit within the police, as described here by Tim: *“I’ve also referred him to the vulnerable person unit… section of the police… and we have the police do the weekly checks, call and see Edward, have a drink of tea with him… and things like that – it’s been really useful”* (11.513).

4.1.2.3 Sub-theme 2.3: The therapeutic relationship was more important than the type of therapeutic approach used

It was found that choice of therapeutic approach was considered less important than the actual physical presence and application of the therapeutic relationship itself and whilst therapists’ affinities for or choices of particular theoretical approaches and their use of therapeutic methods varied and was important to them, all forms required adaptations to make the therapy effective for PWLD.

The importance of the therapeutic relationship (in facilitating change and positive developments for clients) was agreed as the most important element of the therapy sessions overall. Tim described it as *“it’s the core, it’s absolutely core… without the relationship you* *wouldn't be able to progress onto the other phases… so it's absolutely critical…"* (Tim – T - Triad 3 - 8.376). Janice spoke about making Neil and his needs central to the therapy sessions, which was built upon a firm foundation of a trusting therapeutic relationship: *"It had to be at his pace really, the whole therapeutic approach"* (Janice – T -Triad 5 - 5.134). She spoke about putting Neil first and helping him feel comfortable in the sessions, despite having PDA, *"'We'd have to talk about them as though they were things I was thinking about, rather than saying 'You do this' and 'Your Mum's told me that'"* (5.118). Penny also spoke about the relationship being central in her chosen approach, which is arguably the key point of the PCA: *"it's the Person-Centred Approach – I find that by having that approach, I can build up that relationship and it works for me!"* (Penny – T -Triad 4 - 1.29).

Nichole explored how she was able to adapt and use approaches with Jacky in mind: *"initially we started some counselling in a therapeutic way and then we used various different things – kind of pulled a mixture of things together, in order for Jacky to be able to understand and work with them…"* (Nichole – T -Triad 2 - 3.80). She was focused on finding a way that would be most helpful for Jacky*: "you kind of consider different approaches to figure out which is more appropriate for Jacky"* (6.206).

Tim also explained his rationale behind the approaches he used, in terms of being geared towards working most effectively with Edward and building upon their therapeutic relationship, before attempting to introduce therapeutic challenge*: "initially, on the onset I chose Person-Centred, Rogerian – primarily to build up the therapeutic relationship between us… which were great for the foundations… And then I brought into it... Gestallt, Fritz Perls… and that were to help me with the therapeutic challenge…. in with that I also introduced Eric Berne's Transactional Analysis, to help us to look more closely at how he does interact with others and to try to help Edward to become more self-aware of how he was presenting."* (Tim – T -Triad 3 - 3.108).

Therapeutic methods used by therapists varied according to client needs and it was clear that different therapists had different preferences and ways of working. For Penny, the PCA was her chosen approach, partly because, *"well for me it's having those core conditions* [PCA]" (Penny – T -Triad 4 - 12.363). Janice also described using the PCA in her work with Neil: *"I took a laid-back, Person-Centred approach, let him lead the session"* (Janice – T - Triad 5 - 5.115). Both counsellors had backgrounds which included initial training in PCA, which may have influenced their work and subsequent decisions.

Eve was the only therapist who had selected a new approach. It was the first time she had used a Compassion Focussed Approach in providing therapy for someone with a learning disability, which she described her rationale behind: *"I thought from the start that I had in my mind, from the referral information… that working in a compassion-focussed, therapeutic model, would be helpful given his presentation, mood and his history, and as I met him over the first few sessions it was apparent that that did seem a good way of working with him"* (Eve – T- Triad 1 - 1.23). Eve added that due to the approach being less familiar to her, *"I had to do a lot of reflection… particularly as it was a new approach"* (11.349).

Nichole and Tim had used a mixture of therapeutic approaches and methods in their therapy sessions, which they both attributed for different phases of the therapy or for use with various specific issues within the therapy as a whole, such as here described by Nichole (many approaches used at once): *"so we used a mixture of CBT with you know, negative thoughts and automatic thoughts… we did some timeline work and story work… to try to build up a picture of the past and so on…and we used some neuro-linguistic programming, to do with some of the past traumas.. And I used some energy therapies as well, to help decrease her state of arousal… We also used various kinds of relaxations techniques, so we tried out a selection of those… So yes, it was quite a mixture of different approaches really."* (Nichole –T - Triad 2 - 3.83).

4.1.3 Super-Ordinate Theme 3: Coping & Adaptations

A third major or super-ordinate theme to emerge, was that of the importance of adapting and making adaptations, coping and managing (for PWLD and in terms of helping them to cope or manage better, or facilitating the therapy). This related to the presenting therapeutic issues, the difficult emotions, behaviours and challenging aspects of life being addressed.

4.1.3.1 Sub-theme 3.1: People with learning disabilities struggled to deal with difficult emotions and life events without support.

All the PWLD interviewed spoke about i) struggling with dealing with difficult emotions and life events; all had experienced strong, challenging emotions ii) that they could not resolve alone or without support.

The difficulties experienced, necessitating referrals for psychological therapy, were in one sense diverse and wide-ranging, due to the individualistic experiences and variety of life-events involved, but in another sense, there was a consensus regarding the actual tangible experience of struggle and dealing with difficult emotions, thoughts and behaviours. Some people had found their emotional difficulties unbearable at times, resulting in self-harming behaviours and extremely painful feelings which could also be experienced physically, such as client 2 Jacky: *"I used to cut my arms and … I was in a lot of pain, so I used to cut my arms, thinking it would release the pain – the pain'd be coming out of me"* (Jacky – PWLD - Triad 2 - 1.12). Partly as a result of the therapy, Jacky started to question this behaviour and consider other ways of coping*: "and then I think sometimes, 'why am I doing it for? I'm not gonna get nowhere, I'm just gonna kill meself'… and then I put them back"* [tablets] (3.66).

Sid also described feelings of inner-torture, *“I ripped hell out of myself”* (Sid – PWLD - Triad 1 - 4.105), which at times he found unmanageable: *“I thought, ‘if I’m never going to get rid of this I’m going to do something to myself – because I can’t stand it’”* (4.91). Abbey spoke about her feelings of inner confusion, having felt “*weak”* and not knowing which way to turn, prior to starting her counselling sessions: *“it’s really helped… made me release everything… realise what I couldn’t see, and I felt so weak… I just didn’t know what to do and now I feel so much more stronger –“(*Abbey – PWLD -Triad 4 - 4.101).

All the clients interviewed spoke about the difficulties they had experienced prior to engaging in psychological therapy and how the therapists had helped them, such as Edward, who again described the process and with gratitude, in terms of ‘cracking into’ him: *“and Tim… mainly broke the ice really… and helped me to get through it actually… and I’m a better person… to this day, thanks to him…”* (Edward – PWLD -Triad 3 - 4.105). Sid described how as a result of his therapy, he was now “*thinking… good things – instead of thinking bad things…”* (Sid – PWLD - Triad 1 - 4.111). He explained how Eve had supported him to change his extreme negative, self-critical thoughts: “*she gave me something about being nice to myself and all this sort of thing – don’t beat yourself up…”* (5.128). He felt that as a result of the support, *“I feel… I can do things more*…” (6.159).

Many of the clients interviewed expressed overt, enthusiastic gratitude and appreciation for their therapist and the improvements they had made as a result of the therapy, but others were more self-conscious such as Neil, who despite describing his sessions *as “Counselling sessions are quite depressing, you know, talking about depression is quite a depressing thing”* (Neil – PWLD - Triad 5 - 3.58), he nevertheless described positive differences in his life as a result of his sessions with Janice: *“The difference is how I’m dealing with things”* (4.106).

Many of the participants with learning disabilities also spoke about the length of time that was required, in order to make progress and see changes in themselves. This ranged from months in the case of Abbey: *"It took a long time… cos I couldn't remember... but a lot of things since have really come to light, that've helped me remember what happened and to move on from it…"* (Abbey – PWLD -Triad 4 - 2.50); to several years, in the case of Edward: *"it took a few years to really… it took a long time really, to get me right…"* (Edward – PWLD - Triad 3 - 2.53). Edward recalled how much his situation had improved and resolving a difficult situation for him now can occur much more quickly, with the help of his support team (support workers, parents and Tim): *"then if I was in a strop, it took months… to get me right… and now it's just… the same day, really… less than an hour really some days.."* (2.55).

4.1.3.2 Sub-theme 3.2 Adaptations are essential for therapy with people with learning disabilities

For therapists and support workers who were facilitating therapy, it was found that there was i) a need in PWLD, for adaptations and reasonable adjustments, in order to be able to communicate effectively with the staff involved, and ii) a need for the application of 'reasonable adjustments' and putting adaptations into practice by the *staff* involved, to enable therapeutic interventions to be effective. The term 'reasonable adjustments' refers to that part of equality law within the Equal Opportunity Act 2010, where it was recognised that achieving equality for disabled people may mean changing the way that a work environment or employment is structured. This can include removing physical barriers, as well as providing various forms of additional support for PWLD, such as allowing extended time for psychological therapy sessions or GP appointments.

The need for adaptations and 'reasonable adjustments' was explained by support worker 4 Kevin, in describing his wife Abbey: *"She forgets things, she's got a limited understanding* *about it, and a limited concentration"* (Kevin – SW - Triad 4 -1.14). He elaborated that it was important in order for Abbey to understand instructions and targets, for her to take *"Just one step at a time. That's what Abbey's doing. Focus on that and then the next one and then the next one"* (3.71). There was some element of Kevin finding this challenging at times, such as in his description here: *"I have to keep reassuring and keep going and going and going – to make sure – to make her think – "* (1.15). Triad 5 support worker Paul also referred to this need for adaptations, to facilitate change in his work with Neil (in this case, allowing extra time and the previously mentioned building of trust): *"I think with Neil you need a lot of time and he needs to get to know you and trust you" (*Paul – SW - Triad 5 - 2.57*).*

Applying 'reasonable adjustments' and putting adaptations into practice was something fundamental that all the therapists were aware of, mentioned and gave examples of in their work, starting with Janice's assertion that, *"You have to do reasonable adjustments"* (Janice – Triad 5 - 21.598), to which she added, *"you really have to be as flexible as you can be"* (21.616). Janice allowed for 'reasonable adjustments' in terms of providing additional time for Neil's sessions, due to his Pathological Demand Avoidance diagnosis and the difficulty that having a conventionally set 50 or 60 minute session would have posed for him initially - *"I set times rather than it being an hour's session, I set the time of three hours, which gave him an hour to come downstairs, and feel confident to start to speak, then an hour of him avoiding any issues, and then the third hour started to be more productive"* (3.83). Penny also referred to breaking sessions and information into manageable pieces, or stages: *"It's in stages, it's got to be monitored, that what I've done for the past seven months, bit by bit"* (Penny – Triad 4 - 14.438).

'Reasonable adjustments' were referred to by Tim, as being important in terms of transparency of intentions and clarity of communication*: "So long as you provide and you're mindful of applying reasonable adjustments throughout our session, being very open, very transparent… explaining everything as you go along, I think it's a right positive experience"*

(Tim – Triad 3 - 8.369). Eve spoke about her concern to adapt her materials for Sid: *"Sid couldn't read or write, so I was quite anxious about … I had to make sure that any information was really accessible"* (Eve – Triad 1 - 8.262); she added *that "I think it was quite helpful to adapt the materials for him"* (9.275). Eve worked closely alongside Sid to ensure the resources she used were appropriate and presented at the most helpful, meaningful level for him to understand: *"we came up with a joint formulation, in quite a simplified version. It wasn't any complex terminology or any sort of complex models"* (1.27). She described *how "he came up with this compassionate owl, so I printed out a picture of that and he came up with some phrases about that that he could use when he was being self-critical"* (9.269) this appeared to be a good example of client-centred working and the use of mutually explored and agreed adaptations, to facilitate maximum use and benefit.

4.1.4 Super-Ordinate Theme 4: Positive Outcomes

The fourth major theme to emerge was that of positive outcomes from the psychological therapy and support work provided. This came from all three groups of participants and was found within all five separate triads. There was a clear agreement amongst all participants interviewed, about the importance and usefulness of empowerment as facilitated by psychological therapy, for PWLD, most of whom agreed that they felt better about themselves and more confident as a result of the therapy sessions. Perhaps as expected, given the non-concrete nature of the notion of empowerment, the therapists and support workers were more able to clearly articulate their opinions about the importance of empowerment.

4.1.4.1 Sub-theme 4.1 - Positive, empowering, outcomes experienced from therapy.

As a result of their therapy sessions and the interventions involved, the PWLD generally spoke about experiencing very positive, empowering changes in their lives, which were categorised as follows: i) general and more specific improvements, ii) gratitude and appreciation for the therapy; iii) sometimes however it was a struggle to perceive positive changes.

In terms of making improvements, the clients interviewed explained these in both general and more specific descriptions. Edward for instance, gave general feedback about some of the improvements in his life: *“he’s keeping me on an even balance…”* (Edward – PWLD - Triad 3 - 4.115); Jacky similarly gave examples of her improvements, such as: *“I never used to walk to the shops on me own…I never used to come down here on me own…But I do now”* (8.211). She was also able to specify changes in hearing voices, which had previously been more of a problem for her prior to working with Nichole: *“I still hear things, but I know they’re not there”* (8.216).

Sid was able to explain that Eve had helped him in terms of overcoming his persistent negative thoughts: *“I think it’s just talking and relaxing and keeping my mind away from … from my thoughts”* (Sid – PWLD - Triad 1 - 3.88). He also spoke about participating in new activities and feeling proud about achievements since engaging in the therapy sessions, *“I feel… I can do things more… And I’ve passed my chain-saw course, so that’s made me feel better”* (6.159). Abbey also described in some detail her feelings of personal improvements as a result of the therapy with Penny, *“It’s really helped… made me release everything...realise what I couldn’t see, and I felt so weak… I just didn’t know what to do and now I feel so much more stronger –“* (Abbey – PWLD - Triad 4 - 4.101). With a clear link here to empowerment, Abbey added, *"But now I'm stepping up to the mark and doing more things, realising things"* (3.74).

Gratitude and appreciation for the therapy was evident and in abundance with most of the clients interviewed, such as Edward's warm description of Tim's input in his life: *"and Tim… mainly broke the ice really… and helped me to get through it actually… and I'm a better person… to this day, thanks to him…"* (Edward – PWLD - Triad 3 - 4.105). Abbey also expressed effusive appreciation of the help she had received from Penny: *"Definitely, definitely, it's really helped me*" (3.69) which she reinforced with, *"If anything, it's really helped – it's really helped me move on –" (*5.114).

Sometimes however, it was a struggle to perceive positive changes. This was the experience of Neil, who declared, *"No amount of therapy sessions is going to make me like the neighbours"* (Neil – PWLD - Triad 5 - 10.262). Nevertheless, Neil was able to distinguish between difficult life experiences and his own increased capabilities in coping with them: *"I'd say since the earlier sessions, my life has got more difficult… The difference is how I'm dealing with things"* (4.105). Neil also explained, *"I still get very – sort of pissed off, about life in general… But I don't tend to feel so much – depressed, about in general"* (7.178). So even Neil's initial reluctance to admit positives could not conceal some of the improvements evident as a result of the therapeutic and supportive influences he had experienced with Janice and Paul.

Interestingly, all client participants also expressed warmth, appreciation and agreement to having an empowering focus in their lives, apart from Neil, who pointed out that sometimes empowerment can have its drawbacks: *"It's very boring, 'cos all I seem to do is sit around in the flat all day!"* (6.170). This highlights that for some PWLD, empowerment and self-determination is not enough; they may also need support and encouragement to plan activities and meaningful occupation. This may sometimes be linked to a lack of engagement in meaningful activities, which further reinforces the importance of appropriate support for PWLD.

4.1.4.2 Sub-theme 4.2 - Therapeutic approach used and presenting problem affected type of empowering outcome

The therapeutic approaches used by each of the therapists involved are included in the therapist table in Appendix F. This is in addition to the other participant background information and reasons that referrals had been made for the clients to access psychological services. There was some suggestion of an evidence of empowerment operating differently, based upon firstly the approach used by the facilitator, as well as secondly, the presenting problem necessitating therapeutic intervention.

As mentioned, the therapeutic approaches of the therapists varied considerably, although most tended to utilise more than one model, as summarised here for example: "*yes it was quite a mixture of different approaches really." (T -Nichole 3.83)*. However, it was generally found that when humanistic-orientated models were used for self-esteem related problems, the kind of empowering outcome to emerge tended to show an increase in confidence, a more relaxed attitude towards their lives and an ability to be more self-reliant. A rationale behind choice of approach in such circumstances was described by therapist 1 Eve: *"I thought from the start that I had in my mind, from the referral information… that working in a compassion-focussed, therapeutic model, would be helpful given his presentation, mood and his history, and as I met him over the first few sessions it was apparent that that did seem a good way of working with him" (T -Eve 1.23).* Client 1 Sid's improvements were also reflected an increase in personal empowerment as he spoke about enjoying his work placement again and was starting to interact more socially, as well as achieving the goals described in earlier themes.

Client responses towards their therapists appeared more trusting, (linked to super-ordinate theme 2) when focussed attention was particularly paid to the relationship dynamics between the receiver and provider of the therapy. This also links again to the importance of the therapeutic relationship. When cognitive-orientated and skills-specific plans were applied, the PWLD showed improvements in their coherent patterns of thinking and behaving, able to articulate more clearly information about the goals they had achieved or targets they had been able to work towards, due to following a very structured programme. Nichole discussed her use of specific approaches for particular problems: *"we used some neuro-linguistic programming, to do with some of the past traumas... And I used some energy therapies as well, to help decrease her state of arousal"* (T – Nichole 3.83).

Secondly, and possibly more convincingly, the type of presenting problem affected the nature of the empowering outcome, as those clients wanting to work with issues relating to how they felt about themselves and to process painful past memories, were keen to communicate these intentions to their therapist and possibly most willing to engage in the therapeutic process. Initial motivation, intentions to overcome emotional challenges, as well as an ability to communicate with their supporters, appeared helpful in terms of successful outcomes of therapy. Clients such as Edward and Neil, who were referred for psychological therapy due to behavioural problems and significant displays of anger, required longer to make noticeable improvements, especially where they had experienced difficulty with accessing or exploring their emotions at the onset of the therapy.

Similarly, some clients responded angrily at first to therapeutic challenge, although all were fortunately able to work through difficulties with committed therapists and support workers as well as benefitting from extended periods of therapeutic involvement. Therapist 3 Tim described the Gestallt approach being useful for such challenge, having already built up a firm foundation using a Person-Centred Approach: *"initially, on the onset I chose Person-Centred, Rogerian – primarily to build up the sort of therapeutic relationship between us…*

Which were great for the foundations you know… And then I brought into it... Gestallt, Fritz Perls… and that were to help me with the therapeutic challenge" (T -Tim 3.108). Tim's client Edward spoke enthusiastically about the therapy, so they had clearly worked through any difficulties encountered earlier in the therapy.

4.2 Participant Conceptualisations of Empowerment

Table 4.2 shows a summary of all 15 participants' individual conceptualisations of empowerment. The information was obtained by some explicitly stated views, as well as other less direct feedback to questions gathered during the interview process. The use of prompts, minimal encouragers and other facilitation skills derived from counselling training were helpful to the investigator when conducting the interviews, to allow more information to be collected.

The table shows that firstly, the participants with learning disabilities provided information about empowerment which was generally gathered from linked comments and questions typically relating to positive outcomes. Their conceptualisations of empowerment were associated with: (i) improvements in mood and feeling better about themselves or their past experiences; (ii) dealing better generally with life; appearing less miserable to others; participating in more social activities; (iii) greater self-awareness and confidence; (iv) knowing who/where to go to for help; (v) having happier, more satisfying relationships and treating others better (systemic benefits); (vi) greater autonomy and independence; and (vii) improved communication skills.

Table 4.2: Participant Conceptualisations of Empowerment with illustrative quotations

Participant Pseudonym & (Triad)	**Conceptualisation of Empowerment** (some explicitly stated & some gathered from other linked comments & questions)
Sid (PWLD#1)	Agreed he found the sessions helpful - *“good”; “I think I’m getting better”* (improvements in his mood); *“thinking good things - instead of thinking bad things”.* Nicer to himself. *“It’s helping yeah. I think it’s helping”.* Improved life events & successes – e.g. passing chain saw course. More active/independent – started Ju-Jitsu course; more goals in life (e.g. yellow belt); Looking better/less miserable to others.
Jacky (PWLD#2)	Making health improvements (e.g. from 40-60 cigarettes per day to 10); more independent & active (e.g. walking to clinic or shops alone); knowing who to contact/who can help (even if still unable in places). Learning how to stay safe. Feeling better/less affected by past & traumas. Less self-harm. More self-awareness (e.g. questioning her thoughts about over-dosing). Confidence, trusting herself more.
Edward (PWLD#3)	Being/feeling independent; having a job; sense of worth/self-esteem; having skills; own flat. Having a therapist/people who are interested in & care about him*: “he’s been interested in me and helpful”* (very grateful for help/support – attributes his progress to their help). Respect from others. Able to communicate better & sort out problems faster/easier with carers. Feeling better/improved mood. Treating people better (esp. parents).
Abbey (PWLD#4)	Making improvements, doing more, *“stepping up to the mark”.* Realising things/increased awareness; thinking more clearly & calmly. Communicating more effectively (esp. with husband). Feeling stronger & more confident. Doing more independently (e.g. bus travel/to appointments). Able to move on from the past. Getting over fears. Feeling more autonomous. More assertive. Able to stick up for herself (e.g. with ex-wife).
Neil (PWLD#5)	Being independent = important but can be boring (sitting around in flat alone/getting round to doing domestic tasks). Therapy won’t change the neighbours/environment/worried about losing his temper when bullied/less depressed now – just *“pissed off!”* Dealing with life better now (life itself no easier or even more difficult).

Eve (T#1)	Working with someone in a way that enables them to have some control. *"A means of making changes that are really important to them". "Many LD clients don't have experience of having choices and control – so being able to experience that within a therapeutic relationship is key to the work we do". "All therapy should be empowering!"*
Nichole (T#2)	Giving our clients some sort of control over what they do or how they feel *("some LD clients might exert control over some specific type of behaviour because that's the only thing that they have control over"* – so working out how they can have control or working with care providers, how they can help with support in empowering them more) – increasing control and having responsibilities for things.
Tim (T#3)	Empowerment is *"crucial, absolutely crucial and I think it's the goal which all therapists aim to achieve with their clients". "It's about somebody having the confidence to be totally self-governing and to speak up for what they think's right and wrong and to express their need… without feeling embarrassed or feeling as though they're not able to do so". "Able to have a say in his life, to steer his own boat".*
Penny (T#4)	*"It's who you are really… you have to go out there and get it!" "for me… it is a biggie". "To actually believe in yourself, you have a right to do things…" "Helping clients to do whatever they want to do", "give it a go!....or, ok, well find something else!"*
Janice (T#5)	*"Trying to help a person to speak up, speak out & stand up for themselves, appropriately & in a way that doesn't get them into trouble"* (may see Empowerment as aggression – so need to explain the difference). Trying to empower others as well (carers etc). Using appropriate adult language. Trying to get everyone involved *"on board"*, working together. Helping people move on with their lives & feel happier & more confident.
Robert (SW#1)	*"Giving people the chance to be themselves" Not to feel that they're treated any differently to anyone else. "It's all about people feeling they've got a sense of worth, by contribution".* Treating people as equals. Giving people a chance.
Malcolm (SW#2)	*"Giving people back what they lack, or lost confidence with, building that confidence up so that when they're not sure about something, reassuring them".*
Ray (SW#3)	*"It's everything really – you've got to feel… cared about really, you've got to feel wanted" "You've got to feel … like there's a purpose that you're here – everyone needs a purpose, don't they –"*

Kevin (SW#4)	Encouraging someone to be more independent & confident (agreed with interviewer's explanation). Helping people develop. *"To be independent", "not just being reliant on people"*
Paul (SW#5)	*"I like a challenge… and to think I've made a difference" "I like to achieve stuff with people and I want them to achieve… thinking about how they feel…"*

[Notes: Person with a learning disability - PWLD; Therapist – T; Support Worker - SW]

Secondly, the therapist participant reports conceptualised empowerment in terms of: (i) allowing greater choice and control; (ii) being able to make meaningful, important changes and having greater responsibility for things in their lives (PWLD); (iii) being more ‘yourself’, more authentic; (iv) being proactive and enjoying life; (v) being self-governing and able to express thoughts and feelings confidently; (vi) having greater self-belief; (vii) appropriate use of language to avoid getting into trouble; and (viii) working and living together more effectively and moving on more happily in life.

Thirdly, the support worker participants framed their conceptualisations of empowerment in terms of: (i) being able to retrieve lost powers of self-governance; (ii) encouraging a return of self-confidence; (iii) having a purpose in life; (iv) being able to contribute to one’s community effectively; (v) feeling wanted and valued by others; (vi) having independence and (vii) positively influencing others to make satisfying changes in one’s life.

To answer the question what constitutes empowerment in therapy and its importance as an outcome, the findings from the participants with learning disabilities highlighted the relevance of the therapeutic relationship and positive life-enhancing changes that made daily living easier and more pleasant. This included clients’ recognition and appreciation of their therapist’s efforts, which ranged from general gratitude for their physical presence, as described by Jacky: *“She were just there for me”* (Jacky – PWLD -Triad 3 - 6.153), *“She’s just a nice person”* (5.120), and recollection of enjoyable shared memories of support: *“I’d love to see Malcolm – cos I know… he’s only been to my house once… I wanted to get a taxi and he said ‘No, you’re walking!’”* (13.344). Edward mentioned Tim’s help, as well as his parents’ input in his life, the relationship with whom he said had much improved in recent years and he was treating them much better as well: *“thanks to Tim’s help… and especially my mum and dad’s help as well… with treating them like dirt… and I don’t treat ‘em like dirt as much, anymore…”* (Edward – PWLD -Triad 3 - 2.57). Therefore, empowerment for PWLD often spread more widely than only to the individuals themselves, frequently causing systemic improvements in the lives of others attached to them.

Empowerment for the therapists was related or equated with choice, control, independence, autonomy, enablement and self-management of challenges. Some of the therapists referred explicitly to the importance of empowerment in affecting clients' ability to make choices and have some control in their lives, as mentioned here by Eve: *"It's a really key theme… so many of our clients… don't' experience you know having choices and control"* (Eve – T - Triad 1- 11.356). She elaborated upon the processes used within therapy, *"I think it's working with somebody in a way, that enables them to, have some… I suppose – control?"* (1.343). Nichole agreed with this, as in her response here: *"I think a lot of our work is around empowering our clients, to give them some sort of control over what they do or how they feel…"* (Nichole – T -Triad 2 - 8.241).

The importance of empowerment as an integral aspect of therapeutic work with PWLD was highlighted by the fact that several therapists also suggested that it was something that all therapy should embody, in general – as here voiced by Eve, Nichole and Tim: *"All therapy should be empowering!" (*Eve 13.404); *"that's* [empowerment] *kind of part of the therapeutic process in a way isn't it?"* (Nichole 8.265); *"so empowerment, I think it's crucial, absolutely crucial and I think that's the goal which all therapists aim to achieve with their clients – empowerment – you know"* (Tim 9.398). They were in agreement about the importance of having an empowering focus in therapy; Nichole expressed this, saying *"yeah it's really important… in the therapy and how you try to help someone…"* [having an empowering focus in therapy] (8.266).

The client participants spoke about the empowering effects and positive outcomes of the therapy, rather than complex conceptualisations of what they thought empowerment was; its meaning and importance was implicated in the concrete, positive, life enhancing results created from the therapy. The client participants were presented with a simplified definition of empowerment (included in service-user versions of interview questions – see Appendix G), which they commented upon in terms of its application to and meaning in their own lives.

Developing this theme, the therapists spoke about how empowerment relates and equates to self-advocacy, self-determination, confidence and opportunities. They felt that empowerment can allow PWLD to speak up for themselves and be more confident in making decisions or changes in their lives, such as Tim's comment here: *"that's what empowerment means to me, it's about somebody having the confidence to be totally self-governing and to speak up for what they think's right and wrong and to express their need… without feeling embarrassed or feeling as though they're not able to do so"* (9.409). Eve spoke about the resilience she often found in her clients, which empowerment can support. She also talked about how she endeavoured to build resilience by helping people to realise that disempowering life circumstances were not due to any fault of their own (empowerment being needed since disability was seen as a disadvantage): *"I think the empowerment work works against that, in helping them to maintain that resilience - to understand that it isn't them, a fault within them"* (12.371).

Penny, due to being from a minority ethnic group, felt a personal connection with some of the feelings about equality and the need for empowering disempowered groups in society. She felt a keen desire to encourage her clients to *"go for it"* and embrace life: *"I think…empowerment, it's who you are really, you don't know what you're capable of doing… without empowerment you don't know… And I just feel … you have to go out there and … get it!"* (12.375). Janice added that empowerment can help people to voice their wishes and that therapy can help them do this in an appropriate, helpful way: *"It's trying to help the person to speak up, speak out, and stand up for themselves, appropriately and to do it in a way that doesn't get them into trouble"* (Janice – T- Triad 5 - 19.522).

The support workers interviewed were also keen to reinforce the importance of an empowering focus in their work. Robert spoke about this in terms of individual expression and the opportunity to feel comfortable about being 'themselves': *"giving people…the chance* *to be themselves"* (Robert – SW - Triad 1 - 4.106). For Robert, this was facilitated in a work-based placement, where people had the chance to contribute to their local community and feel satisfaction in developing their practical skills, *"It's all about people feeling they have a sense of worth, you know, by contribution…"* (4.109). Malcolm also felt that his work involved empowering, as restoration of power and confidence taken by society; providing reassurance, encouragement and affirmation of the person: *"giving people back – what they lack, or lost confidence with"* (Malcolm - SW -Triad 2 - 4.120). Malcolm added that he did this by *"building that confidence up so that when they're not sure about something, reassuring them."* (4.121).

Ray was keen to support the process of psychological therapies for PWLD, adding, *"It's a real good thing"* (Ray – SW -Triad 3 - 5.135) and *"I think it's very successful. I'd recommend it to anyone…"* (5.133). Finally, Kevin spoke about how this was inherent in the approach he used or aspired to, with his partner, Abbey: *"Oh I'm for it, I'm all for it. That's what I've been working on with Abbey"* (Kevin – SW -Triad 4 - 9.250).

The findings indicate that the overarching ideas, benefits and importance of empowerment from each group suggest (a) therapy supports people to work through their emotional and mental health issues and manage their associated behaviours/moods/thoughts more effectively and (b) therapy enables people to exert more self-determination – particularly in terms of autonomy and self-mastery elements, but also inter-personal relatedness aspects and assertiveness or self-advocacy, which is linked to speaking up and accessing support.

4.2.1 Empowerment per triad: overlap and differences

Following from the previous section, 4.2 where individual participant conceptualisations of empowerment were explored, the researcher considered the similarities and differences in the findings regarding empowerment per triad. This has been presented in Table 4.3 and is summarised in this section.

Triad #1

In Triad #1, client Sid had been referred due to recurrent depression and all involved considered that he had made progress since engaging in the therapy sessions: becoming happier in mood, more relaxed, more confident and participating more actively in life. Table 4.3 shows that there were many overlapping themes relating to empowerment in this triad, with Sid valuing the therapeutic relationship, the positive changes in his life in the areas of mood, work, achievements and general engagement, whilst again affirming the importance he placed upon trust in the therapeutic relationship and feeling heard. Therapist Eve also highly value the therapeutic relationship and mentioned the importance of choice and control in terms of helping PWLD feel empowered in their lives (and specifically Sid). Differences in this triad included Eve's use of a new, novel approach, which she had not tried before in her work with PWLD but detailed how useful and relevant she found a compassion focused approach in helping Sid through his emotional journey. Eve also spoke about not always needing to share information with others and she explained that there may be times when a joint, MDT approach is not always best for the client. Support Worker Robert agreed with this point and also stressed the importance of confidentiality and respect for a client's wishes. Robert spoke about the importance of the work placement that he was involved in, in terms of values, person-centred ideals and the encouragement of empowerment. Robert agreed with most other facilitators about the fundamental importance of support for PWLD in the therapeutic healing process.

Triad #2

In Triad 2, client Jacky again spoke about the importance to her of the therapeutic relationship in terms of empowering outcomes from the therapy; again, this included the importance of trust and rapport, which had been essential for allowing sensitive disclosures of information and being able to engage fully in the therapeutic process. Jacky reported increased empowerment in terms of confidence and self-esteem, as well as being better able to make choices and experiencing more control over her own life. Individual differences could be seen in terms of the particular work carried out by therapist Nichole, although she concurred with the empowering improvements mentioned by Jacky; she referred to specific details such as a reduction in self-harming behaviours which were mentioned by both in their interviews and Jacky being less affected by previously traumatic memories. Nichole also mentioned specific empowering therapeutic adaptations and choices that had been made in the therapy sessions to enable Jacky's understanding and progress – these included the use of mixed approaches according to need and the timeline (of Jacky's life) they were following. These differences arguably still contain much overlap in terms of general processes and results from the therapy, when compared with other triads. Nichole reinforced the overlap regarding therapeutic adaptations which had helped facilitate empowerment and positive outcomes in her work.

Support worker Malcolm showed agreement with most other support workers in terms of the mutual satisfaction gained from the support and therapeutic work involved between the three in this triad, speaking about the rewarding nature of his work, as a result of the relationship involved, and the empowering outcomes experienced by all of them. Malcolm also was in agreement with the importance of MDT involvement, which he considered assisted empowering outcomes for Jacky in areas ranging from finances, her physical health and attending GP appointments. His emphasis upon the helpfulness of practical support resonated with other support workers, as he explained that empowerment had been evident as a result of the travel training he was involved with, support around social and independent living skills, increasing levels of assertiveness and a gradual reduction in exploitation as a result of all of these and the MDT support in Jacky's life.

Triad #3

In Triad 3, client Edward had participated in therapy sessions with Tim over a long period of time, originally due to workplace bullying and a crisis in his mental health. Throughout the duration of the sessions and via a series of important stages facilitated by Tim and the support of Edward's parents and a team of support workers, Edward experienced considerable empowering improvements in his life situation, both physically and psychologically. One of the key differences in Edward's therapy sessions was the fact that he had requested his parents to attend and share all the information elucidated and explored by Tim. He considered that this had contributed to the success of the therapy. Overlapping themes relating to empowerment included the gratitude and appreciation he felt for the sessions and all involved, which Edward spoke warmly about. He also mentioned the importance of trust and understanding on the part of his therapist Tim, which he experienced as non-judgemental and helpful – another overlapping theme, which his support worker Ray also mentioned, as did many of the other participants in other triads.

Therapist Tim referred to overlapping themes such as the value of the therapeutic relationship, which he stressed had been of greater importance than the psychological approaches used, for creating empowering outcomes. Other overlapping themes raised by Tim included the appropriate sensitive sharing of confidential information, which assisted trust and engagement in the empowerment process, as well as the importance of applying reasonable adjustments and flexibility in working with PWLD. The main difference mentioned by Tim was linked to Edward's wish to have his parents present in the therapy sessions: systemic empowering benefits were also evident, including for his parents and support workers, as their lives were positively affected by Edward's life improvements, such as now being able to take holidays and support workers benefitting from Edward's generally calmer and more content state of mind. The key difference mentioned by Support Worker Ray relating to the empowering outcomes in this triad involved the way that the therapy did not stop once Tim left Edward's house: Ray continued discussing the important themes of the session with Edward, engaging in de-briefs, follow-up practical work together and offering additional support. Overlaps referred to by Ray included the importance of support networks which contributed to facilitating empowering outcomes and also the fact that such positive, empowering outcomes evidently did occur as a direct result of the therapeutic process (with improved communication and social skills, community access and involvement and significant life changes such as Edward moving into his own house).

Triad #4

In Triad 4, Abbey clearly experienced empowering and life-enhancing benefits as a result of her psychological therapy sessions with Penny. Her relationship dynamics were affected, and improvements were particularly noticeable in the area of self-confidence, communication and self-awareness. Overlapping themes reported by Abbey again included the value of the therapeutic relationship, which she attributed to therapist sensitivity, with a professional who was encouraging and not patronising of her, enabling her to feel trust towards Penny and allowing for important disclosures during the duration of the sessions. Differences were also highlighted by Abbey, which included specific outcomes personal to her situation, such as gaining meaningful insights about past relationships, through processing, analysing and exploring relevant issues. Abbey was the only client interviewed who was married, another striking difference in this triad; her empowering outcomes had involved focus upon her relationship with her husband and previous difficult relationship dynamics.

Abbey’s therapist Penny revealed several overlapping themes, such as the mutual satisfaction she felt from engaging in the therapeutic relationship, which helped bring about some of the empowering results for Abbey. Similarly, use of adaptations to enable Abbey’s understanding during the therapeutic process were an overlapping theme mentioned as crucial by Penny. Differences however, she described in terms of Abbey’s husband (also her support worker) being an integral part of the sessions, although for different reasons to those described in triad 3: Kevin was important in the empowerment process because of the educational, LD training and sign-posting elements which were involved and that Penny had endeavoured to make available for Kevin, in order to help both him and Abbey in improving their relationship. Penny also considered her therapeutic approach (PCA) as increasingly niche within the NHS, which she felt keen to protect as well as to promote as helpful and empowering, largely she felt, due to the three core conditions involved. Support worker Kevin was unusual in the research due to his position as Abbey's husband and having a role as her support worker; he said that the close therapeutic work between the three parties was very helpful in the facilitation of empowerment for Abbey. Overlaps referred to by Kevin included mention of the practical tasks which were helpful for Abbey, ranging from journaling, logging her thoughts, practising independent travel, goal-setting and help with coping strategies. As with other support workers, Kevin discussed positive, helpful benefits arising from the therapy (Abbey 'moving on' from her past, releasing difficult memories - instead of taking them out on him - and being more able to cognitively analyse past processes).

Triad #5

In Triad 5, Neil had benefitted from therapeutic sessions with Janice which started whilst he was in the process of leaving school, to go to college and struggling with his mental health problems due to PDA and OCD-related issues. Neil was different to the other clients interviewed as it emerged that following eventual IQ assessment, he did not meet the service criteria due to being much more intellectually able and linked to this was his greater career aspirations, which affected his views about whether he thought empowerment was actually a good thing or not. Neil highlighted drawbacks and limitations to empowerment, reporting feeling bored and lonely being on his own in his flat all the time and complaining that no amount of therapy would change his neighbours. Despite this Neil acknowledged the progress and positive outcomes since the start of his therapy, which included increased self-insight and awareness, which was linked to being more empowered and independent than he had been previously – an overlapping theme in this and other triads.

Therapist Janice mentioned the chief area that was different as dealing specifically with Neil's PDA diagnosis, which both facilitators experienced as difficult to work with and involved additional adaptations, with greater need for patience, flexibility and a definite need to go at a slower pace in terms of session length requirements. Overlaps however were described by Janice as the more general adaptations needed in her work with PWLD and to take into account individual differences in order to help bring about empowering outcomes. She similarly felt that empowerment was helped due to the therapeutic relationship, where trust and the development of a good rapport were particularly essential elements. Support Worker Paul mentioned a difference relating to empowerment in this triad whereby the facilitators noticed positive changes and progress more than the client Neil, which Paul partly attributed to Neil's personality style and PDA diagnosis. Paul listed many overlapping areas such as facilitator satisfaction from achievements in the work and having a genuine desire to help; the importance of teamwork and MDT working in order to create empowering benefits; plus and linked to his style of working, the importance of practical support (including social, goal-setting, independent living skills, and particularly attending appointments, police and court interviews with Neil).

Table 4.3: Empowerment across the triads: overlaps & differences

Triad # → Participant Group ↓	Triad #1 (Sid/Eve/Robert)	Triad #2 (Jacky/Nichole/Malcolm)	Triad #3 (Edward/Tim/Ray)	Triad #4 (Abbey/Penny/Kevin)	Triad #5 (Neil/Janice/Paul)
PWLD	O Value of therapeutic relationship. O Positive changes leading to improvements in mood, engagement with life, work, achievements. O Importance of trust and feeling heard.	O Value of therapeutic relationship. O Importance of trust & rapport – important for disclosure, engagement & therapeutic progress. O Empowerment via increased confidence and self-esteem, choice & control and responsibilities.	► Requested parental involvement in therapy sessions, contributing to their success & empowering outcomes. O Gratitude & appreciation for the therapy sessions & attendees. O Importance of trust & understanding (non-judgemental).	O Value of therapeutic relationship (therapist sensitivity, encouraging, not patronising, trust allowing disclosure). ► Specific, empowering outcomes included gaining insights form past relationships, processing & exploring issues. ► Client was married – empowering outcomes included focus upon this & previous relationship dynamics.	► Higher IQ than other LD clients, service inclusion criteria & higher career expectations affected perception of empowerment. ► Highlighted drawbacks & limitations to empowerment (bored/lonely in own flat; can't change neighbourhood). O Positive outcomes & progress (increased self-insight & awareness) linked to empowerment
Therapists	► Use of specific psychological approach (CFT) O Importance of choice & control O Importance of therapeutic relationship ► MDT approach & information sharing not always appropriate or needed.	► Specific, empowering improvements – reduction in self-harming behaviours & less affected by past traumas. ► Specific empowering therapeutic adaptations & choices (mixed approaches according to need/timeline issue). O Therapeutic adaptations helped facilitate empowerment & positive outcomes.	O Value of therapeutic relationship (more important that psychological approach used for facilitating empowerment). O Importance of applying reasonable adjustments & flexibility in LD work, to enable empowering results. ► Systemic empowering benefits were also evident (including for parents & support workers). O Appropriate, sensitive sharing of confidential information assisted trust & engagement and the empowerment process.	► Use of specific, single psychological approach (PCA) considered helpful in empowering outcomes (importance of 3 core conditions). ► Including client's husband (also support worker) was important in the empowerment process re LD educational, training & sign-posting elements. O Use of adaptations in therapy helped facilitate empowering outcomes. O Mutual satisfaction helped results.	O Adaptations were needed to create empowering outcomes. ► PDA diagnosis was difficult to work with & involved additional adaptations (patience, flexibility, slower pace). O Empowerment was helped via the therapeutic relationship (trust & a good rapport were essential).
Support Workers	► Importance of voluntary placement (values, ideals & encouragement of empowerment). ► Sense of worth via work/contribution to local community. O Fundamental importance of support via facilitators in healing process. ► Importance/respect of confidentiality.	O Mutual satisfaction & rewarding work from the relationship/& empowering outcomes. O Practical support helped facilitate empowerment (travel training, social & independent living skills, assertiveness, reduced exploitation). O MDT involvement assisted empowering outcomes (finances, physical health, GP appointments).	► Continued therapy work after the sessions (de-briefs, discussion, practice & additional support| contributed to empowering results). O Importance of support networks contributing to facilitating empowering outcomes. O Empowering positive outcomes resulted from the therapy (improved communication & social skills, community access & involvement, life changes – e.g. moving into own house).	► Support worker was also client's husband – close therapeutic work between 3 parties, assisted the empowerment process. O Practical tasks helped facilitate empowering outcomes (journaling, logging thoughts, independent travel, goal-setting & help with coping strategies). O Positive, helpful benefits from the therapy (moving on from past, releasing difficult memories, analysing past processes).	► Facilitators noticed positive changes & progress more than client (linked to PDA diagnosis/personality style). O Facilitator satisfaction from achievements & progress, with genuine desire to help. O Importance of teamwork & MDT working for creating empowering benefits. O Importance of practical support (social, goal-setting, independent living skills, attending court & appointments).

Key: O = overlap ► = difference

5. DISCUSSION

This chapter provides an overview of the research findings, particularly in terms of the pertinent themes discovered and how these answered the original research questions; how these corroborate previous published research findings; the strengths and limitations of the research; clinical implications; suggestions for future research from the study; culminating with a conclusion about the research as a whole.

5.1 Overview of the Findings

A number of significant key themes emerged from the data analysis, which served to meet the research aims and addressed research questions for the study. The following summary returns to the main research questions which were presented at the start of this thesis (Introduction and Section 2.13 of Literature Review), here examined through the resulting themes extracted from the findings in Chapter 4.

5.1.1. In what ways do *people with learning disabilities* experience empowerment from psychological therapy and the therapeutic relationship?

In *Super-ordinate Theme 1: Values, Stigma & Social Equity*, it was found that PWLD experienced empowerment through their therapists' and support workers' awareness of a variety of challenges for their clients and in the therapeutic support they provided through the therapy sessions. PWLD were found to have an awareness of stigma and were in many cases sensitive to other people's perceptions or judgements about them (sub-theme 1.1), which at times negatively affected their feelings of psychological wellbeing. By the facilitators recognising the many limitations and challenges involved in working with PWLD (sub-theme 1.2), which they commented upon in detail, they were able to use their specialist insights and practical experience for the benefit of their clients and others involved in providing support. Their clients reported feeling more understood and valued as a result.

This links into *Super-ordinate Theme 2: Building Relationships, Collaboration & Trust,* as it was found that through building supportive relationships, which involved trust on the part of the clients and efforts to develop rapport in order to allow this by their supporters (sub-theme 2.1), PWLD could experience greater empowerment in their lives. This was sometimes reported as being a new experience and the therapists agreed about how important it was for their clients with learning disabilities to feel safe in the therapy, in order to allow disclosures and facilitate developments within the therapeutic relationship. Collaboration and MDT/joint working (sub-theme 2.2) was also associated with successful therapeutic work and empowerment for PWLD, as reported by all three stakeholders involved in the research; since working together both therapeutically and via the involvement of other appropriate multi-agency professionals, was found to be enjoyable and helpful. Nevertheless, it was found that the therapeutic relationship itself was of most importance (and particularly prized by the PWLD interviewed) in facilitating empowerment, than the particular type of therapeutic approach used by therapists (sub-theme 2.3).

The importance of making adaptations for their clients, on the part of the therapists and support workers, as well as PWLD learning to cope and manage the difficulties that had necessitated their referrals for therapy, was also found to be crucial in helping PWLD to experience empowerment, as found in *Super-ordinate Theme 3: Coping & Adaptations.* This was particularly due to PWLD struggling without additional support (sub-theme 3.1), which they described in their own words in various ways. The PWLD interviewed agreed that their experience of life had been harder prior to receiving therapeutic support, particularly in terms of their emotional difficulties and inter-personal relationships, which they had had little opportunity to discuss with anyone effectively before. Some referred to a preference for their specialist therapists from the NHS learning disability service, as compared to previous experiences of more generic counsellors. The therapists and support workers interviewed similarly agreed that adaptations were essential for working successfully and in order to facilitate empowerment as part of the therapeutic encounter with their clients (sub-theme 3.2), which included working more flexibly; adapting resources and materials in order to maximise understanding; applying reasonable adjustments tailored to individual differences and needs; and splitting the therapy into steps or more manageable stages.

Lastly, *Super-ordinate Theme 4: Positive Outcomes,* was unanimously agreed upon as a significant and important theme by all the participants, but particularly the PWLD, who spoke about the positive, empowering outcomes they had experienced both within and resulting from, the therapy (sub-theme 4.1). A sub-theme of this was that the therapeutic approach used and as well as the kind of presenting problems, affected the type of empowering outcome experienced by PWLD (sub-theme 4.2), which emerged from the data analysis process and more explicitly from the facilitators' reports. Conceptions of empowerment were more directly obtained from the participants without learning disabilities.

5.1.2 How do *psychological therapists* and the *support workers* of people with learning disabilities enable clients with learning disabilities to experience empowerment from the psychological therapy received within the NHS?

In terms of the facilitators' enabling processes, it was found in *Super-ordinate Theme 1: Values, Stigma & Social Equity*, that the psychological therapists and support workers interviewed enabled PWLD to experience empowerment from the psychological therapy received, by application of their specialist knowledge of working with this client group, such as an awareness and sensitivity about how to communicate best with PWLD and effective ways to instruct or support other supporters involved. This included for example, training carers to notice the particular words and body language that they are using, to avoid patronising or disempowering language and instead to use positive, confidence-building, encouraging and supportive approaches. The facilitators were found to be aware of the impact that associated limitations and challenges such as these can have upon their clients (sub-theme 1.2), and the stigma that can result from a lack of awareness of the potential effects. The application of psychological insights such as these was considered likely to be more widely helpful in society and in improving historically disempowered cultures and experiences for minority groups, as discussed in Section 2.6.

From *Super-ordinate Theme 2: Building Relationships, Collaboration & Trust,* it was apparent that the psychological therapists and support workers of PWLD were also very aware of the importance and empowering results that trusting therapeutic relationships can have upon their clients. As mentioned, feeling safe was described as extremely important, to allow therapeutic disclosures and in order for progress to ensue from the therapy; it was mentioned on numerous occasions by both PWLD and therapists. Use of systemic, multi-agency support was found to be very beneficial and enabled PWLD to experience greater empowerment than they may otherwise have done if working with a single agency. It achieved this by being able to involve other professionals, work jointly and sign-post when needed to other services both within and outside of the NHS. The therapists also gave greater weight in their interviews to empowerment within the therapeutic relationship via attending in more detail to the development of this relationship and their associated concern for individual therapeutic needs. These factors superseded the use of specific therapeutic approaches in importance, although these were still mentioned and clearly important to the therapeutic work.

Super-ordinate Theme 3: Coping & Adaptations, was again a key theme to emerge and mentioned by the therapists and support workers in terms of encouraging empowerment for their clients with learning disabilities. This theme is linked to the others due to the necessity for therapeutic treatment plans, formulations and processes to be adapted for PWLD (sub-theme 3.2), which includes the materials used; the structure, organisation and logistics of sessions; the language and pace of the interactions and many other additional considerations which may not be so pertinent to non-LD clients. By paying attention to individual needs and applying reasonable adjustments, facilitators of psychological therapy found that they were more able to have successful results and improved therapeutic outcomes, addressing the clients' presenting problems and therapy referral issues.

As a result of applying the above adaptations, taking into consideration the importance of social inequalities, the existence of stigma and societal values, as well as by building rapport and developing trust in the therapeutic relationship, the therapists and support workers found that PWLD were more likely to experience positive, empowering outcomes from the therapy (sub-theme 4.1), as explored in *Super-ordinate Theme 4: Positive Outcomes.* All the facilitating participants referred to improvements in the PWLD they were working with, as well as the professional satisfaction and personal sense of fulfilment and contribution that they experienced in their work as a result of seeing their clients overcoming problems, displaying improved mood and psychological wellbeing, making positive life-changes and increased resilience.

An interesting sub-theme was that the way therapy was approached can cause empowerment to be experienced in differing ways: whether the therapist focussed more upon the relationship (as with Therapist Penny's Person-Centred counselling approach, which Client Abbey found very supportive and encouraging in helping her to make changes), or when the therapist used a more problem-solving approach to specific issues (such as Therapist Nichole's use of CBT for targeting Client Jacky's negative and automatic thoughts, enabling her to develop greater self-control over the internal voices she was hearing and allowing her to practice more assertive communication with her family), influenced the way that empowerment manifested.

5.1.3 Does choice of therapeutic approaches & methods influence or facilitate positive outcomes & empowerment in people with learning disabilities?

In terms of the research question regarding whether choice of therapeutic approaches and methods influences or facilitates positive outcomes and empowerment in PWLD, this was answered most succinctly in *Super-ordinate Theme 2: Building Relationships, Collaboration & Trust* and *Super-ordinate Theme 4: Positive Outcomes.* As described, it was evident that the therapeutic relationship was viewed as more important than the type of therapeutic approach used (sub-theme 2.3), but it was also found that the kind of therapeutic approach used affected the type of empowering outcome, as described above (sub-theme 4.2).

Super-ordinate Theme 1: Values, Stigma & Social Equity, included facilitators' awareness of social values and inequalities, which sometimes was implicated in their choice of therapeutic approach used or strategies proposed at key points of the therapy, to deliver the most empowering, effective results. Similarly, *Super-ordinate Theme 3: Coping & Adaptations,* links directly to choice of approach and methods, since some of the adaptations involved related to considerations about how therapeutic material was presented for PWLD, such as those who could not read or write, or those who needed simplified visual information to support their cognitive understanding. As outlined in Chapter 3, all the clients involved in this particular research only had a mild learning disability, so the adaptations required may not have been as great as if the PWLD had had more severe learning disabilities.

In summary, bringing this section back to the lived experiences of the stakeholder groups, what was most important to the PWLD interviewed, was being able to feel safe, heard, understood; able to express themselves easily to their therapist or support worker without negative judgement; to feel valued, happier and able to make positive changes in their lives, both emotionally and in physically evident ways. Their support workers indicated that making a noticeable, practical contribution to helping improve the lives of PWLD was important;

working effectively alongside the therapist and other services involved and being adaptive and responsive to the particular needs of their clients. In terms of the therapists interviewed, their views about the therapeutic alliance showed that an understanding and sensitivity to the unique, individual needs of PWLD was vital; as was the importance of professional ethics, maintaining professional boundaries, whilst allowing a safe space for clients to develop a therapeutic rapport and feel PWLD could trust them enough to open up and disclose previously unspoken or painful memories, which they could then work through successfully together.

In terms of the optimum amount of support, linked to the therapeutic relationship and workers involved, it was clear that multi-agency working, and clear communication was generally helpful, effective and well-utilised by the therapists and support workers working with PWLD. Some therapists spoke about problems that can occur when there is a lack of support (or funding) and there may also be times when MDT working is not necessarily the preferred mode, such as when a client does not want or need confidential information sharing with other members of staff and counselling input is sufficient to help them and facilitate empowerment.

5.2 Relation of findings to previous literature

As outlined in Chapter 2, previous research by Jones (2013) identified various gaps and issues which were felt to be sparsely examined in the existing literature in the area of therapy with PWLD. The researcher addressed some of the limitations highlighted in Jones' (2013) study by focusing upon the views of PWLD with whom therapeutic relationships are established (as well as the support workers or carers). The present research supported some of Jones' recommendations regarding therapists needing to facilitate reassurance and having the necessary skills for successful therapeutic approaches. This was also found in all

the triads in the current research, with facilitators stressing the importance of trust and rapport in order to develop the therapeutic relationship. The need for adaptations in the therapy was also a shared key finding in both studies. As in Jones' study, a significant volume and richness of data emerged from the present research, which necessitated making decisions about prioritising the organisation of information.
Jones reported the therapeutic relationship to be fundamental yet difficult, due to various factors including the client's experience in previous relationships and the need for multiple relationships in their lives, to help support them. This was found in most of the triad groups interviewed in the present study, although a warning also arose regarding the possibility of oversharing of information and the importance of maintaining a truly confidential approach when possible, in line with the ethos of counselling psychology. Jones also found that therapeutic approaches needed to be collaborative, which was again found to be significant in the present research, as one of the crucial therapeutic relationship factors and sub-themes (sub-theme 2.2). In the present research as outlined in this thesis, the fundamentality of the therapeutic relationship reported by Jones was expanded, in terms of the critical elements of building relationships, collaboration and trust.

Jones specified a need for further research into the therapeutic relationship between counselling psychologists and PWLD and the important, valuable contribution that PWLD themselves can make to research concerning the therapeutic relationship – this present research met this gap, by including PWLD as one of the three key participating stakeholders in the study.

Research gaps which had been identified by Lewis, Lewis and Davies (2016) about the experience of psychological therapy by PWLD were also addressed, as it had been suggested that it may be useful to conduct interviews or focus groups with staff/families/professionals, to explore their perspectives on the outcomes of psychological therapy for service users with LD and to explore what they consider as possibly helpful or unhelpful. This was achieved in the present research, using the triads described earlier in this thesis, which also helped with validating the findings and in strengthening the methodological vigour, via triangulation of three sets of participant data, from the three separate stakeholders involved.

In terms of the context of the models and definitions of empowerment that were described in section 2.7, the findings in this study did appear to fit with Oladipo’s (2009) broad definition of empowerment being an enabling process, as all of the PWLD interviewed reported having been able to exert some form of increased control of their lives and the environment or people around them. Some also stated that they had been able to achieve self-defined goals since embarking upon their psychological therapy sessions (such as Sid, who had been able to attend his voluntary work placement more regularly and pass a chain saw course, as well as starting new martial arts classes and becoming reunited with his daughter).

Compared to other relevant studies outlined in section 2.7, such as Cattaneo and Chapman’s (2010) model of personal empowerment, both the subjective and physical evidence of empowerment (creating an impact upon relationships and one’s social surroundings) that they proposed as important in their model, were found in the present study. For example, all the participants in Triad #3 agreed that there had been systemic benefits for others in addition to the client Edward himself, as a result of the therapy. Neil in Triad #5 did query to what extent therapy could change his neighbours, but he had nevertheless been able to acknowledge that he was better able to cope with life, even if some elements had become more difficult subsequently.

Cattaneo and Chapman (2010) also referred to their model of empowerment as being a dynamic process, rather than a linear drive towards stronger feelings of internal power, whereby individuals take action towards a meaningful goal, observe and reflect upon the impact of their actions – this was found in the present research findings, as most of the

PWLD were quite clear about what they wanted to achieve from the therapy and able to articulate their experience of the process. This also fits with Zimmerman's (1995) definition relating to the importance of reaching self-defined goals. Jacky in Triad #2 had started to learn how to say 'No' to her family in order to avoid financial exploitation. Several service-user participants (including Jacky and Abbey in Triads 2 and 4) and their facilitators described improvements resulting from travel training and support around independent living skills, because of both the therapy sessions and the practical support provided by their support workers. Cattaneo and Chapman's six step model for attaining personal empowerment included the suggestion that the more meaningful one's social influence, the more empowerment would be felt; this was also evident here, for example, in Edward's description of his charity work and engaging in volunteering to deliver aid during a trip to Africa, where he experienced a personal sense of empowerment and the effects of his actions upon other people.

The findings in this present study detailed the process-orientated elements and described the practical issues involved, relating to empowerment specifically facilitated by the therapeutic relationship (and support worker contributions), whereas some of the models of empowerment described in section 2.7 (including Cattaneo & Chapman's (2010) personal empowerment; community and patient empowerment; and empowerment in the research context) focused more on describing the positive effects of personal empowerment more generally. Oladipo's (2008) Psychological Empowerment Model however does include the idea that any economic and or social empowerment of the masses may not be possible without psychological empowerment (PE). This may be seen in the present research in the example of Sid in Triad #1, who as a PWLD, experienced financial limitations impacting upon his personal experience of empowerment; conversely, as his PE was positively affected by the therapy and resulting life changes, Sid's social and potentially even economic forms of empowerment were also favourably implicated. Whilst Super-ordinate Theme 4 refers to the Positive Outcomes that took place as a result of the therapeutic relationship and therapy sessions, the other three main themes provide additional detail regarding the processes involved that facilitate and can be routes towards empowerment, which constitute a useful addition to the wider research literature available.

The present findings fit within the context of the previous literature in the area of stigma research and other findings concerning experience of social exclusion, rejection and negative personal experiences causing a reduction in psychological wellbeing in PWLD (Rutter, 2005). One such example was the degree of social anxiety felt by the client Jacky and her mistrust of people in general and some agency-employed support workers specifically. In terms of the importance societally for a fairer allocation of resources, this research also supported Kagan’s (2002) emphasis on the importance of equity for PWLD (Section 2.6).

In terms of social justice research and the greater prevalence of inequalities in the lives of PWLD, as mentioned in Section 2.5.2 regarding the social model of disability, Slorach (2016) and Thompson (2017) referred to the economic difficulties of disabled people, which was mentioned in the present research in three out of five of the triad groups interviewed (in terms of having a lack of money or experiencing financial exploitation). Similarly, Shakespeare’s (2013) advocation of a pluralist, nuanced approach to disability was supported in the present research findings in terms of a multitude of different, systemic factors being mentioned by the participants as explanations for the difficulties experienced by PWLD, causing them to be referred for psychological therapeutic support (including social, behavioural, psychological/emotional contributing factors). The phenomenological framework underpinning the current research was considered appropriate as using an interactionist view allowed the voices of each of the three stakeholder groups to be heard.

5.3 Strengths & Limitations of the study

Upon entering the data analysis stage, the researcher found that choices had to be made about what to include and exclude in this project, as space did not allow an exhaustive inclusion of all significant themes mentioned by the participants. It was clear that there were additional themes and information contained within the interview transcripts and from the IPA analysis that were not mentioned as extensively, or for which there was not sufficient data and so coupled with the thesis space limitation, were not reported or explored. Nevertheless, the researcher became aware of more integral important strengths and limitations in the study, which are discussed in this section.

One key area of strength included the present study's contribution to knowledge regarding the impact of therapy and building of the therapeutic alliance with PWLD in counselling psychology. It has also added to knowledge regarding important elements of the therapeutic experience for PWLD and which factors facilitate empowerment both within and outside of the therapeutic encounter. This research is also, to the knowledge of the author, the first to explore empowerment specifically in the area of therapy and the therapeutic relationship with PWLD.

The inclusion of three separate stakeholders in this research offers something new, relevant to each group and to services providing support services for PWLD and is a novel element and a significant strength of this study. By triangulating that with the perspectives of their support workers and therapists, it also provides a more complete picture of the lived experience of therapy and highlights the contrasting perspectives in the therapeutic process. However, in many services offering therapeutic support for PWLD, there are other people also involved, including SALT and various related MDT professionals. It may have been interesting and insightful to gather more information to include these other professionals also; this would be a beneficial direction for future research work.

As mentioned in Chapter 3, all participants were obtained from the same service, using a purposive convenience sample. The researcher had initially discussed the proposed study in departmental team meetings, with other psychological therapists, in order to recruit willing participants. This was nevertheless still thought to fit with IPA, because of the individual nature of each participant and their responses to the questions asked. It also met a homogeneity requirement of IPA. However, having prior knowledge of the therapists and support workers could feasibly have affected the accounts provided and hence the findings from the data collected. The insider status of the researcher may also have influenced the interpretations made due to prior service knowledge. The researcher however had no specific prior experience or contact with any of the PWLD involved and so responses may not have been very different had a completely unknown interviewer been involved.

Capacity to consent to participating in the research was mentioned in section 3.4.3; participants were questioned on several occasions about their understanding of the research project and their wishes regarding continued involvement with the research before and after being interviewed, whilst reviewing their transcripts on other possible occasions via their therapist and the researcher. However, the use of a specific tool to assess capacity to consent within this particular context may have provided additional support, such as suggested by Hamilton et al.'s (2017) study, which is a useful example in the process of assessing mental capacity for research. Fifteen respondents (71%) gave specific suggestions: seven (33%) suggested supported decision-making/decision aids; four (19%) suggested visual aids; four (19%) suggested reconfirming consent at the end of data collection; three (14%) suggested including family/supporter/informants; and three (14%)

specifically suggested “person-centred options.” Future research could therefore beneficially include such processes when considering capacity to consent in related research.

A lack of negative comments about the therapy by all groups of participants could also suggest a possible desire to please researcher, with a reluctance to express criticism despite assurances of confidentiality. As the researcher was part of the same service, with most clients still being engaged in therapy and valuing the support, this could have created additional reasons for not wishing to say anything critical. Future researchers could repeat this work with participants from outside their service, to reduce the likelihood of social desirability bias in future research.

The Reflexivity section (Appendix B) mentions the researcher’s position regarding her beliefs about the usefulness and importance of therapy, which may have influenced the participants’ responses and her interpretations. It could be argued that the fact that the LD participants rarely mentioned or were reluctant to talk about negative or critical aspects of the therapy received, supports the evidence obtained regarding the value they placed upon the therapy and the therapeutic relationship. Similarly, although all participants were able to consent for themselves in terms of taking part in the research and had been given the option of having an Advocate present during their interviews, only one chose to be accompanied by family members, his support worker and psychological therapist in the interview, which could potentially have affected his account and disclosure during the interview. The participant expressed gratitude towards his helpers who were present, but had requested their involvement, which had also been the case during all his therapy sessions.

This is not unique to the LD client population, as other researchers have also found non-LD clients are more likely to speak in positive terms about their therapy despite aspects that may have been less than satisfactory (Manthei, 2007). This suggests that clients may be tolerant of their therapist being less than perfect (an actual topic of discussion between

Client 1 Sid and Therapist 1 Eve in this study), whilst also being of benefit to the therapists and the process involved, by being aware of such perceptive abilities within the client.

One particular methodological limitation considered by the researcher was that triad ideographic accounts instead of ideographic accounts for each individual participant were ultimately presented in the thesis, therefore it could perhaps be questioned if IPA was the best fit? A more thematic analytic approach might instead have helped more with cross-case comparisons? However, the experiences of the stakeholders were foremost in the mind of the researcher when she embarked on this study and useful information was nevertheless gained regarding what is important for PWLD and empowerment from therapy.

One of the participants from the PWLD group (Client 5, Neil) emerged to not meet the service (or participant) criteria, as an IQ testing conducted after the interview showed he did not have a learning disability, although he did have ASD, PDA and OCD (see Appendix A), which caused him to experience mental health difficulties and additional support needs and hence originally justified the therapist's decision to include him on her caseload – he accessed the service for two years. All other participants had mild learning disabilities, which brings into question the initial recruitment and selection phase of the study and whether changes were needed for the recruitment criteria, as this may have impacted upon the homogeneity of the sample? It would therefore be recommended that future research use stricter criteria. Inclusion of this participant could be considered a criticism and a violation of the homogeneity assumption, but as the researcher had not known this prior to collecting the data, it was felt that his contribution would not have been honoured and the interesting insights gleaned from his account, if he had been excluded. Interestingly, there was much commonality between Neil's ideographic account and that of the other participants.

Following from this, a strength and limitation of the study in terms of the participant samples used, related to the use of a relatively small homogenous sample for each of the groups interviewed. Homogeneity is typically an important criterion for good quality IPA research. The three different participant samples were considered homogeneous and representative in terms of meeting job description roles and service user eligibility, but as only five participants from each group were included in the study, it would be difficult to generalise the findings to other members of the same group (for example, other PWLD accessing other services and living in other parts of the UK may have very different experiences and therefore accounts, to those collected and presented for the purposes of this research). However, the researcher endeavoured to include sufficient background information about the participants to enable transferability of the findings and the small sample was considered to also be a strength, because of the amount of detail and quantity of rich information that was available to the researcher as a result of interviewing a small number of participants from each group.

A lack of homogeneity also existed regarding differences in number of therapy sessions attended, the mode of therapy, personal characteristics, as well as the presenting problems, and only four out of five participants met the inclusion criteria of having a ‘significant’ degree of learning disability, though all accessed the LD service as a result of mental health support needs. However, the Royal College of Psychiatrists (2004) has mentioned the idiosyncratic nature of services providing psychotherapeutic support to this population (in terms of a lack of homogeneity reflecting the range of skilled practitioners, range of problems and diversity of people). The sample therefore was arguably representative of this and homogeneous in so far as it was all people with developmental disabilities utilising learning disability services for mental health support.

The recruitment of participants was both a strength as well as a limitation within this study, as the sample was convenient to access and easily obtained due to the researcher herself being employed by the CLDT being researched, so it was not difficult to access any of the three groups of participants. However, it could be argued that such a convenient sample may be less representative, and the data more easily skewed in the direction of the researcher's interests and by the therapists involved, to only select particular clients with positive outcomes that would reflect well upon their practice. This could result in a somewhat biased sample, with those clients having had more negative experiences not being approached or selected. The researcher was mindful of this during recruitment and balanced the pressures of recruitment with this limitation. To explore empowerment experiences the researcher had to increase the likelihood that participants had potentially been empowered.

It was possible to slightly adapt each participants group's interview schedule, although each of the three sets of interview questions did cover similar general areas. This was necessary primarily due to the differing level of cognitive functioning and individual needs of the service-user participant group, who required a simpler, more easily understood language in their questions. Communication mats had been offered at the onset of the interviews, but none of the service-users requested this additional communication aid. Or perhaps the researcher was being sensitive to their feelings by not making assumptions regarding their abilities and level of understanding (the possibility was available if they wanted it). The possibility of using an advocate was also mentioned at the start of the interviews, this perhaps this goes some way to mirroring the empowerment process within the interviews themselves, in that the researcher respected the clients' wishes and encouraged their opinions.

As mentioned in section 3.3.2, despite there being two short interviews, they were succinct and provided a wealth of information. The variations were attributed to differing personality and communication styles of the participants involved, as despite further prompting, limited responses were obtained from some participants – this was particularly noticeable in two of the support workers. Smith, Flowers and Larkin (2009) refer to the importance in IPA of 'going deeper' and 'exposing the obvious within an interview': therefore, additional probing questions may have been beneficial where individual responses and opinions were being sought from less talkative respondents. Nevertheless the researcher also felt the need to respect the decision of participants when they indicated that their account was complete, which these two participants did.

Lastly a challenge was making the word empowerment understandable to all participants; future research could give more concrete examples, but the research nevertheless offered participants with learning disabilities the chance to outline which aspects of therapy they found useful and by triangulating this with the views of the two other stakeholders who were better able to articulate their thoughts about what this meant to them – synergies between the three groups could be gleaned, with the therapist and supporter working as a conduit into the perspectives of PWLD on empowerment.

5.4 Implications for Research, Practice & Stakeholder Groups

5.4.1 Implications for people with learning disabilities

Although it may not be possible to categorically determine whether the particular therapeutic model used, or the qualities of the therapist, affected the outcome or the positive experiences of the therapy, the study nevertheless showed that PWLD can meaningfully engage with therapy and experience satisfaction from it, facilitated by appropriate supports, including adaptations of resources and structure of therapy sessions. The empirical data from this research indicated that PWLD benefit from feeling comfortable, valued and trusting of their therapists, in order to be able to disclose information that they may find difficult to talk about.

In terms of measuring or exploring the empowerment for people with more severe learning disabilities, this brings into question how to measure this appropriately and effectively and how to obtain such information (see Section 5.4.4 below). It may be necessary to use different methods and make greater use of other MDT professionals and independent advocates. Implications emerged about what therapists and support workers should aim to achieve in therapy from the lived experience and how this feeds into empowerment for PWLD, including providing greater flexibility around session organisation and pre-therapy input. There would be a greater challenge in exploring empowerment in people with more severe learning disabilities.

Section 5.4.7 below discusses social equity from the perspective of counselling psychologists, but from the point of view of PWLD who were interviewed, the findings showed that research around stigma and social justice is still very much needed (as mentioned in Chapter 2 by Parritt, 2016). For example, clients Edward and Sid’s descriptions of experiencing bullying, Jacky’s feelings about being judged by agency workers and Neil not wanting to access an NHS LD establishment, showed that they had experienced and were all uncomfortable with and aware of the effects of labelling upon themselves personally.

5.4.2 Implications for Support Workers

Previous research has shown that support networks have a significant impact upon the lives of PWLD and play a central role in their lives (Dagnan & Waring, 2004). Contact with staff members such as support workers is valuable on a day-to-day level and also has been found to be helpful in terms of supporting the role of the therapeutic process or specific therapy goals collaboratively worked upon by the client, therapist and support worker. (Brown & Marshall, 2006). Rose, Loftus, Flint and Carey (2005) found when exploring factors associated with the efficacy of a group intervention for anger in PWLD, that reductions in provocation inventory scores immediately after group attendance, were more likely to occur when participants were accompanied by a member of staff who knew them (as well as if they had higher scores on a test of receptive vocabulary). Rose et al. (2005) also found there to be benefits of maintenance and generalisation of therapeutic gains, made more possible with the presence of a trusted support worker. The present research concurred with these claims, as the participants with learning disabilities frequently expressed gratitude for their support workers and others who helped them. The other participants involved in facilitating the therapy also spoke about the importance of various forms of support for PWLD. A systemic approach within services and good communication between all involved in the care of PWLD appears important in terms of empowerment, as their experience very often is rather that of disempowerment and as referred to in Chapter 2, attempts to challenge such systems are often still met instead by attempts to pathologise ‘challenging’ behaviours in PWLD (Goble, 1999).

Relationships with staff members including support workers is often short-lived but still emotionally invested in by the PWLD, as this present research also found (such as client 2 Jacky asking to see support worker 2 Malcolm again, despite him being male, which usually was a deterrent for her). Evidence points to the importance of such relationships (Royal College of Psychiatrists, 2004), so this has implications for the people working as support workers, including training, career progression, adequate pay and pre assessment for the role.

Feeling heard and valued was clearly important to the clients with learning disabilities in this study, which is supported by other research where an association has been found between not feeling heard and having the label of having a learning disability (Brooks & Davis, 2007). Having the space provided within therapy sessions to be able to talk more freely was also an important element referred to by some participants in this study and supported by other research (MacDonald, Sinason & Hollins, 2003). The value of support workers helping to continue and develop some of the therapeutic goals and work from the therapeutic sessions is an area that would benefit from further focus and examination.

The support workers in this particular research appeared to be very well-liked, having good relationships with the PWLD that they supported (in different capacities) – this contrasts with some research which has suggested that it is not just the PWLD that have difficulty or frustration with communication (Hodges, 2003), as care staff may also find it difficult or even painful to fully engage with the expressed life experience of the people they support, causing them to not hear or listen. This distancing has been termed 'emotional immunity', particularly to behaviours that staff find challenging and may be a form of self-protection from emotional overload (Whittington & Burns, 2005). This again highlights the need for specialist therapeutic support and MDT training for all staff involved, although how possible additional specialist help is in the current economic/political climate is debateable.

5.4.3 Implications for Psychological Therapists

An emphasis on the therapeutic relationship continues to be important and has long been considered as crucial to successful therapy, especially within counselling psychology (Clarkson, 2003; Lambert & Barley, 2001). This element is lent further credibility considering that clients themselves identify this as so important to them and as standing out from their therapy sessions, (as has been found in this study). Working relationally with clients with learning disabilities is clearly important, whilst bringing additional challenges, as has been described. The therapists interviewed in this study showed agreement with the findings from Shankland and Dagnan's (2013) study mentioned in Chapter 2, as they clearly also believed that psychological therapy can be successfully provided for PWLD, with positive experiences having been reported by both parties. Similarly, Brown et al.'s (2011) findings were here reflected in the life-enhancing affect of using modified psychological therapies for PWLD and Willner's (2005c) study showed the importance of an empowering focus on relapse prevention strategies (rather than cure), which was implemented by therapist Tim in his longer-term work with Edward.

Empowerment in the research context as delivered by psychological therapists was highlighted as important in Chapter 2 by Statham and Beail (2018), who emphasised the need for clearly identified goals before starting therapy sessions. Statham and Beail also showed how feasible it is to carry out research with PWLD (using thematic analysis and transcribed interviews in this example), showing that qualitative methods and a participatory paradigm can be very helpful in developing interview questions, conducting interviews and even in the analysis stage of research. This fits with the qualitative interview approach taken in this study and suggests that an even greater amount of participant involvement in research relating to PWLD can be very fruitful.

Some PWLD described being able to talk more freely with their therapist than they had found possible in the past – in terms of less judgement and greater acceptance, than talking to some members of staff and others in their social support network. Suggestions have been made in previous research that the therapeutic relationship is even more important in complex and longer-term difficulties (Sanders & Willis, 2005). These aspects have also been found reported with non-LD clients (Carey, Carey, Stalker et al., 2007), but this current research highlights the importance of specialism and training on the part of the therapists, as the clients and support workers described them being different to generic or non-LD specialised therapists (not being ‘patronising’ and feeling understood was mentioned several times). Other studies also reporting on the importance of PWLD not feeling patronised and feeling listened to and understood include those of Pert et al. (2013) and Stenfert Kroese et al. (2016).

The fact that the therapists were perceived and experienced as sources of help and support engendered with trust, allowed clients to be more open and honest (this was supported by the support workers as well as the clients). This aspect of the therapeutic relationship could be seen as particularly important since PWLD often experience unequal or highly dependent relationships with others. Therefore, this is important for therapists to be aware of and considered during and after initial training. Adaptations which can assist the therapeutic process may include setting an agenda, guided discovery and cognitive mediation for example) – in order to reduce the tendency towards acquiescence, of this client group in therapy (Jahoda, Selkirk, Trowser, Pert, Srenfert-Kroese, & Dagnan, et al., 2009). A referral-specific structured focus to therapy programmes was also found to be helpful in facilitating empowerment in the present research. Jahoda et al. (2009) also found it important to consider the interpersonal context of therapy, in order to ensure effective work within sessions; they mentioned the importance of collaborative work with family members as well as support workers. This finding was reflected in the current research in client Edward for example, who wanted his parents to be included in all of his therapy sessions, or client Abbey, who sometimes included her husband and carer Kevin in the sessions.

5.4.4 Theoretical Implications

As noted in Chapter 2, Cyril, Smith and Renzaho's (2015) systematic review of empowerment measures in health promotion, described the psychometric qualities of quantitative scales used in measuring empowerment in health promotion settings and gaps in the measurement of various domains of empowerment using these. The current research findings concurred with the diversity found in the concept of empowerment, as psychological, social, economic, organisational, political and community contexts were all encountered and referred to by the fifteen participants involved. Cyril et al.'s scales failed to adequately measure the community and organisational domains however, which are arguably equally important for the achievement of health programme outcomes. These scales would therefore likely need adaptation to make them adequate in coverage and suitable for use with PWLD, in all domains of empowerment being measured. As this relates to the present research, it would have been interesting to use a specific empowerment scale to measure changes before and after the therapy sessions, in the participants with learning disabilities, as well as further consideration of concrete examples of empowerment which could be better communicated to and understood by PWLD.

In terms of how this current research can inform such scales, the findings indicate firstly, that psychological empowerment was the priority here and was the main form of empowerment being investigated; this only represents one dimension of empowerment however, so future research could perhaps beneficially focus more upon the social and political elements involved, which were also mentioned to a lesser degree. The 20 scales examining empowerment measures that were reviewed by Cyril, Smith and Renzaho (2015) looked at domains ranging from personal competence, group orientation, self-determination and positive identity (Brookings & Bolton, 2000), emotional empowerment, inner peace, self-capacity, functional empowerment, healing and connection (Haswell et al., 2010), to self-esteem self-efficacy, power-powerlessness, community activism, optimism and control over the future and righteous anger (Rogers et al., 2010) and intention, participation, motivation, critical awareness (Kasmel et al., 2011).

Section 4.2 outlines the participant conceptualisations of empowerment that were highlighted as important in this study and include some of the above domains, such as those relating to self-esteem, self-determination, choice and control, functional empowerment in terms of making practical life changes (from moving into own flat, to learning to travel independently and communicate their wishes more effectively). The definition of empowerment used in section 1.2.1, as well as Table 4.2 (Participant Conceptualisations of Empowerment) could be helpful in informing such domains for subsequent or future measures of empowerment.

Secondly, the findings (although focusing upon personal or psychological empowerment, as opposed to community and patient empowerment, for example), highlight that when measuring empowerment, as suggested by Cyril et al. (2015), mixed methods may be helpful to enable adequate measurement of empowerment across a variety of domains.

Obtaining information that is meaningful and accessible to the PWLD involved in such research is clearly essential. Use of adapted resources and materials, as well as a variety of formats appears important (symbols and pictures were included in both the therapeutic sessions carried out by therapists and the research materials included in this present study – e.g. the adapted version of the Information Sheet in Appendix H). Further use could be made of ‘talking mats’ and other visual and multi-sensory information-presentation formats (similar to the Easy-Read versions of leaflets suggested by Ward & Townsley (2005), in section 2.7.2). Several of the client participants in the present study found such information and resources important throughout their therapy sessions, including Sid in Triad #1, who could not read so benefitted from the use of pictorial aids (e.g. the ‘compassionate owl’ that his therapist Eve helped develop) and Edward in Triad #3, who mentioned the adapted smiley face chart he had created alongside his therapist Tim.

Particular implications in terms of social justice research and social equity have been mentioned from the perspective of PWLD and also in Section 5.4.7 below, regarding this study and the area of empowerment for PWLD via therapy. Section 2.2 also referred to some of the reasons for the greater prevalence of psychological problems and well as other life challenges and resulting feelings of disempowerment in PWLD, which result from power imbalances, stigma and social inequalities. This can cause reduced well-being, feelings of alienation (Swain, 2012) frustration and rejection, which the present research identified in some of the PWLD interviewed, such as the client Edward who spoke about work-place bullying and being paid less than people without learning disabilities. This was also raised in Section 2.2 by previous researchers and policy-makers, having been shown to be greater in the population of PWLD, resulting in greater need for psychological support (NICE, 2018).

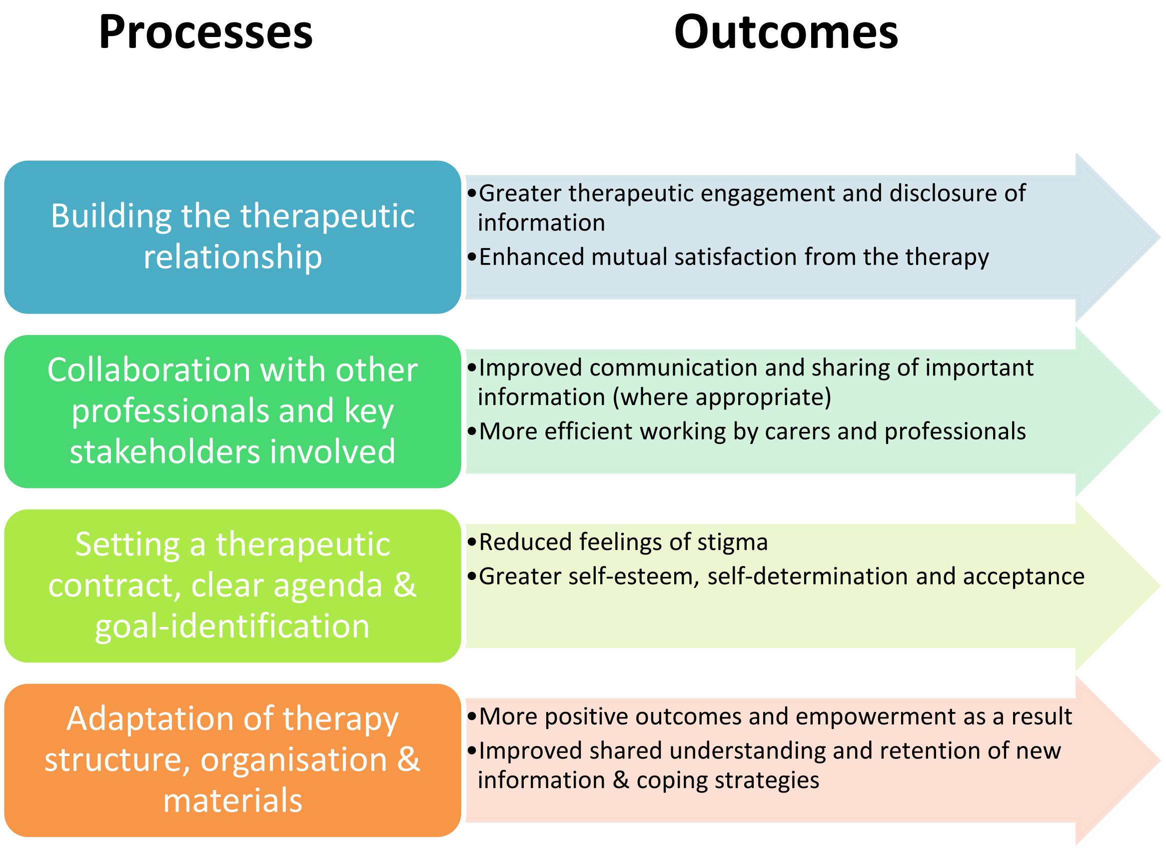
Theoretical implications relating to definitions of empowerment and the therapeutic relationship include alignment with Zimmerman’s (1995) reference to enabling people to act on their own in order to reach their self-defined goals: the findings in the present study were in agreement with this theoretical stance, such as client Abbey's personally set relationship and communication goals and progress for example, or client Sid's feelings of empowerment and goal-attainment as a result of therapist Eve's presence and the therapeutic relationship involved. The Latin root 'passe' mentioned by Zimmerman (equating to power and freedom) was very relevant for most of the participants interviewed based on their accounts. Similarly, Zimmerman's (1995) personal, psychological empowerment arguably dominated this present research, as most referred to their direct personal experience of the PWLDs: for example, client Jacky becoming more assertive, more able to travel independently and engaging in less self-harming behaviours.

Cattaneo and Chapman's (2010) model of empowerment which focused on actual, physical evidence that empowerment has created an impact upon the person, their relationships and social surroundings, was also directly relevant to the findings in the current study, as it was not just the subjective feelings of being empowered, but increased social influence that was seen and reported by various participants. An example of this can be seen in Triad 3, where client Edward's support staff and others involved all experienced the positive impact resulting from his therapeutic sessions, as well as Edward himself. This links to the use of empowerment measurement tools mentioned earlier. Cattaneo and Chapman also mentioned the importance of empowerment being a dynamic process, meaningfully goal-orientated: their six steps could perhaps be usefully included in future similar interview questions, or the importance of each step of their model measured in turn.

Oladipo (2008) argued that any economic or social empowerment of the masses may not be possible without psychological empowerment (PE) and linked this to Maslow's (1943) Hierarchy of Needs model. This study included the example of client Edward, whose personal processes affected his interaction more widely and created a greater social impact with others, but the PE came before the additional benefits.

Figure 1 below is visual representation of empowerment processes which can occur via the therapeutic process derived from the accounts and findings in this present study.

Figure 1: Diagram showing an elaboration of how we theoretically understand empowerment via the therapeutic process, from the perspective of PWLD & other related stakeholders



5.4.5 Methodological Implications

As previously described, the IPA methodology in this research was adapted following suggestions from Smith et al. (2009). Several studies examining the experience of the therapeutic process have successfully used this approach with PWLD (MacDonald et al., 2003; Merriman & Beail 2009; Pert et al., 2013). In a review of previous IPA studies, Smith et al., (2011) found that there are certain standards that could affect the credibility of the method (IPA). These include describing a research paper as ‘good’ if it contains sufficient focus upon certain topics; as this research relates to empowerment facilitated by the therapeutic relationship, the question of whether the interviews allowed sufficient focus upon these issues could be asked. However, due to the length of time allowed for each interview, it was thought that this would provide the participants with sufficient time to explore empowerment and elaborate upon this key area.

Since the interviews were semi-structured in nature, it was possible for the researcher to make prompts and follow-up any responses further to elicit more information, so this standard highlighted by Smith could be argued as having been addressed. Nevertheless, it could also be argued that additional, more specific questions relating to empowerment and the therapeutic relationship could have been asked of each participant. According to Smith’s guidelines, this research could perhaps have been improved by focusing upon just one of these topics in further detail. Different researchers may have made different choices, which is all part of the IPA approach, with idiographic interpretations and importance attached by the particular investigator doing the research (which varies from person to person).

An interpretivist approach (Smith et al., 2009) was moreover taken - as opposed to using a more positivist ‘scientific method’ - since the researcher was aiming for a more subjective exploration of the participants’ own experiences, rather than striving for neutrality and objectivity in the data collection and analysis. In addition, Smith and Osborn (2003) argue that IPA offers theoretical, as opposed to empirical, generalisability, whereby readers can create their own links between the findings, their own experiences and the literature. The phenomenological approach taken was important for including and recognising the point of view of PWLD, as advocated by Shakespeare (2013) in chapter 2, hence the use of IPA. This most closely aligned to the intended position within this research, where PWLD’s voices could be prized and all stakeholder participant experiences included.

However, the researcher considered that in future it may be useful to combine both Framework Analysis (FA) and IPA, as had been originally considered, (since there is considerable overlap and room for both: for example, in the higher number of participants than average for IPA studies and therefore the suitability for developing themes in FA). As mentioned in section 3.1.1, it may have been useful to have had a first stage of analysis via thematic framework analysis, to inform, followed by a second stage using IPA. Nevertheless, the researcher wanted to focus on and prioritise individual perception and experiences, which arguably this study has successfully achieved. Additional research around the social processes involved and underpinning the experiences, via FA or Grounded Theory would be useful as part of future research endeavours.

In terms of outcome and evidence measures, although not a major theme discussed within this research, this is a useful topic for psychological therapists. The therapists involved in this case did not use standardised protocols, but before and after measures were mentioned by some (by the two counselling psychologists, Eve, who used the Glasgow Depression Scale at the start and towards the end of her therapy sessions with Sid to highlight improvements in his mood, as well as SUDs scales used effectively by Nichole (Subjective Units of Distress) during different phases of the therapy with Jacky, to monitor how she was feeling and review her progress. This links to implications regarding therapeutic practitioners' use of qualitative vs quantitative approaches in their therapy work and research with PWLD, which would also be an interesting area for further research.

5.4.6 Practice and Policy Implications

The present study has implications for a wide range of multi-disciplinary professionals involved in helping relationships (as also referred to by Jones, 2013) as well as for theory, service provision, service plans and training, which may aid the development of a greater therapeutic culture for PWLD.

In terms of the nature of therapeutic relationships, practice implications have been identified in previous research relating to a lack of experience (of emotional relationships in particular), on the part of PWLD (Emerson et al., 2001) and having to develop friendships with those employed to help them, due to limited opportunities for intimate relationships and a lack of social networks (Hodges, 2003). This was evident in the current research for example where one client Edward, was talking about his therapist Tim as being a good friend (although considerable progress had clearly been made in the therapeutic work); previous research has highlighted the likelihood of confusion in PWLD around interpersonal boundaries and in differentiating between roles of the therapist as a professional or a friend (Caine & Hatton, 1998). Therapists Nichole and Janice also spoke about the importance of clarity around therapeutic boundaries, tailored to the level of cognitive understanding of the particular client: this is one area very relevant to practice implications.

A further practice implication linked to difficulties regarding the therapeutic relationship with PWLD relates to the importance of sufficient support and advocacy workers. This was highlighted by therapist Eve, who mentioned her efforts in trying to overcome this, speaking about the difficulties experienced by PWLD, feeling a need to remind her clients that their struggles were not due to them being at fault and suggesting the importance of advocacy and forms of support to encourage PWLD suitable learning opportunities to express themselves and communicate their feelings and needs. This also raised the issue of working sensitively around self-blame and choosing appropriate forms of therapy to help overcome this, which the CFA appeared helpful for in this example.

Linked to the above point, is the importance of building rapport and a good therapeutic relationship, between PWLD and their therapists or support workers. A trusting therapeutic relationship was clearly very important to all the client participants in this research, as discussed by themselves, their support workers and especially their psychological therapists.

This was essential in order to disclose information and sometimes a new experience for the PWLD. Sensitivity and empathy were again required on the part of the supporters in order to develop a good alliance, with a specialised understanding of the particular challenges faced by PWLD: again, suggesting the importance of thorough, specialised training. Several of the client participants referred to feeling understood by their therapist compared with previous, non-LD counsellors they had experienced, which was helpful in terms of successful outcomes.

In terms of policy implications from this research, the present findings could indicate some conflict with the IAPT agenda mentioned earlier in this thesis, as the degree of adaptations needed by PWLD to have successful therapy, discussed by the three stakeholder participants (particularly the facilitators of the therapeutic work), would appear to show that it is not always possible to fit therapy for PWLD into short blocks of sessions or standardised protocols. Indeed, additional flexibility, creativity and individualised programmes appeared to be required in all five triads explored. Despite this, there are many programmes being designed, trialled and delivered which do suggest that structured therapeutic programmes are being well-utilised by some services for PWLD in the UK (Shankland & Dagnan, 2013). In general, however, the needs of PWLD are such that greater adaptations are necessary than with mainstream psychotherapeutic services. The importance of Easy-Read and other forms of accessible information and reasonable adjustments as being helpful in facilitating empowerment was also referred to by all the therapists involved in this current study. A point previously raised by Ward and Townsley (2005) (more specifically in terms of community and patient empowerment, but equally relevant here).

Moreover, publications such as the government's White Paper '*Valuing People'* with its four key principles (civil rights, independence, choice and inclusion) have helped the situation for this group, as has other legislation, such as the Human Rights Act (1999), Disability Discrimination Act (1995) and The Equality Act (2010), in which disability was deemed a ‘protected characteristic’, applying equally to all PWLD. With a combination of legislative changes such as these and increasing societal awareness of and acceptance of the importance of psychological therapy for PWLD, it is likely to become more difficult to justify their lack or absence from psychotherapeutic services.

5.4.7 Implications for Counselling Psychology

The research findings in this thesis, in addition to previous related studies, suggest that having a constant critical eye and a reflective viewpoint, should arguably permeate the way that counselling psychologists’ approach all of their work (Orlans & Van Scoyoc, 2009). The findings also support the idea that for counselling psychology, social justice as a concept refers to people’s potential in the society in which they live and is a transferable concept which is meaningful in whichever place or country a person lives. This has been described as one of the dimensions of inter-nationalism (James, 2016) and an important focus for counselling psychologists as active participants in systems that can at times hinder clients’ ability to function (Toporek et al., 2006).

In terms of a social justice agenda within the discipline of counselling psychology, as outlined in Chapter 2, it is clearly important to consider that this generally focuses on equity or equality for individuals within society, involving access to a variety of different opportunities and resources, rights to self-determination and participation in decision-making; the importance of autonomy and freedom from oppression, and a balancing of power across society Cutts (2013). This research supports Cutts’ recommendations in terms of a need to consider what the adoption of a social justice perspective entails for UK counselling psychology: such as in the areas of training, NHS involvement (or other related services), involvement in private practice.

A social justice agenda can clearly be linked to the empowering outcomes discussed in this thesis, which in turn has implications in terms of how counselling psychologists can work differently and the direction in which this work takes the field. Non-discrimination has been described as being intrinsic to the beliefs and values of counselling psychology (James, 2016) which may necessitate greater proactivity and political engagement at times? As mentioned at the beginning of this thesis, counselling itself has been described as being a power and socio-political act (Katz, 1985), which also links back to the ‘call for action’ (Steffen & Hanley, 2013) described in Chapter 2, urging counselling psychologists to be more proactive in their work with disadvantaged groups, and supports the important ethical codes of conduct within counselling psychology, including principles such as beneficence and non-maleficence, as well as the importance of honouring and protecting clients’ needs: all of which the findings in this thesis are supportive of.

The present research also highlights the importance of exploring power inequalities in society (most participants mentioned stigma-related issues, as shown in Super-Ordinate Theme 1) and has contributed to responded to the ‘call for action’ such as the significant information provided by the PWLD, who are still a disadvantaged group in society. By obtaining their direct experiences, this research has been able to build upon mounting evidence regarding the positive contribution that psychological therapy can make to raising awareness and helping overcome some of the power inequalities present in society. This research has been very relevant and helpful in contributing to the data available regarding the therapeutic relationship.

In addition, as mentioned in Section 5.4.5, IPA as a research methodology appears compatible with the philosophy and ethos held within counselling psychology. An increasing number of research studies are effectively using IPA methodology with this population group to explore important elements of therapy and the lives of PWLD. Warnock (1987) referred to the fact that by focusing more closely on the individual, it takes us closer to the universal;

hence IPA can easily move from general statements about idiographic examples, at the same time as being able to retrieve information from specific participants when needed.

5.5 Recommendations & Suggestions for Further Research

In addition to suggestions included in previous sections of Chapter 5, Table 5.1 below highlights the researcher's main recommendations and suggestions for further research:

Table 5.1 Summary of key areas for future research

Recommendation for Further Research	Description of Key Recommendations
Specifics around the therapeutic relationship and facilitation of rapport	A further, detailed investigation of helping roles is recommended, around use of therapeutic relationship for therapy with PWLD, as the present research has been very broad and includes many areas – it would be useful to pick up on some of these and investigate in further depth (e.g. actual specifics: what brings about rapport? Body language? Questions? Smiling? Trustworthiness? Power relationship?)
The effect of choice of therapeutic approach	A useful area for further research would be to look in more detail at what difference different therapeutic approaches make, for PWLD. A more language-based approach may have focused on interesting use of language, metaphors, imagery (this detail still exists in the transcripts – which could result in a substantially different project or outcome).
The work that paid support staff carry would benefit from further examination	The quality of support work clearly affects the positive quality of life outcomes for PWLD This is still relatively overlooked as an area for research. Hastings (2010) suggests that the research in this area has been typically problem-orientated, rather than focusing on the way that staff speak about and perceive the relationships they have with their service-users. Therefore, a more theoretical or conceptual understanding of these roles and working relationships may be helpful.
Further exploration of the working therapeutic alliance is recommended for further study	A more detailed exploration of the working alliance and person-to-person aspects of the therapeutic relationship could beneficially be looked at, in greater detail.
Exploration of transference & counter-transference in therapy with PWLD	Further investigation of transference and counter-transference issues which are arguably deeply embedded within LD work and the relational dynamics (neither the researcher nor any of the psychological therapists interviewed for this particular research classified themselves as specialising in psychoanalytic models of working).
Examination of the therapy needs of PWLD with moderate-severe needs	This study included only people with mild learning disabilities - therefore excluding a group of people at the more moderate and severe end of the spectrum - more adaptations may be required, which does not mean this group would not benefit from 'talking therapies'. Additional issues of gaining consent would be involved, which could create further complications, but this area would benefit from further examination in future.
MDT & collaborative therapeutic work	One of the main themes from the present study related to the importance of joint and inter-disciplinary team working. It would be useful to further explore different ways of working, making greater use of MDT colleagues.

Therapeutic support with homogenous groups (presenting problems).	Elements relating to the homogeneity of the presenting problems could be queried in the present study, so this limitation could influence future research. Given the variety of therapeutic approaches which were used by therapists in this study and the mixture of presenting problems by the PWLD, future studies could endeavour to focus upon a certain approach for one group of similar problems.

5.6 Conclusion

The following definition of empowerment was used for the purposes of this research:

‘providing an increase in freedom, self-reliance, choice and action, enabling people to act more independently to make decisions and reach desired goals’.

In terms of the original research aims and questions outlined in earlier chapters, this study was successful to the extent that PWLD were able to express what they found most helpful and empowering in the psychological therapy received from psychological therapists. The therapeutic relationship was examined and highlighted as a critical element of therapy for PWLD. The research was also able to comment upon particular psychological therapeutic interventions and to consider how empowerment is conceptualised by the main stakeholders (section 4.2,Table 4.2), presented here in the therapeutic encounter: between PWLD, (which related to positive outcomes, including improved mood, greater autonomy and life skills, confidence and more satisfying relationships), their therapists, (from greater choice and control, self-governance, personal authenticity, to improved levels of self-belief, communication and more effective interactions with others) and their support workers, (including a return of self-confidence, feeling a purpose in life, being able to contribute to one’s community, having independence and positively influencing others to make satisfying life changes).

This research shows that PWLD can have the ability to examine their internal processes, interpersonal and life events, can express and articulate themselves and communicate both in psychological therapy and in terms of describing their experience of it. The therapeutic relationship clearly does encourage or facilitate empowerment, which thus benefits the population group of PWLD when engaging in therapy. There may be other ways that empowerment can take place and be enabled for PWLD, which could beneficially be further explored in ongoing social justice-related research. Qualitative enquiry is a good way of exploring this.

Adaptations that help communication expression and understanding include the development of trusting relationships with professionals as well as skilled support workers. Practitioners can help facilitate this by careful preparation prior to therapeutic involvement and utilise communication aids including simplification of language, creative and flexible approaches to their work, as well as by tailoring their sessions to the individual needs.

This is the first research to explicitly explore empowerment in the provision of psychological therapy for PWLD, which is facilitated by the therapeutic relationship. This research has therefore made a significant contribution to knowledge. The work builds upon previous knowledge and research including that of Jones (2013), supporting findings that the therapeutic relationship is of paramount importance in the successful provision of psychological therapy for PWLD. It also confirms the important contribution that support workers make in the lives of PWLD and in the facilitation of therapy, alongside psychological therapists. Collaborative working and the successful utilisation of MDT services have been shown to be key ingredients in the provision of therapy with positive outcomes resulting for the clients accessing support from the NHS service involved with this study. It is hoped that further research will continue to build upon the areas highlighted as significant in this thesis.

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APPENDICES

APPENDIX CONTENTS

Q Interview Summaries: i) individual participants; ii) triad groups; iii) overall summary & general themes

R Analysis Process & Notes (Initial themes – overall participant summaries themes; table of participants' conceptualisations of empowerment; exploration of Research Aims & Research Questions outcomes)

APPENDIX A: GLOSSARY OF ABBREVIATED TERMS

- **ACC = Augmented and Alternative Communication**
- **ADHD = Attention Deficit-Hyperactivity Disorder**
- **ASD = Autistic Spectrum Disorder**
- **CBT = Cognitive Behavioural Therapy**
- **CFT = Compassion Focused Therapy**
- **CLDT = Community Learning Disability Team**
- **DA = Discourse Analysis**
- **DSM-V = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition**
- **EFT = Emotional Freedom Technique**
- **GP = General Practitioner**
- **IAPT = Improving Access to Psychological Therapies IPA = Interpretative Phenomenological Analysis**
- **ICD 10 = International Statistical Classification of Diseases and Related Health Problems 10th Revision**
- **IQ = Intelligence Quotient**
- **LD = Learning Disability**
- **MDT = Multi-Disciplinary Team**
- **NHS = National Health Service**
- **NICE = National Institute for Health and Care Excellence**
- **OCD = Obsessive Compulsive Disorder**
- **PWLD = People with Learning Disabilities**
- **PTSD = Post Traumatic Stress Disorder**
- **PCA = Person-Centred Approach**
- **PCT = Primary Care Trust**
- **PDA = Pathological Demand Avoidance**
- **SALT = Speech and Language Therapy**
- **TA = Transactional Analysis**
- **WHO = World Health Organization**

APPENDIX B: REFLEXIVE ACCOUNT

It is important to include a section on reflexivity within this thesis, particularly due to the nature of the qualitative approach and methodology (IPA) involved in this research. The reflexive section has been included in the Appendix due to the large amount of data involved in this research project, which impacted upon the word limit allowance.

Whilst IPA aims to explore participants' experiences from their perspective, it is not possible to completely separate the researcher's own view of the world and the interaction between researcher and researched (Willig, 2008). Any exploration of reflexivity or subjectivity is likely to consider the researcher's own role in the collection of data, connected to the researcher's personal values, interests, experiences and beliefs, which influence and shape the research process/findings. There is also a link that is pertinent here between therapy as a researcher and as a therapeutic practitioner, in terms of the application of reflexivity: both can be considered forms of social action, which aim to explore and alleviate human suffering on different levels, via increased knowledge and understanding (Henton, 2016).

Finlay & Gough describe reflexivity as '*bending back upon oneself'* (2003, p.ix), which is needed by a researcher when reflecting upon the presence of their own mind or their personal subjectivity and as a starting point for deciding to do any research (Henton, 2016). An awareness of how this contributes to the evolving field of the researcher, or how this limits what may be constructed is a useful part of the process. The implicated concept of uncertainty also seems important and linked to personal subjectivity, as without it there could be a danger of '*veering too far towards omnipotence or narcissism'* (Henton, 2016, p.137). Consideration of other contrasting theories, research approaches and methods, as well as reflecting upon one's own influence within the research planning, collection and analysis stages, are all essential to ensure accountability and a questioning attitude (McLeod, 2003). This is also particularly important within the discipline of Counselling Psychology, which has been described as positioning itself between a variety of other related disciplines, including psychotherapy, philosophy, rhetoric, poetry and anthropology – a '*fertile meeting ground for diverse knowledge and practices'* (Davey, 2010, p.79).

Reflexivity is a concept that is not identical to reflection but is related to it. The concept of reflexivity represents the idea that '*the observer and observed cannot be separated and that a reciprocal relationship exists between the two'* (Finlay & Gough, 2003, p.67). A further discussion of this as it relates to IPA methodology can be found in Chapter 3, but it will hopefully suffice here to say that reflexivity is a significant concept within the qualitative research paradigm, where subjectivity and meaning making are explicitly recognised, although it also has its place within quantitative research (Kasket, 2012) and within science as a whole. A more reflexive view of research in general has developed over the past century by philosophers of science as well as psychologists, with an increasing recognition of the importance of the role of reflexivity in good science (Chalmers, 2013; Donati, 2016). Following this discussion of the tenets and considerations in reflexive work the author will now reflect on her experiences in conducting this research work.

The researcher's own reasons for choosing to explore the facilitation of empowerment within psychological therapy for PWLD, stemmed from her previous interests developed through her Master's degree dissertation, which involved vignette methodology and semi-structured interviews with therapists working with PWLD, to examine the issues influencing their choice of therapeutic approach in their work. This earlier research had purely involved therapists' views about their work, so the investigator was aware that the clients' own voices had not been expressed: key characters and participants in the therapeutic partnership/relationship. As the researcher began to read more widely and examine recent information from other studies, it became apparent that there were gaps in the literature regarding clients as important participators (within research), as well as examining the importance of their carers and support workers (e.g. Jones & Donati, 2009; Jones, 2013). This links also to the importance of participatory research discussed in Chapter 2.

Therefore, the researcher was keen not to overlook clients' views and voices, which she was particularly aware of, due to her own position and work as a counselling psychologist, within a Learning Disability service. Having a significantly MDT- orientated focus was also an important value within the service where the researcher worked. Moreover, this was significant within her own work, as she had experienced an MDT focus as being generally positive in terms of the support and shared communication between professionals and support workers, which benefitted the service-users involved. This resulted in a wish to also include an examination of the impact that support workers can have upon the therapeutic outcomes of PWLD. Both of these elements: (i) the inclusion of PWLD and (ii) their support workers, were deemed to be very worthwhile and fruitful additions to the researcher's original project ideas. The researcher felt that this was a good way to obtain more information and allow triangulation of data from all three perspectives involved in the process: the three-way focus upon the therapeutic relationship via triad interviews, comprising the client, his/her therapist and his/her support worker.

Although it can always be questionable whether the researcher's understanding is a correct and accurate account of the participants' experience, this can in part be reconciled by acknowledging clearly how the interpretations have come about and where assumptions have been made. IPA allows for the possibility of checks to be made afterwards with the participants if needed, following the analysis. The researcher / I hoped that both important generic themes from the analysis and unique information relating to the individual lives of the participants, would emerge from the interview data. The researcher felt that this had mostly been achieved, but following carrying out the research, became aware that greater opportunities to provide feedback on the part of the participants and to address capacity to consent issues could have been improved by more organised meetings for feedback, for example. The researcher discussed this with her supervisors and reflected that as an early researcher, this was one area that had been highlighted for her as important in future projects. The importance of obtaining and assessing for capacity to consent for PWLD in taking part in the research throughout the entire project, is particularly important given the topic of research, as discussed in section 3.4.3 by Hamilton et al. (2017) – including use of symbols and simplified versions of research materials and checking for reconfirmation of consent (and retention of understanding) at the end of the data collection.

The above point leads onto the related issues of trustworthiness and quality in qualitative research, especially regarding this particular study. The researcher learnt that making checks prior to carrying out the research is vital, even if carrying out checks retrospectively can still be useful. In a future related study, the researcher reflected upon the importance of checking at an early stage and throughout the research process, with quality assessment frameworks such as Kmet, Lee & Cook's (2004) criteria regarding evidence of trustworthiness in qualitative data, (mentioned in section 3.5.1).

The researcher's own work as a counselling psychologist also involved regular therapeutic contact with clients who accessed the NHS adult Learning Disabilities service involved. Partly due to the priority of focus within the philosophy of Counselling Psychology, of Humanistic principles and the therapeutic relationship and partly due to the researcher's personal affinity to Humanistic therapeutic approaches which she included within her own toolkit, she was very aware of an active wish to help encourage and facilitate empowerment with her own clients. The researcher was however aware of her own position and assumptions at the onset of the research planning stage, in terms of regarding therapy as being useful and the therapeutic relationship as being important. Similarly, empowerment, social justice and an aim to help promote equality for all people, were moral concepts which were important for the researcher.

Because of the element of subjectivity that is inherently likely to be held by anyone, the researcher found it helpful to discuss the above ideas and concepts with her supervisory team, who had a variety of different backgrounds and experience (in Counselling Psychology, Clinical Psychology and Health Psychology), in order to consider the interview schedule and topic questions to be used in the semi-structured interviews - which ensured that a range of alternative answers, perspectives and understandings from the participants could be elicited, understood and presented. Assumptions about the importance of heterogeneity within the participant sample were also discussed, as the researcher had originally held assumptions which focused upon the importance of the therapeutic relationship (as producing positive, empowering effects), with less importance given to the diversity of the sample.

As a result of the research, the researcher is now even more aware of the importance of self-advocacy and the usefulness of independent advocacy services in helping PWLD express their own views. She was also keen to include information regarding adaptations for therapists working with PWLD, in potential training opportunities, particularly for other therapists and support workers, as she felt this would be a good use of the research findings and opportunity to discuss them with other health professionals. By the end of the project, the researcher felt more confident about carrying out therapy and service-related research and in adapting processes to allow greater understanding and involvement by PWLD.

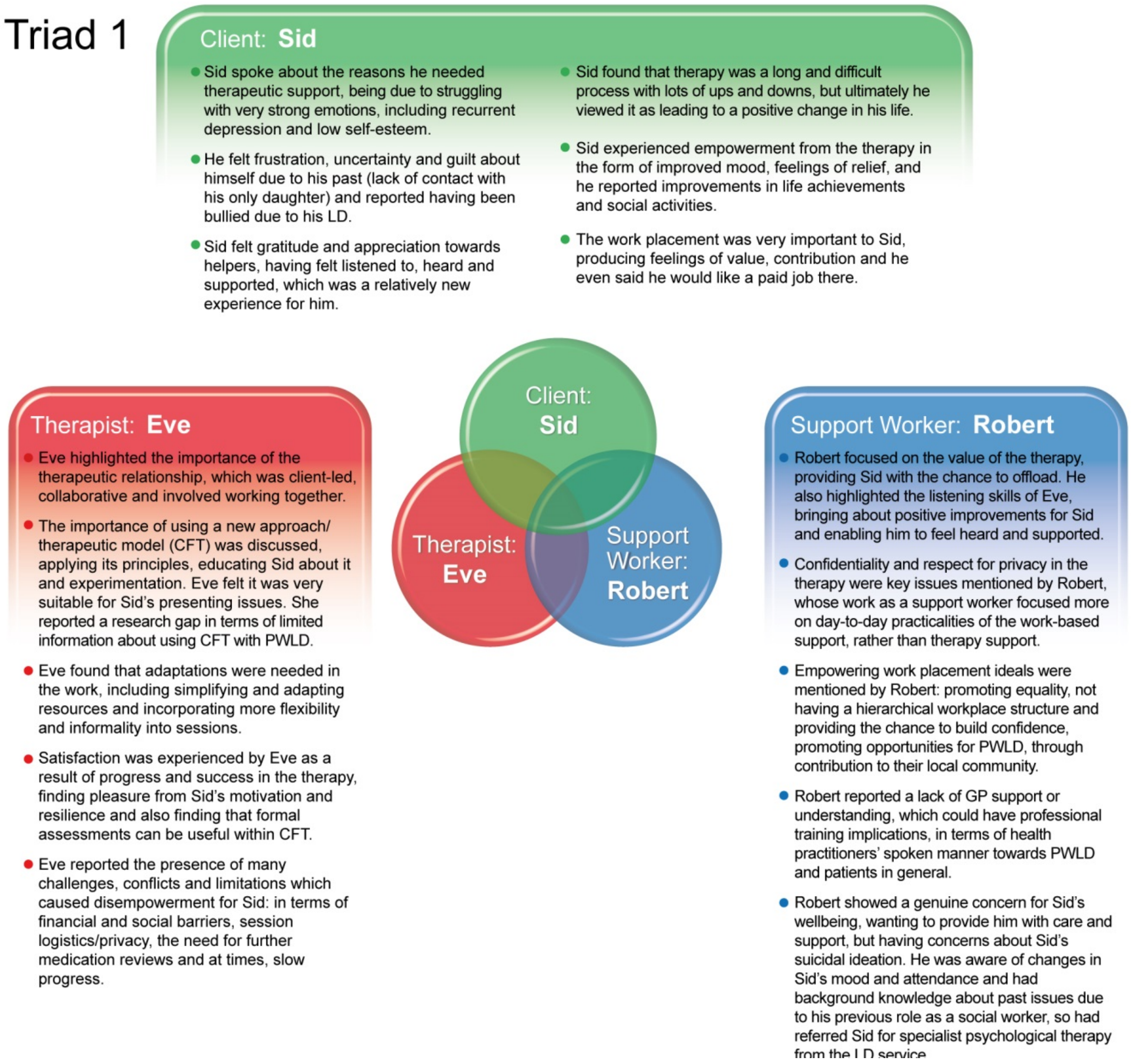
Despite finding the process very demanding and time-consuming, the researcher also found it to be extremely rewarding and satisfying, as stages of the project were completed. The collection of data via the semi-structured interviews was a particular highlight, as she found carrying out the interviews very interesting, varied and stimulating, sparking an interest in further researcher-practitioner related work.

APPENDIX C: IDIOGRAPHIC TRIAD ACCOUNTS WITH DIAGRAMS OF THEMES

<u>Interpretative Idiographic Analyses</u> (Accounts of Each Triad)

1.Triad One: Sid (client), Eve (therapist) & Robert (support worker)

Figure 1. Overview of Triad 1.



Client: **Sid**

- Sid spoke about the reasons he needed therapeutic support, being due to struggling with very strong emotions, including recurrent depression and low self-esteem.
- He felt frustration, uncertainty and guilt about himself due to his past (lack of contact with his only daughter) and reported having been bullied due to his LD.
- Sid felt gratitude and appreciation towards helpers, having felt listened to, heard and supported, which was a relatively new experience for him.
- Sid found that therapy was a long and difficult process with lots of ups and downs, but ultimately he viewed it as leading to a positive change in his life.
- Sid experienced empowerment from the therapy in the form of improved mood, feelings of relief, and he reported improvements in life achievements and social activities.
- The work placement was very important to Sid, producing feelings of value, contribution and he even said he would like a paid job there.

Therapist: **Eve**

- Eve highlighted the importance of the therapeutic relationship, which was client-led, collaborative and involved working together.
- The importance of using a new approach/ therapeutic model (CFT) was discussed, applying its principles, educating Sid about it and experimentation. Eve felt it was very suitable for Sid's presenting issues. She reported a research gap in terms of limited information about using CFT with PWLD.
- Eve found that adaptations were needed in the work, including simplifying and adapting resources and incorporating more flexibility and informality into sessions.
- Satisfaction was experienced by Eve as a result of progress and success in the therapy, finding pleasure from Sid's motivation and resilience and also finding that formal assessments can be useful within CFT.
- Eve reported the presence of many challenges, conflicts and limitations which caused disempowerment for Sid: in terms of financial and social barriers, session logistics/privacy, the need for further medication reviews and at times, slow progress.

Support Worker: **Robert**

- Robert focused on the value of the therapy, providing Sid with the chance to offload. He also highlighted the listening skills of Eve, bringing about positive improvements for Sid and enabling him to feel heard and supported.
- Confidentiality and respect for privacy in the therapy were key issues mentioned by Robert, whose work as a support worker focused more on day-to-day practicalities of the work-based support, rather than therapy support.
- Empowering work placement ideals were mentioned by Robert: promoting equality, not having a hierarchical workplace structure and providing the chance to build confidence, promoting opportunities for PWLD, through contribution to their local community.
- Robert reported a lack of GP support or understanding, which could have professional training implications, in terms of health practitioners' spoken manner towards PWLD and patients in general.
- Robert showed a genuine concern for Sid's wellbeing, wanting to provide him with care and support, but having concerns about Sid's suicidal ideation. He was aware of changes in Sid's mood and attendance and had background knowledge about past issues due to his previous role as a social worker, so had referred Sid for specialist psychological therapy from the LD service

Figure 1 provides a summary of the following idiographic account of Triad 1 and highlights the key themes (Chapter 4) evident in the triad.

Sid was a 49-year-old man with a mild learning disability, who had been referred to the specialist LD service for counselling by his GP, due to a history of recurrent depression and suicidal ideation. Eve was a senior counselling psychologist in her late 40s, who had been working therapeutically with Sid for about six months and Robert was a support worker in his 60s at Robert's work placement, who had also known Sid before in his previous role as a social worker. Sid spent several days each week engaged in a voluntary outdoor work placement, where he was involved in caring for the environment and with woodwork. He described his work as *"interesting. "It's never boring"* and admitted that he kept *"saying I want a* [paid] *job down 'ere".* Sid's placement was clearly an important theme for him.

Eve described a strong physical sense of Sid's negative mood and heaviness at the onset of the therapy sessions (*"it seemed like a dark cloud"),* which Sid also spoke about in terms of being weighed down by feelings of failure and having been bullied, whilst in education and by local peers, related to his learning disability (Super-ordinate themes 1 and 3 in Chapter 4; sub-theme1.1 and sub-theme 3.1). Sid described the pervasive, plaguing nature of his negative thoughts prior to the therapy with Eve *- "she came across because I was depressed - depressed and I was fed up"; "I couldn't get out of it… just constantly, constantly, constantly."* Sid also spoke about having been quiet and withdrawn, having to force himself to come to work (that he otherwise enjoyed): *"I forced m'sen* [myself] *down 'ere every day –"* He described a very negative self-concept before the therapy*: "I always used to put m'sen* [myself] *down, I used to rip hell out of myself –"*

Sid also felt guilt at not having been present in his daughter's upbringing and experienced frustration at not being able to do more or to access more social opportunities, due to financial restrictions. Sid spoke most about his feelings before the therapy and the intensity of his experiences, but he also spoke warmly about both supporters and positively about the help that they had provided *("he is there if I need him, he's helped me out a lot… he's a good 'un, Robert is!*"), as well as the improvements in his feelings that they had helped to bring about.

Eve chose to use a Compassion Focused Therapy (CFT) model, as she felt it could be utilised well, given Sid's background and presenting problems. Using this approach was an important theme for Eve and it was the first time she had used this approach with a client with a learning disability, but she felt that despite being a little experimental, the approach *"just fell into place at the right time"* and flowed well, *"weaving it into the sessions", "feeling the way", "trying to walk next to him"* and *"constantly gauging the pace".* Eve found a gap evident within LD research for CFT, as there was very little formal research existing in this area currently (it being focused primarily on populations without learning disabilities).

Eve considered that the therapeutic relationship was very important in her work, as it was *"the vehicle* [via which] *the process happens".* The CFT approach seemed a particularly reflexive model, with Eve stating that *"within sessions I was quite aware of our relationship and what I was feeling and what that might have meant" - "in terms of what he might have been experiencing"*. The approach appeared to fit well within Counselling Psychology as a whole. Eve also spoke of the need for non-judgemental listening in therapy, again key in Humanistic approaches, whereby Sid or other clients could "*make changes that are really important to them".* (Super-ordinate Theme 2: Building Relationships, Collaboration & Trust')

Robert was very respectful of Sid's privacy and did not ask questions about the counselling, so in some ways had a more limited therapeutic involvement than other support workers. He also showed a genuine concern for Sid's wellbeing and mentioned a lack of GP support or understanding, whilst highlighting the value of the therapy.

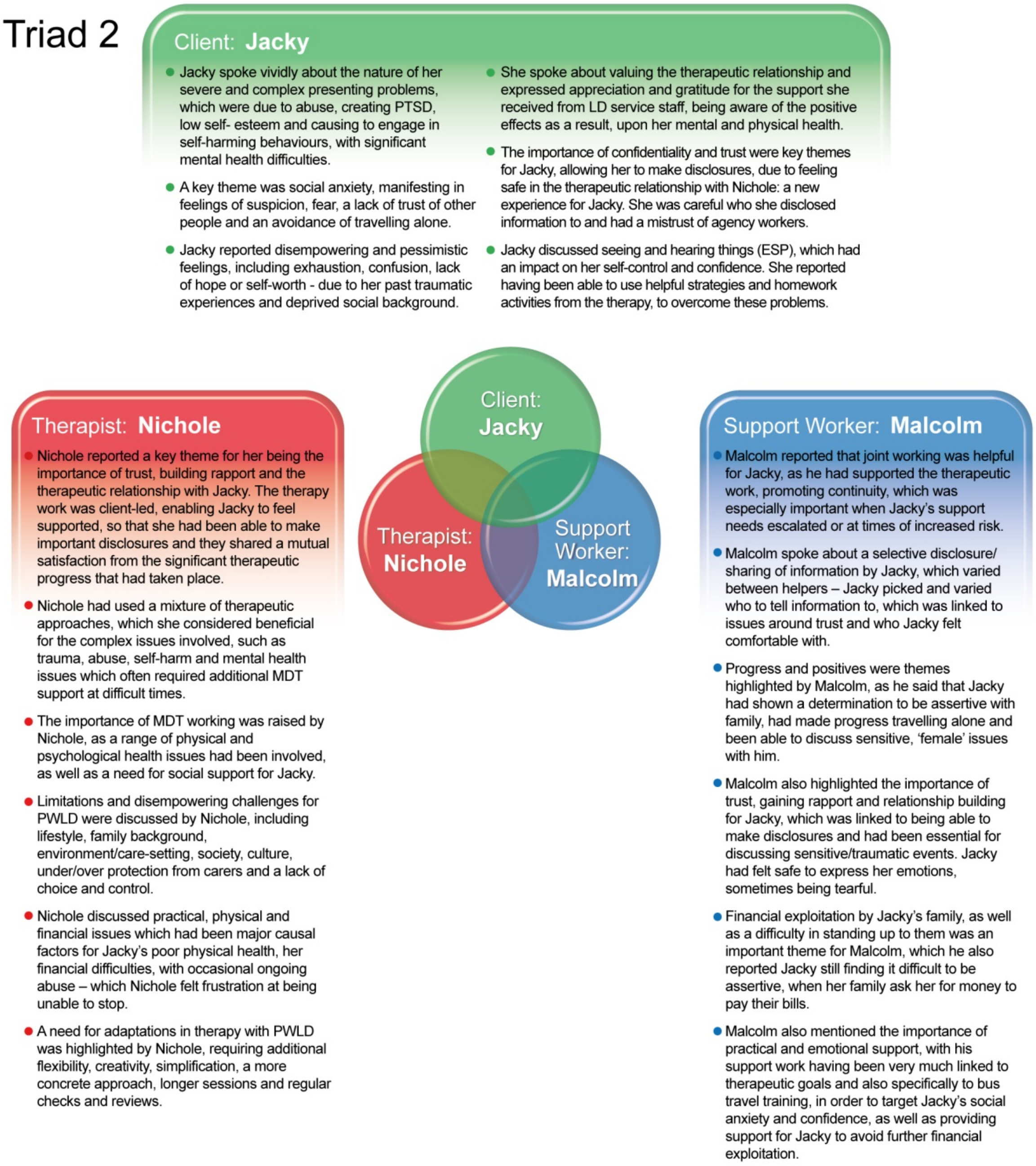
Eve spoke about the importance of validating Sid's experience with him, *as "he felt that a lot of his experience was that people couldn't understand the depths of his depression and were* *always telling him…'you can pull yourself out of that' and not taking him seriously… having someone acknowledge that was really important to him".* Eve also spoke about disappointments where Sid felt he wasn't improving fast enough or moving out of the depression quickly enough and he visited his GP for a medication increase. However, Eve (and Robert) were fundamental in being able to support Sid through his healing process, providing reassurance and exploring his self-critical expectations. Eve and Sid had explored people being *"strange creatures",* agreeing that it was be ok to be imperfect: Eve was able to share Sid's journey and consider together that *"we're all human beings and none of us are perfection".* This shared part of the therapeutic process seemed very important and helped with Sid's recovery. (Super-ordinate Theme 2: 'Building Relationships, Collaboration & Trust').

Although Sid was not able to be more specific about his conceptualisation of empowerment due to the cognitive and communication limitations inherent with his learning disability, he agreed that the sessions were helpful *("It's helping, yeah. I think it's helping"; "I think I'm getting better").* Sid was able to discuss the positive changes in his appearance (improved mood and looking less miserable*: "I always used to get told, 'cheer up!' cos I always looked miserable… but not so much now"*), his thoughts (thinking fewer self-critical thoughts) and his life, as a result of the therapy. Sid spoke what he had liked most about the sessions – *"I think it's just talking and relaxing and keeping my mind away from... my thoughts",* focusing on *"thinking good things – instead of thinking bad things".* Improvements since the counselling were quite varied and wide-ranging, such as starting a Ju-Jitsu class and setting himself some goals (to achieve his brown belt), achievements at work – *"I've passed my chain-saw course, so that's made me feel better"* and the happiness he felt about being reunited with his daughter (Super-ordinate Theme 4: 'Positive Outcomes').

Eve referred to empowerment as a critical theme in LD work due to limitations in choice and control. This she felt was often due to restrictions in a person's social situation, *"the circumstances they're living in"* and stated, *"I think the empowerment work works against that, in helping them to maintain that resilience" – "to understand that it isn't a fault within them".* Eve related this to the impact of Sid attending a special school when he was younger: *"He felt that he hadn't had any opportunities to take exams and the right support in school…he'd experienced quite a bit of bullying."* Eve also mentioned the importance of practicalities and adaptations when working with PWLD, such as in Sid's case the use of pictures (including a *"compassionate owl*") as he could not read or write. Eve concluded "*All therapy should be empowering*!" Robert spoke about the importance of treating people as equals, providing opportunities, *"Giving people the chance to be themselves",* not to feel treated any differently to anyone else and summarising, *"It's all about people feeling they've got a sense of worth, by contribution".*

2. Triad Two: Jacky (client), Nichole (therapist) & Malcolm (support worker)

Figure 2. Overview of Triad 2.



Triad 2

Client: **Jacky**

- Jacky spoke vividly about the nature of her severe and complex presenting problems, which were due to abuse, creating PTSD, low self- esteem and causing to engage in self-harming behaviours, with significant mental health difficulties.
- A key theme was social anxiety, manifesting in feelings of suspicion, fear, a lack of trust of other people and an avoidance of travelling alone.
- Jacky reported disempowering and pessimistic feelings, including exhaustion, confusion, lack of hope or self-worth - due to her past traumatic experiences and deprived social background.
- She spoke about valuing the therapeutic relationship and expressed appreciation and gratitude for the support she received from LD service staff, being aware of the positive effects as a result, upon her mental and physical health.
- The importance of confidentiality and trust were key themes for Jacky, allowing her to make disclosures, due to feeling safe in the therapeutic relationship with Nichole: a new experience for Jacky. She was careful who she disclosed information to and had a mistrust of agency workers.
- Jacky discussed seeing and hearing things (ESP), which had an impact on her self-control and confidence. She reported having been able to use helpful strategies and homework activities from the therapy, to overcome these problems.

Therapist: **Nichole**

- Nichole reported a key theme for her being the importance of trust, building rapport and the therapeutic relationship with Jacky. The therapy work was client-led, enabling Jacky to feel supported, so that she had been able to make important disclosures and they shared a mutual satisfaction from the significant therapeutic progress that had taken place.
- Nichole had used a mixture of therapeutic approaches, which she considered beneficial for the complex issues involved, such as trauma, abuse, self-harm and mental health issues which often required additional MDT support at difficult times.
- The importance of MDT working was raised by Nichole, as a range of physical and psychological health issues had been involved, as well as a need for social support for Jacky.
- Limitations and disempowering challenges for PWLD were discussed by Nichole, including lifestyle, family background, environment/care-setting, society, culture, under/over protection from carers and a lack of choice and control.
- Nichole discussed practical, physical and financial issues which had been major causal factors for Jacky's poor physical health, her financial difficulties, with occasional ongoing abuse – which Nichole felt frustration at being unable to stop.
- A need for adaptations in therapy with PWLD was highlighted by Nichole, requiring additional flexibility, creativity, simplification, a more concrete approach, longer sessions and regular checks and reviews.

Support Worker: **Malcolm**

- Malcolm reported that joint working was helpful for Jacky, as he had supported the therapeutic work, promoting continuity, which was especially important when Jacky's support needs escalated or at times of increased risk.
- Malcolm spoke about a selective disclosure/ sharing of information by Jacky, which varied between helpers – Jacky picked and varied who to tell information to, which was linked to issues around trust and who Jacky felt comfortable with.
- Progress and positives were themes highlighted by Malcolm, as he said that Jacky had shown a determination to be assertive with family, had made progress travelling alone and been able to discuss sensitive, 'female' issues with him.
- Malcolm also highlighted the importance of trust, gaining rapport and relationship building for Jacky, which was linked to being able to make disclosures and had been essential for discussing sensitive/traumatic events. Jacky had felt safe to express her emotions, sometimes being tearful.
- Financial exploitation by Jacky's family, as well as a difficulty in standing up to them was an important theme for Malcolm, which he also reported Jacky still finding it difficult to be assertive, when her family ask her for money to pay their bills.
- Malcolm also mentioned the importance of practical and emotional support, with his support work having been very much linked to therapeutic goals and also specifically to bus travel training, in order to target Jacky's social anxiety and confidence, as well as providing support for Jacky to avoid further financial exploitation.

Figure 2 provides a summary of the following idiographic account of Triad 2 and highlights the key themes (Chapter 4) evident in the triad.

Jacky was a 50 year old woman who had been referred to the community LD service about ten years previously, with a variety of physical health and psychological issues including PTSD, most of which related to her social/family background, a history of childhood abuse (sexual, physical, emotional and financial) and the subsequent self-harm and psychological trauma and distress she had experienced. At the start of her interview, Jacky immediately explained the reason for her sessions with therapist Nichole - *"I was doing harm to myself", "I* *got raped when I was five years old".* Nichole was a senior counselling psychologist, in her early 50s, who had worked therapeutically with Jacky for several years, helping Jacky work through the traumas which also included work around hearing voices/seeing things, which Jacky reported as a result of her memories and experiences. Malcolm was a community support worker in his 60s who had worked alongside Nichole, mainly supporting Jacky with travel training and her *"phobia of getting on buses".*

Jacky described the nature of her self-harming in graphic detail *("I nearly cut me fingers off…")* and discussed how the therapy work with Nichole had helped her overcome some of the effects of PTSD, as well as coping with, or challenging, some of the voices and images she had been seeing *"I know they're not there. And they could be people on the other side talking to each other, but it sounds like they're saying things about me".* The interview was interesting in terms of Jacky talking about ESP and ghosts: *"she* [Nichole] *said to me "Can you see him in the room?" And there was a shadow there and she said, "He's not gonna hurt you, Jacky, just tell him to go away".* This theme is included in diagram 2 above and is an example of the nature of Jacky's mental health issues, her vulnerability and risk of suggestibility, which pervaded her commentary and was referred to by Nichole in describing their work together.

Nichole described Jacky's complex case and presentations for which she had used a mixture of several therapeutic approaches and techniques, as they worked together on different specific issues. Nichole had started by building up Jacky's trust and developing a therapeutic relationship via therapeutic counselling, with Cognitive Behaviour Therapy (CBT) being used to target Jacky's *"negative thoughts and automatic thoughts",* NLP (Neuro Linguistic Programming) to work on past traumas, and a combination of relaxation techniques and energy therapies such as EFT (Emotional Freedom Technique) - [see Glossary] *"to help reduce her state of arousal*" and to help increase internal control with her feelings. Nichole felt that particularly effective and enjoyed by Jacky, was the work they did together on Jacky's timeline: "*we did some timeline work and story work… to try to build up a picture of the past and so on".* An overlap between the themes highlighted by Nichole in the diagram above and in the Super-ordinate themes is also apparent (Super-ordinate Theme 2: 'Building Relationships, Collaboration & Trust' and Theme 3: 'Coping & Adaptations').

Nichole spoke about how treatment plans had been formulated around specific issues, such as *"exerting more control in terms of hearing voices and how she could manage and what they meant, and how she'd feel*", or being more assertive with her family, since family dynamics and occasional financial abuse were also involved. Nichole allowed Jacky's sessions to be "*led by her really"* and explained that it had not always been a linear process, they sometimes went back to review previous work and episodes on Jacky's timeline. Nichole followed Jacky's life story using verbal and visual methods, emphasising using a concrete approach, with simply explained information, suitable for Jacky's level of cognitive and verbal ability. (These relate to adaptations: Super-ordinate Theme 3 and trust and rapport: Super-ordinate Theme 2).

Jacky was very appreciative of Nichole and others from the CLDT who had supported her over the years, saying about Nichole, "*she's just a nice person", "she were there for me"* and Jacky spoke about feeling *"safe"* when talking to Nichole – "*she just opened me".* As a result of the therapy sessions, Jacky felt she had benefited and "*just shot up*" in terms of personal growth. She asked at the end of the interview if she could see Nichole or one of the LD team community nurses again *"I'd love to see them, just a little bit more...",* indicating how much she had appreciated their involvement in her life. This also indicates a tension that exists between a) the importance for PWLD, of being able to access clearly meaningful relationships, whilst b) enduring service waiting lists; which means that these relationships can be difficult to foster. Satisfaction with the therapeutic relationship was also expressed by Nichole: *"you can't help but like her*" and Nichole described seeing improvements in Jacky as very rewarding, such as overcoming aspects of trauma she had initially presented with and Jacky becoming more effective in learning how to manage her emotional state on her own. These themes of mutual satisfaction, the importance of building trust and the therapeutic relationship, are included in Super-ordinate Theme 2. Physical health problems were also discussed, having been supported by community nurses from the LD team.

Having a health (and adult care) service was very important for Jacky, as she still depended on the support it provided from help with making GP appointments, to encouragement in accessing the community independently. Jacky admitted that she was *“no good with money”,* describing herself as being on “*sick money”.* Nichole and Malcolm spoke about the importance of MDT involvement and practical help and support for aspects of Jacky’s life, such as her finances and avoiding her family pressurising or manipulating her for money, who “*all knew which buttons to press”* [Nichole]. Super-ordinate Theme 2 includes sub-theme 2.2, relating to ‘Collaboration and the importance of MDT/joint working’, which is closely linked to Nichole and Malcolm’s themes, here raised in diagram 2 regarding MDT and joint working. Jacky admitted that she still found it difficult to say ‘no’ to her family or to trust people – part of the reason for her bus travel training with Malcolm. Nichole described her frustration about this: *“I can’t make her be more assertive*” and the impact of long-entrenched family relationship dynamics. (Figure 2 and Super-ordinate Theme 1, sub-theme 1.2)

Although there was evidence of improvements and empowerment in Jacky’s life since engaging in therapy (feeling less affected by her past traumas, engaging less in self-harming behaviours, knowing how to keep safe or where to go for help and being more self-aware) and also from other forms of support from the NHS service she had accessed over the years (such as reducing her smoking from 40-60 cigarettes per day to 10), it was clear that another of her key themes was that there were still many disempowering elements in her life (see diagram above), some of which she was aware of and still struggling with (Super-ordinate Theme 3).

For Malcolm, empowerment meant: *“Giving people back what they lack, or lost confidence with, building that confidence up so that when they’re not sure about something, reassuring them”.* Nichole considered an empowering focus to be “part of the therapeutic process” and empowerment specifically as: *“Giving our clients some sort of control over what they do or how they feel”,* as *“some LD clients might exert control over some specific type of behaviour because that’s the only thing that they have control over”.* Therefore, working out how PWLD can have more control or working alongside care providers, to find out how they can help with supporting to empower service-users more, was crucial for Nichole – *“increasing control and having responsibilities for things*.” Nichole mentioned the issue of over- or under-protecting PWLD, often by parents or carers, so ascertaining what constitutes a balanced, ideal level of protection, can be difficult.

In terms of challenges and barriers to empowering through psychological therapy (Super-ordinate Theme 1, sub-theme 1.2), Nichole commented that there were *“rather a lot”* of challenges, but felt that support workers can be utilised effectively to help support therapeutic work with homework exercises for example and liaising with the therapist about any issues of concern or disclosures they may need to be aware of.

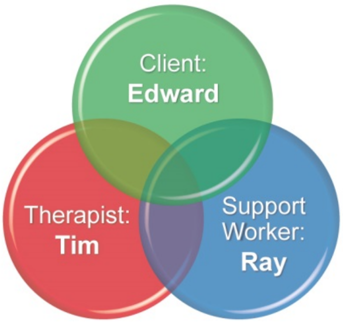
3. Triad Three: Edward (client), Tim (therapist) & Ray (support worker)

Figure 3. Overview of Triad 3.

Triad 3

Client: Edward

- Edward had experienced workplace bullying and institutional abuse, which had created long-lasting traumatic effects, as a result of labelling, segregation and experiencing pay inequalities due to his LD.
- Edward expressed appreciation and gratitude for the supporters who had helped him, particularly feeling understood by Tim, which previously he had not by non-LD therapists; the therapy enabled him to feel safe and supported, able to maintain a more balanced equilibrium in his life.
- Edward emphasised the importance of support networks in his life, particularly those of his family, his therapist Tim, support workers including Ray and his church network.
- Pride in his skills, achievements and progress in work courses was important for Edward, such as his church charity work in Africa, as well as feeling he was becoming "a better person" and having a positive impact upon parents' lives.
- A key theme was that the therapy took time, involving long-term work and the importance of trust and feeling safe in order to make gradual confidential disclosures.
- Edward reported a range of improvements as a result of the therapy, including in his mood and feelings, moving into his own flat and doing domestic chores, as well as improvements in his relationship with his parents.



Therapist: Tim

- Tim raised a key theme about the impact of workplace bullying and institutional abuse upon Edward, which had included labelling, segregation, financial inequalities and a general lack of life opportunities. This eventually led to Safeguarding procedures and had caused mental health problems for Edward, resulting in challenging behaviours and the prescribing of psychotropic medications prior to the onset of the therapy.
- Empowerment via therapy and the importance of the therapeutic relationship was also highlighted by Tim, resulting in improvements in confidence, mental health, communication, relationships, community access, self-worth, choice and control, as well as mutual satisfaction from the therapy.
- Mixed approaches were used by Tim, geared toward specific phases of the therapy, which Tim described in terms of a relationship-building or 'Rogerian' phase, a challenge-phase using Gestallt and TA apporoaches and finally a maintenance phase, where resources such as mood charts and scheduled reviews were included in the therapy programme.
- Tim described limitations, challenges and barriers in providing therapy for Edward, including the use of therapeutic challenge, Narcissism/personality issues, difficulty dealing with change, as well as highlighting problems with segregation and labelling for PWLD generally. He also highlighted potential dangers of using some forms of therapy with forensic clients.
- Family and support networks was a key theme for Tim in his work with Edward, who found that working systemically was beneficial for all involved. This included Edward requesting to include his parents in the sessions and his support workers sharing in therapeutic process. It also included the importance of communication and appropriate sharing of information.
- Tim felt there had been a need for greater support for Edward at difficult times, which had not always been available; he considered that having more support staff in between sessions would have helped reduce the pressure on Edward's elderly parents, as well as resulting in financial and service benefits. Tim also reflected that it was essential to include reasonable adjustments when working with PWLD and he reported that making additional MDT referrals can also be helpful.

Support Worker: Ray

- Ray reported a transformative impact upon Edward, with benefit being gained as a result of Tim's presence; important elements of therapy Ray listed as trust, a non-judgemental attitude and care about confidentiality. Ray also described the importance of emotional expression or release for Edward, increasing his confidence and energy and in turn creating systemic benefits for others in his life.
- Ray also described the importance of joint working in the therapy sessions, with support during and afterwards, where Ray and Edward continued therapeutic debriefing after the sessions. Crucial in the joint approach was the privacy of therapeutic environment, dedication, trust and support of all involved working with Edward.
- Selective disclosure was mentioned by Ray, in terms of Edward being able to disclose private information due to his therapist Tim as a result of their trusting relationship, where he experienced a genuinely non-judgemental, caring approach.
- Ray highlighted the importance of knowing Edward well and therefore having a familiarity or an awareness of triggers, which could lead to behavioural outbursts. By utilising a sensitive, patient approach and being supportive, friendly and caring with Edward, he was able to notice and respond to changes such as facial colour or body posture, which in turn were linked to changes in Edward's moods.
- The helping role of support worker was an important theme for Ray, which included multifaceted elements ranging from practical domestic tasks, checking on Edward's safety and wellbeing, to listening to, supporting and encouraging him, enhanced by knowledge of Edward's issues.
- Ray reported both positive and negative changes in Edward's life since the therapy, which related to his increased independence, confidence, communication and social skills, whilst also including the fact that although Edward now had his own house, the down-side was that he experienced greater responsibilities and pressures as a result.

Figure 3 provides a summary of the following idiographic account of Triad 3 and highlights the key themes (Chapter 4) evident in the triad.

Edward was 47 and had been referred due to past workplace bullying issues, in addition to possible institutional abuse and their effects upon him, although he said the counselling *“covered everything from my childhood, to everything really”.* Tim was a Therapeutic Counsellor in his late 40s who had worked with Edward for over ten years, as he initially *“appeared to be having difficulty managing his strong emotions”* and had experienced what Tim described as a nervous breakdown: *“the presentation prior to therapy… extremely volatile, violent, difficult to communicate…. self-harming behaviours”.* Tim and Edward both mentioned the impact of workplace bullying, linked to Super-ordinate Themes 1: ‘Values, Stigma & Social Equity’, and Theme 3, with sub-theme 3.1 in particular: ‘PWLD struggled without support’. Ray was a support worker in his mid-30s who supported Edward and highlighted his helping role: *“just making sure that Edward’s alright, he’s got everything he needs, he’s looking after himself…”; “I help with appointments as well. Cooking, cleaning, shopping – I do a bit of everything…”*

The counselling with Tim involved longer-term work - *“it took a long time… to get me right”* [Edward], which Edward identified as one of his key themes (see diagram above). It included past memories and events from an old LD institution which had been closed many years ago. Edward said that financial exploitation had also taken place later, whilst he was at work: *“they said if you can’t keep up, we’ll put you back in the disabled area”; “I was on less pay than the others… but I was doing a better job than they were”.* This again clearly relates to Super-ordinate Theme 1 and sub-theme 1.1, about the ‘Experience of Stigma by PWLD’. Edward had also felt powerless to defend himself – *“can’t talk about the union, ‘cos one talk about the union and you’re sacked, really”.* Tim spoke about having initiated a Safeguarding investigation following Edward’s complaints about his treatment many years ago. The investigation proved inconclusive, as *“the allegations were some 30 plus years old... it was found to be impossible to locate medical records from that time, the people who were around at that time had either moved on or deceased... so that were really difficult to resolve…”* but *“Edward did get a sense of satisfaction, a sense of closure from that..”* [Tim].

Tim described his use of formulation in terms of the following issues: Edward’s original difficulties in managing strong emotions, maintaining long-term relationships, PTSD type symptoms (including mood disturbances and flash backs of intrusive images from the workplace), difficulty coping with change or loss, as well as some long-standing behaviours relating to Edward’s parents, *“created during the nurturing process*” [Tim]. Tim also referred to Edward’s self-harming behaviours and history of aggression/violence aimed towards his parents. Tim correlated his therapeutic approaches to three differing phases of the therapy - i) ‘relationship-building’: Rogerian/PCA counselling – to help develop trust and rapport, ii) ‘challenge’: Gestallt – to help with creating change and exploring challenge with Edward and TA, iii) ‘maintenance’ – a combination of approaches and ongoing use of resources such as mood charts.

This use of mixed therapeutic approaches can be seen in triad diagram 3 above, as one of Tim’s identified key themes, although Tim acknowledged that the therapeutic relationship itself was of greater importance in terms of making therapeutic progress than the type of strategies used. This also correlates to sub-theme 2.3 (‘Therapeutic relationship was more important than type of therapeutic approach used’) of Super-ordinate Theme 2. Tim also spoke about symbolic imagery and monitoring Edward’s dreams, which changed depending upon which phase of the therapy he was in – for example snakes appearing in Edward’s dreams at times of challenge and difficulty, whereas less potent, calmer images were reflected in his dreams at times of greater stability. A piecemeal, creative and adaptive approach is common when working with PWLD, as shown here by Tim.

Despite having experienced significant trauma and challenges to his emotional well-being, another important theme for Edward was in terms of being now in a much better place mentally, for which he expressed gratitude and appreciation towards Tim, as well as towards his parents, Ray and other support workers who had helped him. Edward and his facilitators all agreed about his positive outcomes as a result of the therapy, correlating with Super-ordinate Theme 4 regarding 'Positive Outcomes'. Although Edward felt angry and indignant about his past treatment, he said, *"I'm a better person – to this day, thanks to him* [Tim]" and described feeling more stability in his life since working with Tim: "*he's keeping me on an even balance".*

Edward spoke less positively about non-LD specialist counsellors he had met before meeting Tim – *"They didn't understand me"*, whereas he felt that Tim did have a good understanding of him, adding: "he's been interested in me and helpful". Ray elaborated upon this in terms of Tim's supportive approach: *"he just sits there blank-faced, Tim – he never judges – you can tell him anything in the world and he never judges Edward, and that's a very good thing as well. 'Cos that makes Edward speak out more about his problems*". Ray highlighted the transformative effect of the therapy.

Edward also felt understood by his support worker team and felt he was better able to communicate effectively with them since the therapy – *"if I'm in a mood over something, I kind of tell people…"* Edward appreciated the genuine care and support provided by the team, *"they hammer me to say what's wrong… and as soon as I've said what's wrong with me, it's all alright… it's no bother.."* Ray agreed about the importance of the therapy: "everything comes out and it's much better when he talks about it!" - indicating a cathartic effect from the therapy. Ray added that after Tim's visits, Edward's flat often transformed from a *"very hostile environment*" to *"a totally new page*". He also spoke about everyone's commitment to Edward: *"it could all blow up, but it'll be resolved, no matter what – we won't leave the room until it is*". A very mutually positive, genuine and beneficial support network was described by all the participants in this triad, which the researcher found rewarding to hear about.

Edward, in discussing traumatic life experiences, spoke about past memories that he still could not completely lose, *"that will stay with me all my life, I'm sure it will…*" *including "electric treatments, electric shocks, everything, a lot worse…*" and he spoke about watching a DVD of the old institution which had now been converted into flats, which had helped him come to terms with his experiences and moving on in his life (linked to Super-ordinate Theme 1: 'Values, Stigma & Social Equity').

Tim and Ray agreed about the importance of communication and Ray's role supporting Edward following the therapy sessions (which he and often Edward's parents also attended): afterwards they often had *"another discussion ourselves about how it was",* which seemed to help with cementing the therapeutic work achieved in the sessions. Another key theme included in the diagram above that Edward spoke about in his interview, related to his positive work-related and volunteer experiences since participating in the therapy, such as being proud to have been a 'Brewster', with skills in coffee design and having knowledge about different coffee beans, as well as a happy experience related to a church expedition to Africa, where he gave chocolate frogs to African people he was visiting *("They went down like hot cakes they did!")*

In terms of empowerment, Edward spoke about being/feeling more independent, the importance he had felt of having a job, improvements since the therapy in his sense of worth and self-esteem. He also spoke about having developed a variety of skills throughout his life and now having his own flat. Having a therapist and people who were interested in, respected and cared about him, was important for Edward and can be found to correlate to Super-ordinate Theme 2:' Building Relationships, Collaboration & Trust'.

Lastly, Edward described now having an improved mood and being better able to communicate and sort out problems more easily with his carers, as well as treating his parents better *(“since birth I’ve always took it out on me mum and me dad”... “I don’t treat ‘em like dirt as much, anymore…”).* Tim for his part, emphasised that empowerment is *“crucial, absolutely crucial…I think it’s the goal which all therapists aim to achieve with their clients … It’s about somebody having the confidence to be totally self-governing and to speak up for what they think’s right and wrong…to express their needs… without feeling embarrassed or feeling as though they’re not able to do so”.*

Tim used a variety of visual images and metaphors throughout his interview, including this summary about Edward’s progress – he is now *“able to have a say in his life, to steer his own boat”*. Ray commented on the therapy *“”it’s a real good thing”, “I’d recommend it to anyone*” and he agreed that empowerment is *“everything really – you’ve got to feel… cared about really, you’ve got to feel wanted”; “You’ve got to feel … like there’s a purpose that you’re here – everyone needs a purpose”.* Overall, Ray indicated that the changes in Edward’s life had been positive as a result of the therapy, although he did acknowledge that Edward felt a greater responsibility since having his own home. This provides reinforcement for Super-ordinate Theme 4: ‘Positive Outcomes’.

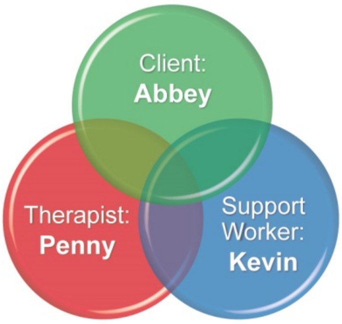
4. Triad Four: Abbey (client), Penny (therapist) & Kevin (support worker)

Figure 4. Overview of Triad 4.

Triad 4

Client: **Abbey**

- Abbey enthusiastically embraced the therapy sessions and the opportunities of empowerment, which enabled her to release the past and move forward, making positive improvements in her life and feeling stronger.
- Dealing with obstacles was an important theme for Abbey, overcoming defensive feelings about her husband's ex-wife stalking them and feeling calmer in general and better able to cope with life.
- Abbey reported the helpfulness of the therapy, which enabled her to process life events, her thoughts and to experience greater mental clarity. As a result she was communicating better and, making changes at home and generally feeling stronger.
- Improved sleep behaviours linked to increasing self-awareness and anger management were themes raised by Abbey, as a result of strategies and goals pursued during the therapy.
- Abbey mentioned the importance during the therapy of gaining insights from her past; processing and reflecting on previous relationships and their impact upon her current one and learning to be more independent.
- Expectations about housework and marriage was a key theme raised by Abbey, since both partners (LD and non-LD) had differing expectations; she felt she was now more assertive and communicating more effectively.



Therapist: **Penny**

- Penny highlighted the importance of working with and supporting the carer/husband also, which involved exploring the impact of the partners' differing approaches and needs, as well as providing training, education, sign-posting and information-sharing.
- The challenges of providing therapy in an LD service was a key theme for Penny, which she found could be more complicated and frustrating, due to less self-awareness, necessitating close monitoring, more frequent reviews and a gradual approach, providing the therapy in stages.
- Penny discussed using the PCA in the NHS, as a niche therapy with PWLD, which was difficult at times due to an emphasis on the medical model in the NHS, with service constraints such as time-limitations, necessitating the need for supervision for the maintenance of her PCA identity.
- An importance for therapist sensitivity and noticing subtleties in LD work was reported, especially when dealing with clients' strong emotions, determining 'truth', using challenging questions, finding a resolution for ending sessions and using personal empathy around knowledge of minority groups, with a motivation to support and empower PWLD.
- The theme of adaptations being needed in LD work was again highlighted, as Penny referred to the need for extra time, dividing therapy into smaller chunks, acknowledging individual differences and abilities, which in turn created a need for additional styles of explanations, with practical exercises and demonstrations.
- Penny also mentioned positives and opportunities for empowerment resulting from the therapy, which created mutual satisfaction from seeing progress occur, enabling Abbey to move on and encourage her transformation.

Support Worker: **Kevin**

- Kevin discussed his role as a support worker and husband/carer, such as his attitude and feelings about the support, which included an element of conflict.
- Kevin highlighted improvements for Abbey since the therapy, although he was still aware of her ongoing needs, which provided evidence of empowerment and her increased independence, in the form of greater self-confidence, capability at home and thinking more clearly.
- An appreciation of the therapy and therapist was expressed by Kevin, as he found that Abbey had felt heard, supported and not judged by Penny; he reported that other non-LD specialist therapists had been patronising and therefore less rapport or therapeutic progress had ensued.
- Kevin discussed Abbey's main problems for which she had accessed therapy, in terms of helping to prevent angry outbursts, her concentration, mental health difficulties and to process past difficult relationships; Kevin considered that she had needed specialist support to aid self-expression, which the therapy had successfully addressed.
- Kevin's perception of Abbey's specific LD needs included her cognitive difficulties, which required extra help, encouragement and support, as she was prone to being forgetful, having a limited understanding and attention-span.
- The impact of physical aggression and subconscious processes was an important theme for Kevin, particularly in terms of Abbey's violent behaviours, which he was surprisingly tolerant about and perceived them as being "subconscious" in cause, requiring a physical outlet which he provided by supplying Abbey with boxing gloves.

Figure 4 provides a summary of the following idiographic account of Triad 4 and highlights the key themes (Chapter 4) evident in the triad.

Abbey was in her mid-thirties and had also experienced previous counselling from other NHS services, including Adult Mental Health and from her GP practice. She had been referred for anger management, although the initial treatment plan evolved as other issues emerged. Penny was a Counsellor in her early 50s whose preferred therapeutic model was the PCA; this was one of her key themes as seen in triad diagram 4 above, about which she experienced some tension in terms of working within the NHS, where a predominantly medical model still existed. Abbey received counselling from Penny for about a year, where they explored past relationship issues still impacting upon Abbey and her current relationship (“*I’d never really come to terms with it”).* Gaining insights from her past was a key theme for Abbey (also included in the diagram above). Kevin was a different kind of support worker to those in the previous triads, in that he was also Abbey’s husband and her main carer.

Abbey was emphatic about how helpful she had found the counselling sessions with Penny – *“Definitely, definitely, it’s really helped me”* and she spoke about how the therapy had helped her release difficult past memories and move on: “*And turn around and say, ‘Goodbye past – moving on!’”* Abbey described the counselling as helping her release, analyse and process her experiences *(“made me realise everything… realise what I couldn’t see, and I felt so weak… I just didn’t know what to do and now I feel so much more stronger”).*

Penny described Abbey as “*quite broken*” and *“very fragile”* at the start of the therapy, but her desire to make the most of the counselling was refreshing and Penny said, *“it’s nice seeing her transform in front of your eyes*”. Penny considered that sometimes having review sessions with both partners had been challenging, as she had needed to take care not to confuse review sessions with couples counselling, as the sessions were primarily for Abbey. She also described some differences of opinion, such as when Kevin decided to buy Abbey a punch bag to release her frustrations – something Penny was not sure was a good idea (given that when Abbey’s referral was received, *“she had a glass bottle at Kevin’s neck”* and her history of violent relationships). Penny felt that Abbey was not keen on this strategy either.

Penny found a key theme was that it was important to discuss Abbey’s LD needs with Kevin (see diagram), so there was also an educational element and a need to explore adaptations that Abbey required, reminding Kevin that *“there’s some things that will not change* [about Abbey], *it’s about adapting… to that*”. Kevin also discussed his awareness of Abbey’s additional LD needs, including her cognitive and mental health difficulties, for which she had needed support (see diagram). Penny’s joint working approach ties into Super-ordinate Theme 2, sub-theme 2.2 regarding the importance of ‘Collaboration when working with PWLD’. A need for sensitivity in her work was also mentioned, which links to several of the super-ordinate themes (sub-theme 1.2: ‘Facilitators’ awareness of limitations & challenge working with PWLD’ and Theme 2: ‘Building Relationships, Collaboration & Trust’).

During the interview, Abbey discussed other strategies involved alongside the PCA counselling she had clearly embraced with Penny, including the use of a sleep diary, *“for my sleeping habits”*. She used it to record ideas, look for triggers and helpful strategies and to *“try out techniques before I go to bed to keep myself calm so I don’t kick Kevin* [husband] *in my sleep”*. During the interview and data processing stages, the researcher reflected to what extent these behaviours whilst sleeping were “*always subconsciously, I might add”?* [Abbey]. An improvement in sleep behaviours was one of Abbey’s key themes and linked to Super-ordinate Theme 4 about ‘Positive Outcomes’. Abbey said she had been able to move on “*from my past”,* which also included getting over her fears, being more assertive and better able to stick up for herself (with Kevin’s ex-wife). Abbey felt confident enough to keep some personal information about her sessions to herself, whilst able to disclose and discuss other parts when she wanted to, with her husband Kevin – this also sounded like a more recent development for her.

There were elements of Abbey’s life where she still was working on developing feelings of empowerment or where she experienced some disempowerment, such as feeling the need to frequently phone Kevin whilst travelling to an appointment or checking his opinion about things ("*It's like he* [Kevin] *says, 'you don't need to call me – let me know when you arrive at your destination when you're on the bus but in between, there's no need to…'*"). Abbey also spoke about some feelings of trepidation regarding Kevin's ex-wife, although this had dissipated a little since they had taken out a legal injunction against her *("we're keeping our guard up at the moment – yes she's gone quiet, but we're just waiting – we're on guard, as you call it!")* – however this could be queried as something not related specifically to Abbey having a learning disability and highlights the fact that many PWLD experience the same or similar life issues as other member of the general population, who do not have the label of having a learning disability.

Overall, in terms of empowerment, Abbey described making improvements in terms of doing more, *"stepping up to the mark*". Abbey said she was realising more things and feeling increased awareness, thinking more clearly and more calmly. Abbey also said she was communicating more effectively and feeling stronger, more confident and doing more independently (such as bus travel/to appointments). One of her key themes related to the helpfulness of the therapy, as she said she had been able to move on from the past, get over some fears and feel more autonomous.

Penny described empowerment as "*It's who you are really… you have to go out there and get it!"* (something one gets for oneself: empowerment from self-advocacy) *"for me… it is a biggie"* (due to Penny being from an ethnic minority group herself and having a shared desire for inclusion and equal access to life's opportunities). She felt it was important *"To actually believe in yourself, you have a right to do things…"* so her aim from which she reported professional satisfaction, was in *"Helping clients to do whatever they want to do", to "give it a go!...or, ok, well find something else!"* For Kevin, empowerment involved encouraging someone to be more independent and confident and he spoke about helping people develop, *"To be independent" and "not just being reliant on people".* Although aware of Abbey's ongoing needs, Kevin articulated her positive improvements and evidence of increased empowerment, in the form of greater self-confidence, capability at home and clarity of thinking. Super-ordinate Theme 4: 'Positive Outcomes' is again therefore clearly implicated in this triad.

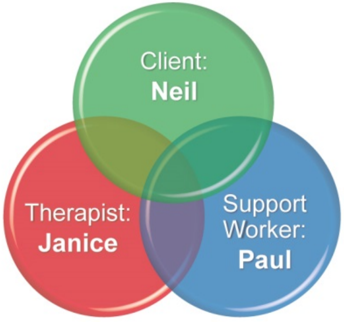
5.Triad Five: Neil (client), Janice (therapist) & Paul (support worker)

Figure 5. Overview of Triad 5.

Triad 5

Client: Neil

- Neil was very concerned about the possibility of having an LD or 'Autism' label and other people's perception of him, which was linked to accessing the LD service and whether he met the required IQ criteria of below 70.
- Disadvantages of independence and empowerment were raised by Neil, who felt vulnerable in his neighbourhood and boredom at being on his own in his flat.
- Neil's interview highlighted his attitude towards professionals and helpers, where he put people in 'boxes' according to their job roles, which was partly linked to his fears about stigma.
- Neil's perception of the therapy vs mum's perception of it differed, in terms of their awareness of improvements in his mood and in his coping skills.
- Insights about himself and self-awareness of therapy was a key theme from Neil's interview, where he often used of humour and sarcasm or irony to mask difficulties.
- Neil's response to the research interview process reflected his PDA diagnosis, with some avoidance behaviours, in terms of questions.



Therapist: Janice

- Janice spoke about the impact of the PDA and OCD on the therapy, which affected the organisation of the sessions, Neil's engagement and the therapeutic relationship.
- Barriers, obstacles and disempowerment around having an LD label, or the expectations and stigma associated with it, influenced the therapeutic process, such as Neil having attended a special school whilst having high expectations of himself, having fears of own aggression and reactions to bullying. These reflected the LD population generally, raising issues about who is the referral for, service criteria issues and the impact of one's environment.
- Adaptations to therapy and 'reasonable adjustments' were important for Janice in her work with Neil, as she was required to go at a slower pace, bring greater flexibility into the therapy and ensure she spoke to him appropriately.
- Janice highlighted the importance to her of using the PCA, to allow the building of trust and development of a therapeutic rapport; this in turn allowed Neil to develop his own individual strategies, at his own pace.
- Achievements in the therapy and therapist satisfaction was an important theme for Janice, which related to the therapeutic progress and rapport, partly facilitated by the use of humour in the sessions.
- Janice also stressed the importance of MDT working with support workers, which included staff training the sharing of relevant information. This also included a need for flexibility, with an element of overlap within professional roles.

Support Worker: Paul

- Paul reported the importance of supporting Neil via a positive, genuine relationship, which involved commitment, effort, building trust and developing rapport. Offering Neil encouragement, praise and seeing past any differences was essential. He also felt that sharing information was helpful, such as around Neil's OCD.
- Paul focused on practical support elements of his work, geared towards the therapeutic issues Janice was working with, which included accessing the community, support with social boundaries and helping Neil with problems at college. He helped Neil with a police interview and was successful in setting small, achievable targets in the work.
- Achievements and satisfaction was a key issue highlighted by Paul, which came from progress seeing Neil's increasing independence, such as going out alone, moving into own flat and carrying out domestic tasks. He found it rewarding helping and motivating his clients with making achievements.
- Paul found that teamwork and liaising with other MDT professionals was extremely helpful, such as sharing information and PDA advice, agreeing that a degree of flexibility was required for LD support and a consistency of approach.
- Challenges and obstacles was another key theme for Paul, relating to Neil's concern about LD stigma and other people's opinions, his family dynamics and significant PDA support needs, which had been difficult initially, alongside Neil's very high aspirations. Paul expressed fears about Neil's future as a result of service gaps.
- Adaptations was Paul's final theme, which he felt were essential, in terms of working creatively with PWLD and utilised by an indirect, chatty and humorous approach, using small, slow steps geared to Neil's own pace.

Figure 5 provides a summary of the following idiographic account of Triad 5 and highlights the key themes (Chapter 4) evident in the triad.

Neil was 19 years old and had accessed the CLDT for two years at the initial request of his mother, who had been concerned about his depressed mood and threats of suicide. Neil had been experiencing difficulties at home – possibly linked to being on the autistic spectrum, and struggling with OCD, although he eventually settled well into his own flat with staff support. Neil had experienced difficulty before the CLDT intervened, although this was not primarily due to a learning disability (Theme 3: Struggled without support).

Janice was an experienced consultant counsellor in her early 60s, who used the PCA in her work with Neil, alongside aspects of Transactional Analysis (TA). Her initial treatment plan involved had carrying out an IQ screening assessment, to find out if Neil was eligible to access the adult NHS service, as he transitioned from children's' services. It later emerged that Neil had a higher IQ than the other clients in this study, ultimately not meeting the service eligibility criteria. He had first refused to undertake the assessments to establish his cognitive level, partly attributable having PDA (Pathological Demand Avoidance). Therefore, Janice changed the original treatment plan, in order to focus on building the therapeutic relationship, which was a key theme for her, particularly via using the PCA. Paul was a support worker in his mid-40s who worked alongside Janice and other members of staff within the team, due to Neil *"not going out and not engaging"* and *"to get him out of the house".*

Initially Neil attended some sessions in the 'Sensory Rooms' of the main LD centre, to help encourage social interaction, but engagement was difficult due to the stigma he associated with accessing an LD establishment, which he therefore felt resistance towards. Paul afterwards supported Neil in the community and with a police interview and court appearance. Super-ordinate Theme 1: 'Values, Stigma & Social Equity' is strongly linked to the key themes of the participants in triad 5, as Neil was concerned about having an LD label, which was similarly highlighted by Janice and Paul.

Neil felt very aware and sensitive about the idea of having an autism diagnosis, being 'different' and strongly resisted being labelled as having a learning disability: not wanting to come near the NHS Learning Disability building and arguing about this throughout his therapy. Paul in supporting Neil could see that Neil was affected by the LD sign outside the building: he *"had a problem with that as soon as he noticed it".* Neil was also affected by labelling and segregation issues via his grandmother, who unwittingly upset him, saying *"he's special and he's going in a special bungalow".* Paul described Neil struggling socially, with social norms and with his autism.

Neil frequently used humour to mask some of these issues and feelings *("I'm a crazy person!"),* or about the therapy: *"I had many weird conversations!"* From his interview, Neil showed some self-awareness, being able to acknowledge his defensiveness to the therapy meetings, describing himself: *"you know, hood up, head on the table*.." as well as to questioning in general - admitting that he behaved with irritation towards people: *"Every person – 'stop asking questions, fuck off! Oh, fucking leave me alone!'*" Neil also felt indignant that his mother had requested the counselling (*"mum thought that I was depressed, and I needed help"),* which brought in the wider issue of whose problem was it and questions about who makes the referrals? Therefore, one of the key themes identified for Neil, was also the contrasting perceptions of himself and his mother, in terms of the need for and results of the therapy. Neil's PDA was also reflected in his approach to the interview questions in general, having some avoidance behaviours linked to his diagnosis; whilst he was aware of some elements of progress in his life, he also reflected some questions and used humour or sarcasm possibly as a self-defensive mechanism.

Janice spoke about the impact of PDA on Neil's life and others around him, including his self-isolation: *"he was locking himself away upstairs for hours on end".* She also spoke about Neil's OCD diagnosis during the counselling, describing how *"he goes over it and over it to such a point that he says he feels like ending it altogether".* So, it was imperative for Janice that she was able to be relaxed and flexible in her sessions (this also applied in general to her work: *"you really have to be as flexible as you can be"*), starting them at three hours and gradually reducing them to one hour. Janice allowed Neil to lead the sessions, going at his own pace and *"gradually eased in topics that were difficult for him",* since he blocked any demands made of him. Paul also spoke about the importance of taking things slowly, sometimes taking a *"backseat"* approach. He described a *"suck it and see"* approach, as Neil was nervous and easily put off. Both Janice and Paul referred to the importance of making adaptations; hence these were key themes in diagram 5 above. This also correlates with Super-ordinate Theme 3: 'Coping & Adaptations', since both clearly found that 'Adaptations are essential for facilitators working with PWLD' (sub-theme 3.2).

Janice described how Neil's mother was initially included in the sessions, since they took place at her home and the issues involved affected the whole family *("before the therapy, he was a difficult person – his whole family were in sort of a melt-down"; "Neil controlled the whole house"*). She discussed the importance of Neil feeling comfortable and people 'gelling' with Neil – *"some of the other people I referred him to, he didn't gel with"*. Janice also spoke about the satisfaction she had experienced from working with Neil*: "it's been a joy to work with him"* and considered that it had been advantageous that they got on well from the beginning. Paul also felt the therapeutic support had been worthwhile – *"to be honest with you, it's all been successful".* He felt this was partly because Neil was "no longer a prisoner in his own home".

Paul had also been able to share with Neil his own personal experience with OCD and queried some 'normal'/age-appropriate behaviours: *"Did you tidy up every day when you were 20?"* Paul had been briefed about Neil's PDA and told not to ask him too many questions at the onset. However, Paul found he needed to adapt some of his PDA training – for example he had been told *"don't praise him",* but found that praise actually worked well in the work and was appreciated by Neil: *"telling him what he's achieved", "I said to him, 'you've got potential!'"* – therefore sometimes training needed adaptations and individualising. Paul also described being passionate about his job – *"I try to have… connections with every person I work with".* These themes of achievements and satisfactions due to the therapy work, tie in with Super-ordinate Theme 3: 'Coping & Adaptations' and also Theme 4 regarding 'Positive Outcomes', since both facilitators reported 'Positive, empowering outcomes' (sub-theme 4.1) as a result of their involvement.

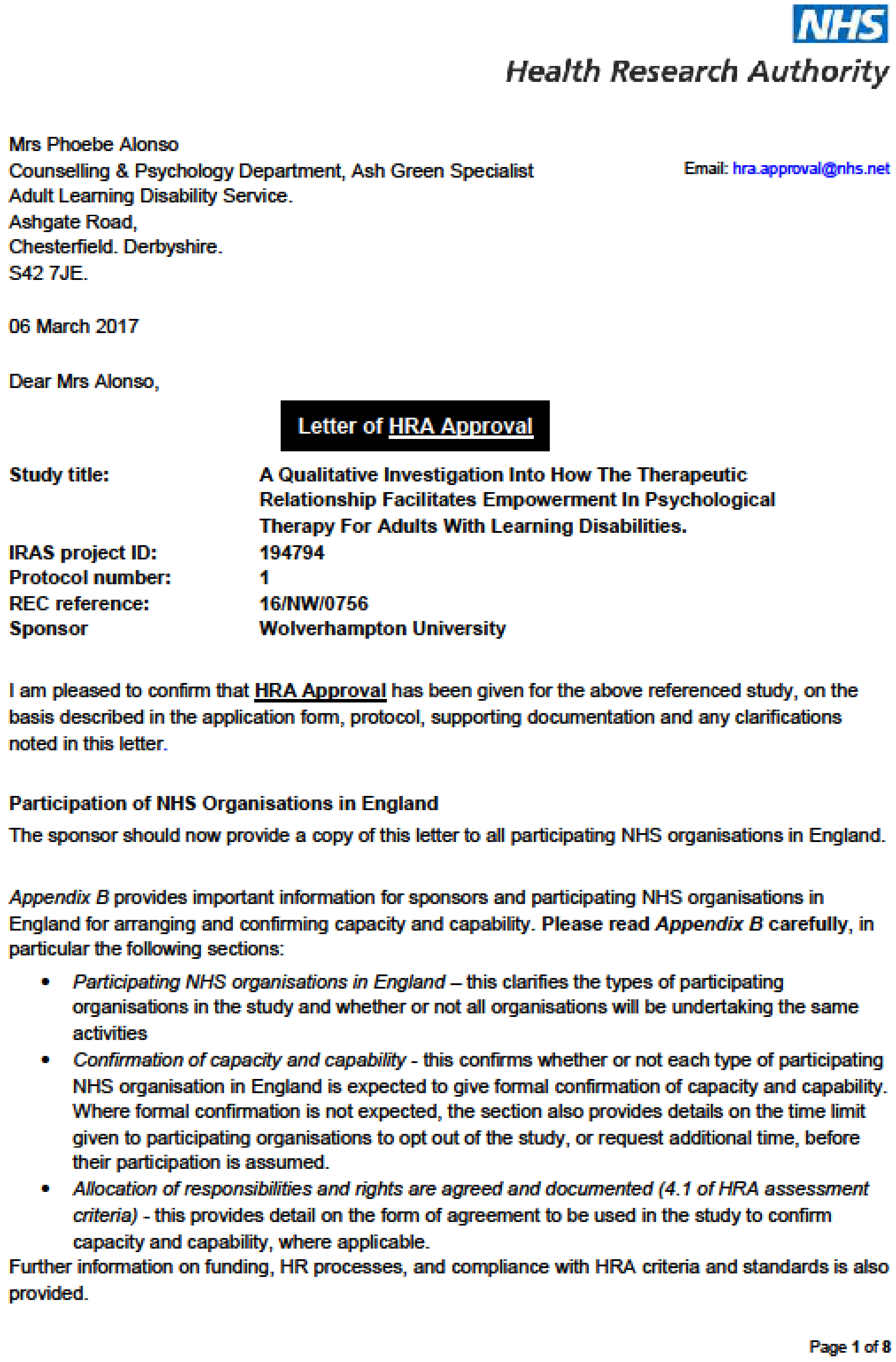
During her therapeutic work with Neil, Janice had provided staff training around *"what PDA means and how it impacts someone's life".* She and Paul highlighted the importance of consistent, multi-team working ("*we can always learn from each other*"- Paul), as other members of staff had also been involved supporting Neil, especially when he first moved into his own flat. Janice felt that Neil had benefitted from *"having fantastic carers"* and she discussed more generally the importance of ensuring that "everybody is on board", as well as highlighting the importance of a person's *"environment"* and support network (particularly important for someone with additional psychological, mental health needs or intellectual difficulties). Neil also spoke about current social difficulties with his neighbourhood and considered that therapy had its limitations – *"no amount of therapy sessions is going to make me like the neighbours!"* This reinforced the issues of environmental and socio-economic factors causing disempowerment for people accessing social housing and may be linked to Super-ordinate Theme 1: 'Values, Stigma & Social Equity'. Neil was worried that he would lose his temper and get into trouble, as this had been a pattern previously: reacting angrily to verbal bullying from his peers and local teenagers, who he described as *"crazy drug addicts".*

Neil spoke about Paul having taken over some of the role and responsibilities of his mum, when he left home and joked about whether his counselling had made him more independent –*"but obviously it's not happening, because I've got a trained counsellor doing my washing up!"* (Janice was present during the interview). Paul said lots of hard work and time was needed for Neil to trust people. A relaxed, friendly and often humorous approach had worked well, with subtle cajoling, avoiding pressure *("I think I get a lot of stuff out of* *him... with jokes"*). Paul had offered to have his IQ tested also: *"if you have it done, I'll have it done!"* and described chatting with Neil about things he likes *("technology and all that kind of stuff"*). Wherever possible, Paul tried to *"make it that it's his idea";* thus, the importance of rapport and trust was again a key element. This theme was highlighted by Paul in terms of the value of a supportive, genuine relationship and was supported by Janice as she mentioned the importance of building a trusting relationship through the use of the PCA, which had enabled Neil to gradually engage with them and experience positive changes in his life. These themes also link to Super-ordinate Theme 2: 'Building Relationships, Collaboration & Trust'.

Neil had mixed feelings about whether he felt empowered, as a result of the therapy or changes in life circumstances. He agreed that being independent was important to him, as he liked having his own flat, but said this also had its disadvantages, complaining about having to do house chores. Neil also said that empowerment could be boring, as he was on his own in the flat all day. Neil set high expectations of himself in some areas, such as wanting *"to go to America and do films"* [Paul] – Paul helped Neil be realistic without dismissing his ambitions: *"but you won't even go on the bus [to college]…won't it be hard for you to go there*?" Paul also helped Neil to set goals and develop his own strategies.

For Janice in her work, empowerment related to *"trying to get the person to speak up, speak out, and stand up for themselves appropriately and in a way that doesn't get them into trouble"* – as Neil sometimes overreacted with other people when feeling attacked, resulting in sometimes unfortunate consequences (such as being reported to the police). Janice also spoke about the importance she felt in LD work to *"not treat them different to anyone else"* and *of "seeing a person in their own right"*, which dovetails with the PCA approach she used. Janice explained, *"we have to unpick a lot more in LD's than you would with the general population"* and she mentioned the importance of providing clients a *"really safe space"* to explore their thoughts and feelings, via the therapeutic relationship. For Paul, empowerment related to his own feelings of determination, motivation and wanting to help others: *"I like a challenge… and to think I've made a difference"; "I like to achieve stuff with people and I want them to achieve…"* (a *"we're gonna get this guy out!"* attitude).

APPENDIX D: HRA LETTER FOR ETHICAL APPROVAL



NHS
Health Research Authority

Mrs Phoebe Alonso
Counselling & Psychology Department, Ash Green Specialist
Adult Learning Disability Service.
Ashgate Road,
Chesterfield. Derbyshire.
S42 7JE.

Email: hra.approval@nhs.net

06 March 2017

Dear Mrs Alonso,

Letter of HRA Approval

Study title:	**A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.**
IRAS project ID:	**194794**
Protocol number:	**1**
REC reference:	**16/NW/0756**
Sponsor	**Wolverhampton University**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

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APPENDIX E: INVITATION LETTERS

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Derbyshire Community Health Services NHS
NHS Foundation Trust

North Derbyshire Specialist Learning Disability Service
North East & Bolsover Community Learning Disability Team
19 High Street
Staveley
Chesterfield
S43 3UU

Tel: (01629) 537456
Fax: (01246) 348057

Roger Simpson,
Clinical Effectiveness Facilitator,
Derbyshire Community Health Services NHS Foundation Trust,
Newholme Hospital,
Baslow Road,
Bakewell.
DE45 1AD.

Dear Roger,

As part of my doctorate course at the University of Wolverhampton, I am proposing to conduct a research project exploring the facilitation of empowerment in people with learning disabilities, via the use of the therapeutic relationship. To do this I require your support with carrying out semi-structured interviews with colleagues from the Adult Learning Disabilities Service Counselling & Psychology Department, one client service-user per therapist and one support worker per service-user, totalling approximately 21 participants. I will also be carrying out pilot interviews with Assistant Psychologists, some of their clients and support workers.

If you agree for this research to take part, it will involve qualitative analysis of transcripts from the recorded interviews, using phenomenological interpretative analysis (IPA). The potential benefits of this research include: information about the experience of empowerment in learning disabled people, via use of the therapeutic relationship, as well as the opportunity to participate in a qualitative research study.

I am therefore writing to seek your permission to conduct this study within DCHS premises, with several of your staff and service users. I enclose a copy of the research protocol for your information.

I look forward to hearing from you.

Yours sincerely

Phoebe Alonso
HCPC Registered Counselling Psychologist
Professional Doctorate Student at Wolverhampton University.

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Derbyshire Community Health Services NHS
NHS Foundation Trust

North Derbyshire Specialist Learning Disability Service
North East & Bolsover Community Learning Disability Team
19 High Street
Staveley
Chesterfield
S43 3UU

Tel: (01629) 537456
Fax: (01246) 348057

A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Dear ……….

I am writing to ask you if you would like to be asked some questions about your therapy. I would like to know how it made you feel about yourself and your life. It is for a Psychology course I am studying at the University of Wolverhampton.

I have also sent you an information sheet, telling you about the questions and what taking part would be like.

If you would like to take part, the questions would take about 1 hour.

I will also be asking some questions to your therapist, your support worker and some other service-users, at another time.

I would be finding out what is important when therapists and clients work together

I would also like to know what makes people with learning disabilities feel helped and better about themselves afterwards.

Anything you say would be kept private.

Any notes I made during the questions would be destroyed afterwards.

I would make an appointment in one of the meeting rooms in one of the buildings you have been to, such as Ash Green.

This would be at a time that you can choose.

Afterwards I would be writing a report about the questions and answers. I would use numbers instead of names, so no one else will know who gave the answers.

If you would like to take part in the questions, please tell your carers or tick the other sheet and post it to me at Ash Green. If you don’t want to be involved, that is fine too.

Thank you very much,

Phoebe Alonso

Counselling Psychologist, studying at Wolverhampton University.

Derbyshire Community Health Services NHS
NHS Foundation Trust

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North Derbyshire Specialist Learning Disability Service
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Chesterfield
S43 3UU

Tel: (01629) 537456
Fax: (01246) 348057

A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Dear ……….

I am writing to invite you to participate in a research project, which I am conducting as part of a professional doctorate course in Counselling Psychology at the University of Wolverhampton. I enclose an information sheet, which explains the title and aims of the project and what taking part will involve.

If you are willing to be interviewed, the interview would take approximately 60 minutes. I will also be interviewing other therapists, support workers and one of your clients/service-users on a separate occasion, as the research is looking at the therapeutic relationship between clients with learning disabilities and their therapists. Anything you say would be totally confidential and any notes made as a result of the interview would be destroyed afterwards. The interview would take place within suitable familiar DCHS office locations, at a time that is convenient to you. A report will be written of the findings and numbers will replace all names so that you cannot be identified.

If you feel that you would like to be interviewed, please indicate on the attached sheet and forward it to me at Ash Green. If you would prefer not to be involved, please destroy/ignore this letter. If you decide not to be involved, I would like to assure you that this will in no way affect your relationship to the researcher, the University of Wolverhampton, or to DCHS.

Yours sincerely,

Phoebe Alonso
HCPC Registered Counselling Psychologist
Professional Doctorate Student at Wolverhampton University.

APPENDIX F: TABLES OF PARTICIPANT BACKGROUND INFORMATION

Pseudonym & Triad No.	Reason for Referral (presenting problems of client)	Diagnosis	Level of LD/Functional Needs	Other Key Background Information
Sid (PWLD#1)	Counselling for Recurrent Depression due to past relationship/family issues & low self-esteem.	Recurrent Depression was reported.	Mild learning disability	Depression due to various struggles in life, partly as a result of his LD label and schooling. Sid also experienced significant guilt regarding past relationships and not having been involved with his daughter as she grew up. An important positive part of Sid's life was his voluntary work-placement, where he benefited from being able to develop practical skills and experienced value from community contribution and team-working. Towards the end of the therapy Sid was re-united with his daughter, an important milestone for him. No other members of the MDT were involved.
Jacky (PWLD#2)	Counselling for past traumas from family issues & abuse, resulting in mental health concerns & self-harm.	PTSD & various physical health issues.	Mild learning disability	Complex issues and symptoms were involved, due to significant and various kinds of abuse, since childhood. Other members of MDT were involved to support additional physical health issues and adult care/financial concerns and support needs. Mental health problems included self-harming by cutting and threatening to overdose on medication or to throw herself under a train. Jacky also reported seeing and hearing things, including ghosts/ESP (extra sensory perceptions). Although no longer sexually or physically abused, Jacky still experienced sporadic financial exploitation from family members, whom she found very difficult to stand up to. Some of the therapy and support work focused upon this, as well as accessing the community on her own, overcoming social anxieties and feeling less traumatised by past memories and experiences.
Edward (PWLD#3)	Counselling for past workplace bullying/abuse, relationship & behavioural issues	Had initially met the criteria for PTSD.	Mild learning disability	Edward reported experiencing workplace bullying/victimisation on two separate occasions/placements. A Safeguarding investigation took place at one point regarding historical institutional abuse, although due to the length of time that had elapsed, medical notes were no longer accessible, and some professionals had moved or died. The therapy took place over a decade and involved joint work with support workers and parents. At earlier times Adult Care and other members of the MDT had also been involved, as Edward had experienced a breakdown as a result of the bullying, almost requiring admission as a hospital in-patient and medication. Edward no longer requires medication and also moved into his own house.
Abbey (PWLD#4)	Counselling for anger management and past relationship issues.	No prior formal diagnosis.	Mild learning disability	The original referral was for anger management, but it subsequently became clear that past and current relationship issues were key and required addressing, as well as learning to become more independent. Abbey's main support worker or carer was her husband, who was also interviewed. Abbey found the therapy very releasing and embraced it with gusto. She reported finding it very helpful and had been able to make significant progress and improvements in her life. No other members of the MDT were involved, apart from occasional doctor appointments.
Neil (PWLD#5)	Service screening assessment and counselling for mental health/behavioural concerns, struggling with transitional issues, PDA & OCD symptoms.	High functioning Autism, PDA & OCD	IQ exceeded service criteria specifications (above 100). Mental health and functional needs resulted in accessing service.	Initially Neil was referred via his mother, who worked at the LD service involved and spoke to the Consultant Counsellor. His level of cognitive ability was unknown, so a screening assessment was initially planned. This took time due to Neil's PDA and unwillingness to be involved with LD services. It later transpired that Neil did not meet the service criteria, having too high IQ & adaptive behavioural scores. OT and Adult Care were also involved, to help facilitate community access (again restricted by Neil's PDA). A turning point took place when he moved into his own flat, although this at times brought additional problems, such as gangs of teenage neighbours. Due to Neil's age, transitional issues were also involved, as he moved from Childrens' to Adults' services.

Pseudonym & Triad No.	**Job Title**	**Reason for Therapeutic Work**	**Therapeutic Model/Approach Used**	**Length of Time Working with Client**	**Other Key Background Information**
Eve (T#1)	Senior Counselling Psychologist	Counselling for Recurrent Depression due to past relationship/family issues & low self-esteem.	Compassion-Focused Therapy	6 months	20 years counselling psychology experience (NHS). BPS Chartered & HCPC Registered Senior Counselling Psychologist
Nichole (T#2)	Senior Counselling Psychologist	Counselling for past traumas from family issues & abuse, resulting in mental health concerns & self-harm.	Integrative/Mixed Therapeutic Approaches	10+ years	21 years counselling psychology experience (NHS). BPS Chartered & HCPC Registered Senior Counselling Psychologist
Tim (T#3)	Therapeutic Counsellor	Counselling for past workplace bullying/abuse, relationship & behavioural issues.	Integrative/Mixed Therapeutic Approaches	10+ years	16 years counselling experience (NHS). MBACP BCU A CAPBS Practice Lead
Penny (T#4)	Counsellor	Counselling for anger management and past relationship issues	Person-Centred Approach	12 months	24 years counselling experience (Relate, NHS). BA (Hons) Social & Community Studies; Certificate in Counselling Skills; Certificate in Therapeutic Counselling; Advanced Certificate in Therapeutic Counselling; Diploma in Therapeutic Counselling.
Janice (T#5)	Consultant Counsellor	Service screening assessment & counselling for mental health/behavioural concerns & PDA	Person-Centred Approach (& some Transactional Analysis)	2 years	20 years counselling experience (NHS). Head of Counselling & Psychology Dept. Fellow of British Association for Counselling & Psychotherapy; Diploma & Master's in Counselling; MSc in Profound Learning Disabilities & Multi-Sensory Impairment; Master Practitioner NLP; Teaching certificate for adults in further education; Special education teaching certificate.

Pseudonym **& Triad No.**	**Job Title**	**Reason for Support Work**	**Type of Support Worker**	**Length of Time Working with Client**	**Other Key Background Information**
Robert (SW#1)	Support Worker (Previously also Social Worker)	Work-placement-based support. No joint work with therapist.	Voluntary Work Placement Support Worker	10+ years	Robert had past knowledge of Sid, as he had previously worked as a Social Worker. This was helpful in terms of understanding Sid's support needs and background experiences causing some of his problems and symptoms. Robert was careful not to interfere with the therapy and respectful of boundaries, so there was not a great deal of joint work involved, although he monitored Sid and his progress. Robert mainly provided skills-based and placement-based support.
Malcolm (SW#2)	Technical Instructor/Support Worker	Support work involved travel/bus training and working with therapist to put into practise activities relating to social anxiety and overcoming past traumas.	Community Support	4 years	Malcolm often worked alongside the therapist Nichole, attending joint sessions, which was useful as Jacky would often choose to disclose information to one of them at a time; this could then be discussed together during the joint sessions. Malcolm followed the therapy work by providing practical support in the community, helping Jacky access the local health clinic or shops, initially with him and then meeting her there, to encourage her independence. Malcolm also provided travel training, supporting Jacky on buses, which she had previously been afraid to travel on alone, due to elements of social phobic behaviour and anxiety about people staring at her due to her past experiences. Malcolm found Jacky was able to trust him despite being male, a new experience for Jacky.
Ray (SW#3)	Support Worker	Supporting Edward in his own home and in the community or accessing appointments. Some joint therapy sessions.	Community Support	4-5 years	Ray's client Edward had requested that his support workers and parents attended all his therapy sessions, which the counsellor Tim remarked as unusual; this worked well in terms of sharing information and everyone working consistently together. Ray was also able to provide a de-brief or further meeting afterwards, to discuss how the therapy session had gone, after Tim had left, so the therapy process was extended, and Ray was able to report any concerns at the next therapy meeting if needed.
Kevin (SW#4)	Carer/Support Worker	To support Abbey (wife) to appointments & to support her at home with domestic tasks.	Husband, Carer & "Supporter"	5+ years	As client Abbey's husband, Kevin was a different kind of support worker to the others and clearly had more information about Abbey and a much closer relationship. Had a paid support worker been available, they may have been chosen instead, although there can be pros and cons to paid vs family carers.
Paul (SW#5)	Technical Instructor/Support Worker	Support to access the community, liaise with other professionals involved working with Neil's PDA & OCD related symptoms.	Community & In-patient Support	18 months	Paul had worked alongside the counsellor Janice, initially attending sessions in the Sensory Rooms of the main LD base, to help encourage social engagement. The client Neil attended some of these, but engagement was difficult due to the stigma he associated with attending an LD establishment, which he felt resistance towards. Paul then worked in the community, visiting Neil at his home with his family and then at his flat, when he moved into his own accommodation. Paul was also able to support Neil in the community via walking, tennis and supporting him with a police interview & court appearance.

APPENDIX G: RESEARCH INSTRUMENT – SEMI-STRUCTURED INTERVIEW PROTOCOLS

Title of Project: A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Interview Schedule – (LD Service-User Participants)

Background

- Why did you come to see …… (therapist)?
- Was this the first time you had seen ….. (therapist)?
- Who asked (therapist) ….. to see you?

Counselling Experience

- What happened in the counselling?
- What did you think about the counselling sessions?
- Can you tell me about your story of your counselling with…..?
- What did you like best about the sessions?
- What did you find helpful about talking to ……?
- Was there anything you didn't like about the counselling?

Results

- How did you feel before the counselling?
- Did you have any homework?
- Did you feel the counselling helped?
- Did you see any changes in your life after the sessions?
- How did you feel at the end of the counselling?

Empowerment

- Empowerment is about feeling better about yourself and being more independent – is this important for you?
- Was there anything making you feel bad in your life before the counselling?
- Does this still make you feel bad?

Additional Questions
- Were any other people also helping you?
- What did they do?
- Did you talk to your support worker about the counselling sessions? Did your support worker help you with any homework?
- Is there anything else you want to say about the questions I've asked you?
- Is there anything else you want to say about this research?

Thank you very much for helping me with these questions.

Title of Project: A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Interview Schedule – (Therapist Participants)

Background

- Can you tell me about your client's referral and what was the purpose of the therapy?
- Have you worked with your client before and if so, could you tell me about this?
- Could you tell me about the Treatment Plan created and any formulations or therapeutic goals involved?

Therapeutic approach & process

- Which therapeutic method or theoretical approach did you use with your client?
- Could you tell me about the journey or story of the therapy with your client? What were your initial impressions and any highs and lows during the therapeutic process?

Outcomes

- How successful did you feel the therapy was?
- How severe were the presenting problems before and after the therapy?
- How would you rate the degree and clinical significance of change?
- What did you find were the best and most successful aspects of the therapeutic process with your client?
- What were the worst and least successful aspects for those involved?
- How did you feel at the end of the therapy?
- Were there any lessons learned or practice development issues that came from the therapy?

The Therapeutic Relationship & 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 do you feel is important in terms of the role of the therapeutic relationship, when providing psychological therapy to an individual with a learning disability? And with ….. (specific client) what was most helpful or important?

Empowerment

- What is your idea about the meaning of 'empowerment' and how is it relevant or important in your work?
- What does empowerment mean to you, in terms of working in the area of providing psychological therapy to people with learning disabilities and the client we are discussing specifically?
- Were there any factors affecting your client, causing disempowerment in their life?
- Do you feel there are benefits from having an empowering focus within therapy?

- Are there any barriers or challenges to empowering through psychological therapy?
- In terms of your experience and understanding of empowerment and the therapeutic relationship with individuals with learning disabilities, is there anything else you would like to add or think we have missed talking about?

Additional Questions

- Could you comment on your involvement with any other therapists or health care professionals also working with your client?
- Do you have any other comments about these questions or this research?

Thank you very much for taking part in this research interview.

Title of Project: A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Interview Schedule – (Support Worker Participants)

Background

- How long have you worked with …… ?
- Could you tell me about your work with …..?
- Why was ……. referred for counselling or therapy and by whom?
- What was your idea about the purpose of the therapy?

Therapeutic approach & process

- Could you tell me about the journey or story of the therapy …..?
- Did you support …. to/from his/her therapy sessions?
- Did you get involved with any homework tasks and if so, what did you do?
- Did you notice any highs and lows that happened during the therapy with …….?
- What do you think was important about the therapeutic relationship?

Outcomes

- What were ….'s problems?
- How severe were ……'s problems?
- Do you think ….. benefitted from the therapy?
- Did …. show any changes at the end of the therapy?
- In terms of the initial referral and therapy goals, how successful did you feel the therapy was?

The Therapeutic Relationship & Learning Disabilities

- What did you notice about the therapeutic relationship?
- Were you able to talk to …. about his/her therapy sessions?
- What do you think …. found most helpful about the therapeutic experience?

Empowerment

- What is your idea about 'empowerment'?
- Is it relevant or important to you in your work?
- How important is empowerment for people with learning disabilities?
- How important was/is empowerment for ….. in particular?
- Were there any factors affecting ……. causing disempowerment in his/her life?
- Did you see any evidence of increased empowerment in ……..?

Additional Questions

- Did you work alongside any other therapists or health care professionals also working with...?

- Do you have any other comments about these questions or this research?

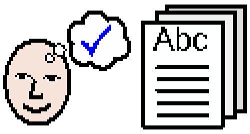
Thank you very much for taking part in this research interview.

APPENDIX H: INFORMATION SHEETS

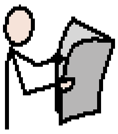
Derbyshire Community Health Services NHS
NHS Trust

Information sheet (Service-Users)

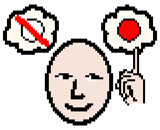
I would like to invite you to take part in some questions about your counselling.



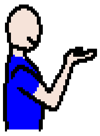
Before you decide it is important for you to understand why the questions are being asked and what will happen.



Please take time to read this information carefully with a member of staff and ask if you would like to know more about anything.

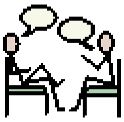


Take time to think about if you would like to take part or not.

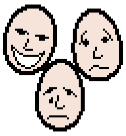


Thank you very much for reading this.

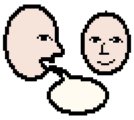
What are the questions about?



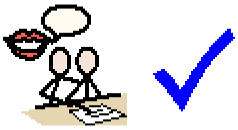
I would like to ask you some questions about what your counselling was like.



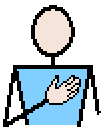
I would like to know how it made you feel about yourself and your life.

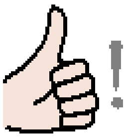


I would also like to ask your counsellor and support worker some questions.



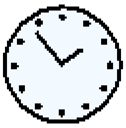
I would be finding out what is important when counsellors and clients work together.



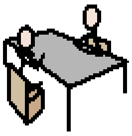


I would also like to know if the counselling made you feel helped and better about your life.

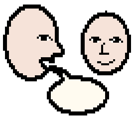
What will happen if I take part?



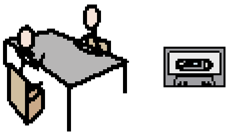
The questions sessions will take place during 2016-2017, taking about an hour.

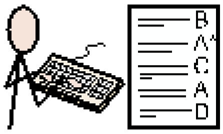


I will invite you to a meeting to talk about the questions.

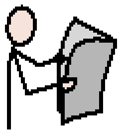


If you have any questions of your own, I will answer them and you can leave whenever you want.

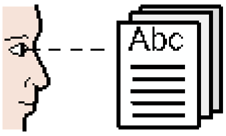




I will be tape recording the questions and answers and writing down all the conversations afterwards. You will be able to see or check these.

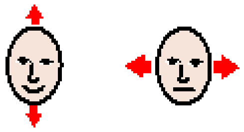


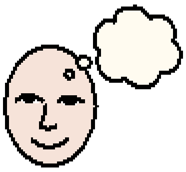
I will read the recordings and find out what is important to you, other service-users, your counsellor and your support worker.



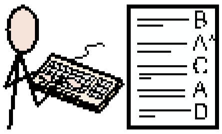
You will be able to see the information at any time for 2 years after the questions.

Do I have to take part? Is there anything else I need to know?

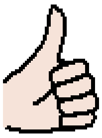


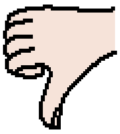


You are free to choose to take part if you like, but you do not have to.



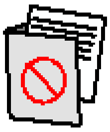
If you choose to take part, you can still stop at any time before I start writing about the results from the answers.



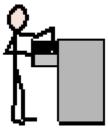


You don't have to give a reason for leaving.

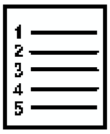
Will my answers be kept private?



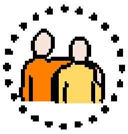
Yes. All the information about your answers will be kept private.



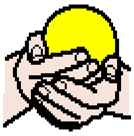
I will keep the writing safe in a locked office.



I will use numbers instead of names in all my notes and reports, so no one else will know who gave your answers.

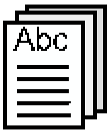


If you tell me that you are at harm during the questions, I will have to speak to someone about it who can help you.

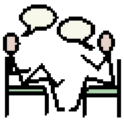


This is part of DCHS safeguarding policy, to keep you and me safe.

What will happen afterwards?



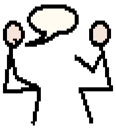
I will write reports for my course and may write about the information in a journal.



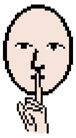
I will arrange to explain the results of all the answers afterwards in a meeting with you.

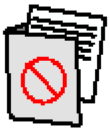
What if I have a problem?

Please ask if you have any questions at any time.



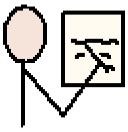
I will be happy to talk with you about the questions after the research is completed.





Your name will not be shared in the reports and all information is confidential.

Who else knows about these questions?



I have written to Wolverhampton University, DCHS managers and an organisation called IRAS (the NHS Integrated Research Application System).

They all check that I am doing my work well and safely.

Contact for further information

Phoebe Alonso, Ash Green, Ashgate Road, Chesterfield, S42 7JE. [redacted].

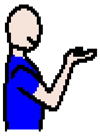
Dr Darren Chadwick, Faculty of Health & Wellbeing, Wolverhampton University. Telephone contact number: [redacted] *or*

Dr Nick Hall, Faculty of Psychology, Wolverhampton University. Telephone contact number: [redacted].

For any complaints or independent advice

Please contact The Patient Experience Team, Babington Hospital, Derby Road, Belper, DE56 1WH.
Telephone contact number:[redacted].

Or the Derbyshire Advocacy Service, Caxton House/HTC Business Park, London Road, Derby DE24 8UP.
Telephone contact number: [redacted].



Thank you very much

UNIVERSITY OF
WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Derbyshire Community Health Services NHS
NHS Trust

Participant information sheet (Therapists & Support Workers)

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. Take time to decide whether or not you wish to take part. Thank you very much for reading this.

What is the purpose of the study?

The purpose of this study is to explore how the therapeutic relationship facilitates empowerment in people with learning disabilities. The procedure will involve using a semi-structured interview schedule, with a set of questions for therapists, support workers and their clients/service-users with learning disabilities.

What will happen if I decide to take part?

All interviews will take place during 2016-7. Each interview will take approximately 60 minutes. Staff participants involved will be support workers and members of the Counselling & Psychology Department within the Adult Learning Disabilities Service, of DCHS. Client participants will have engaged in at least 2 sessions or known their therapist for at least one month.
All participants will be invited to a meeting for an explanation of the research and interview process.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be asked to sign a consent form. All participants will still be free to withdraw at any time prior to the commencement of the data analysis stage and without giving a reason.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The transcription of the interview you participate in will be stored on a password protected computer in a locked office, which you will be able to review. Only the researcher working on the project will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed.

If anything is raised during the interview that indicates that either the participant or someone else is at risk of harm, then these concerns will have to be taken further. Appropriate safeguarding advisors and/or relevant professionals would be contacted as per DCHS safeguarding policy.

What will happen at the end of the research study?

Findings will be disseminated in a report and discussed in departmental meetings. The results are likely to be published following the writing of my dissertation, from 2017 onwards. I will provide further information and details about this when I have them. I will also provide easy-read versions and follow-up meetings for all client participants.

What if I have a problem or concern?

Please do not hesitate to ask any questions about the study either before participating or during the time that you are participating. I will be happy to share findings with you after the research is completed. Your name will not be associated with the research findings in any way and your identity as a participant will be known only to the researcher.

If you have any questions about the method or conduct of the research, please contact me or the following Project Supervisors at Wolverhampton University:
Dr Darren Chadwick, Faculty of Health & Wellbeing
Dr Nick Hall, Faculty of Psychology.

Who has reviewed the study?

This study has been reviewed by the following Research Ethics Committees: Wolverhampton University, IRAS (the NHS Integrated Research Application System), DCHS.

Contact for further information:

Phoebe Alonso, Ash Green, Ashgate Road, Chesterfield S42 7JE.
Telephone contact number: [redacted]

Mr Roger Simpson, NHS Clinical Effectiveness Facilitator, Newholme Hospital, Baslow Rd, Bakewell DE45 1AD.
Telephone contact number: [redacted].

Dr Darren Chadwick, Faculty of Health & Wellbeing, Wolverhampton University. Telephone contact number: [redacted].

Dr Nick Hall, Faculty of Psychology, Wolverhampton University.
Telephone contact number: [redacted]

Thank you very much for taking part in this study.

Date:

APPENDIX I: CONSENT FORMS

Derbyshire Community Health Services NHS
NHS Trust

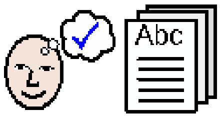
CONSENT FORM

Title of Project: A Qualitative Investigation Into How The Therapeutic Relationship Facilitates Empowerment In Psychological Therapy For Adults With Learning Disabilities.

Name of Researcher: Phoebe Alonso

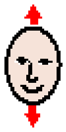
Please tick boxes ✓ Right

1. I have read and understand the information sheet dated ……………….. for the above research study. ☐

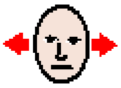


Understanding Information

2. It's ok for me to take part or leave if I change my mind at any time. ☐

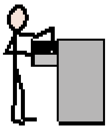


yes



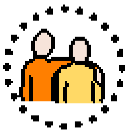
no

3. I understand that information collected from the study may be looked at by regulatory authorities or by persons from the Trust where it is relevant to my taking part in this research. I agree to these persons having access to this information. ☐



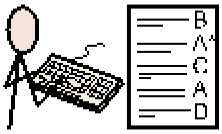
filing cabinet

4. I consent to my counsellor and support worker discussing my care. If anyone involved is worried about my safety, they may need to speak to someone who can help keep me safe. ☐



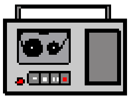
safe

5. I understand that a report may written about what I have talked about, but my name will not be included. I also agree for direct quotes (the actual words I have used) to be included in the final report. ☐



Type report

6. I agree for my questions to be tape recorded and for the information recorded to be used for this research. ☐



tape recorder

7. I can ask anything about the questions or research. ☐

ask for information

8. I agree to take part in the questions and this research. ☐

Right

wrong

sign

………………………..   ………..   …………………………
Name   Date   Signature

………………………..   ………..   …………………………
Name of person taking consent (if different from researcher, state position)   Date   Signature

…………………………   ………..   …………………………

Researcher   Date   Signature

APPENDIX J: LIST OF PSEUDONYMS

List of Pseudonyms

Clients with Learning Disabilities:

1. Sid
2. Jacky
3. Edward
4. Abbey
5. Neil

Therapists:

1. Eve
2. Nichole
3. Tim
4. Penny
5. Janice

Support Workers:

1. Robert
2. Malcolm
3. Ray
4. Kevin
5. Paul

APPENDIX K: EXAMPLE TRANSCRIPT

Transcript of Interview with Eve (May 2016) – 36’ 02”.

Phoebe – Right, thanks very much for coming, Eve. This interview is part of the project that I'm doing – it's a qualitative investigation into how the therapeutic relationship facilitates empowerment, in psychological therapy for adults with learning disabilities. So, I'd like to ask you a few questions

Eve – Ok.

Phoebe - To start off with, to get a bit of background, can you tell me about your client's referral? And what was the purpose of the therapy?

Eve – Ok, thinking back I think Sid was referred by his GP. Erm, he'd been to his GP and he had a history of recurrent depression.

Phoebe – Right.

Eve – And his GP referred him for the current episode. I understand the GP prescribed some anti-depressant medication and there was a request for some counselling to be involved as well.

Phoebe – Right, ok. So, you hadn't worked with him before?

Eve – No, I don't think – I've not worked with him, and I understand that he was assessed as meeting erm, eligibility criteria for the service,

Phoebe- Mmm

Eve – But had not had any, erm, psychology or counselling involvement in the past.

Phoebe – Right, ok. Erm, can you tell me about the treatment plan, or any plans created, and any formulations or therapeutic goals involved?

Eve – Yeah, we - worked jointly really, on the treatment plan, and formulations. Erm, I thought from the start that I had in my mind, from the referral information,

Phoebe – Mmm

Eve - That working in a compassion-focused, erm, therapeutic model, would be helpful.

Phoebe – Yeah.

Eve – That given his presentation, mood and his history, and as I met him over the first few sessions it was apparent that that did seem a good way of working with him. So gradually I talked with him about the approach and as I was gaining history, and we came up with a joint formulation – in quite a simplified version, so, you know, it wasn't any complex terminology or any sort of complex models,

Phoebe – Yes

Eve - but in a way that he could understand, in basically being kind to himself, finding a more helpful way of dealing with the difficulties that he was experiencing.

Phoebe – Yeah. Oh, that sounds really good. Erm... So, linked to that – the therapeutic approach and process, erm, we've mentioned you've used compassion-focused therapy, erm... any other approaches that you've used with Sid?

Eve – It really was purely that, it's quite a complex model, so there were different components to it,

Phoebe – Mmm

Eve – They were all adapted to him at the right time, and pacing it, with him, at the right time, for the different bits of the model

Phoebe – Right

Eve – It all just fell into place at the right time and he took the lead on that, so rather than thinking, you know, ' this session I'm going to do some education work on, on you know, background to background to compassion-focussed -', it was a case of checking with him, you know, would it be helpful at this point to talk a little bit more about that and what he wanted and it worked really well

Phoebe – Mmm. So, he was leading it?

Eve – Yeah, yeah.

Phoebe – Ok. Can you tell me about the journey, or the story, of the therapy with SM? (pause) Yeah can you tell me about the story?

Eve – Erm, he was really, nervous – he didn't turn up to the first session –

Phoebe – Mmm

Eve – That was the first sort of stumbling point really, erm

Phoebe – Mmm

Eve – So from there I understood that it was very difficult for him to come to the session, so yeah, so I met quite informally with him, just dropped in, a week later, just to say hello and introduce myself, so he'd realise it wasn't quite as scary as p'raps he'd thought it might be

Phoebe – Mmm

Eve – Erm, and then just let him lead on the day, erm a lot of it was him talking about his past experiences and how they related to his current difficulties

Phoebe – Yeah

Eve – And a lot of challenges and changes that he'd experienced

Phoebe – Mmm

Eve – And linking those in, to perhaps how he was feeling and the difficult emotions that he was experiencing and also, to the model that we were working with as well

Phoebe – Mmm

Eve – And I feel like the relationship - developed a lot over the course of working with him, I've probably been working with him for about six or seven months

Phoebe – Right

Eve – And that's been really central in our work together

Phoebe – Mmm

Eve – And I think he feels really valued that he's had the opportunity to talk about his experiences

Phoebe – Mmm

Eve – Erm, and to work with somebody… in terms of the journey, I feel like we're coming toward the, end of the journey

Phoebe – Right

Eve – He's shown so much improvement and he's been motivated to make changes – that we're working now on how he can maintain his improved mood and the things that are important to him and the things that he wants to do to make his life even better than it is now

Phoebe – Mmm. Great. Take those positives into the future?

Eve – Absolutely, yeah.

Phoebe – And what were your initial impressions? Were there any highs or lows during the therapeutic process?

Eve – Erm…I think the initial impressions were...it was as if he had a dark cloud over him, I could actually sense that negativity

Phoebe – Mmm

Eve – I could see it physically when he was in the sessions, it was you know, a heaviness... and sometimes that was – it was quite difficult to work with

Phoebe – Mmm

Eve – But in going at his own pace and you know gradually that seemed to lift, in combination with his medication as well

Phoebe – Yes

Eve – And you know we were quite open with that and reflecting that to him, talking about that perception that it seemed like a dark cloud –

Phoebe – Mmm

Eve – And he appreciated that being validated as well

Phoebe – Mmm

Eve – That he felt that a lot of his experience was that people couldn't understand the depths of his depression and were always telling him, you know, 'you can pull yourself out of that' and not taking him seriously and having someone acknowledge that was really important to him

Phoebe – Yeah – recognising it

Eve – Yeah..so

Phoebe – Sounds like that was the 'lows' that he was going through?

Eve – Yeah, and also a low for him and also for me, was when he expressed that he didn't feel like he wasn't moving on as quickly as he wanted to and that he was feeling low and that he was really worried that he wasn't moving out of it at one point

Phoebe – Mmm

Eve - And that he was going to go back to his GP to get some medication reviewed

Phoebe – Mmm

Eve – So… I supported him to make whatever decision he felt was right for him

Phoebe – Mmm

Eve – What I was also saying was, "you've been through all these experiences and this has been a really difficult time for you – things aren't going to change straight away, they might take a while until you feel differently and see things in a different way"

Phoebe – Mmm

Eve – Erm, supporting him to do that, erm but also cos I think for him, he was very self-critical, he had been very hard on himself

Phoebe – Yeah

Eve – So it was reflecting back on that aspect of the model and saying, that you know, that actually that was kind of what he was doing, his expectation that he would be able to pull himself out of it as quickly as he thought he should be able to

Phoebe – Mmm

Eve - Whereas it was ok for him, you know, to - be like that, considering all the things that he had been through

Phoebe – To take his own time?

Eve – Yeah, that that was alright

Phoebe – And it sounds like some of the highs related to his development and improvements?

Eve – Yeah it was great, to see him each session not from that cloud and to see that he was so motivated and saying, 'I've practised my mindfulness exercises and I'm enjoying doing them and I'm making time to do more exercise' and things that were positive

Phoebe – Mmm

Eve – To you know, improve his life

Phoebe – Mmm

Eve – erm to feel that relationship building with him, as well

Phoebe – Mmm

Eve – You know he was quite nervous to start with and then eventually, (background noise) …..and to see that he recognised that the depression wasn't just him, it was.. well a result of his experiences partly,

Phoebe – Mmm

Eve - and part of the model is that we're all human beings and none of us are perfection, and it was about his his ability to say it's part of being a human being and that is ok

Phoebe – Yeah... that's great!

Eve – And it makes me feel better as well, cos I'm human too (laughs) and it made me realise that therapy often isn't perfect either, (background noise) but it's a perspective...

Phoebe – Mmm. Your involvement together?

Eve - Yes.

Phoebe – Mmm. So, moving onto 'Outcomes', erm, howc successful did you feel the therapy was?

Eve – Erm I feel like it went, it's gone really well

Phoebe – Mmm

Eve – Erm, obviously I haven't got anything to compare how it would have gone if I'd used another model... don't know, yeah it just feels like it's been a positive experience for him and ... I just really just enjoyed working with SM – it's great to work with someone who's so motivated

Phoebe – Yeah

Eve – We did a baseline measurement as well

Phoebe – Mmm

Eve – Using the Glasgow Depression Scale, so I think we used that in the first or second session

Phoebe – Right

Eve – And then we redid that, and the score had really significantly decreased

Phoebe – Mmm

Eve – So that was a really useful measure to use with him to show that his mood had improved a lot

Phoebe – Mmm

Eve – He still had some anxieties about it you know, dropping again

Phoebe – Right - an objective measure as well?

Eve – Yes

Phoebe – Mmm – so that's kind of linked on to the next question, how severe were the presenting problems before and after the therapy?

Eve – Erm... they were quite severe before, in that he'd - stopped doing a lot of the things that he actually enjoyed doing, that made his life better, so things that gave him that quality of life he opted out of, I don't think he had the energy to enjoy things, you know, his mood had impacted on his work, he was quite snappy which was out of character, so he felt bad about that

Phoebe – Mmm

Eve – And just that sort of general lack of energy and motivation, like we described it as a dark cloud over him, not wanting to do anything. It felt like a really difficult place to be

Phoebe – That was affecting his whole life?

Eve – Yeah, massively, his relationships, he was quite withdrawn, would have days off work even though he knew it was positive if he could actually get to go there – so that was before -

Phoebe – Mmm

Eve – Whereas now: he's going to work, enjoying it – he's just completed a chain-saw qualification, which he's really proud of

Phoebe – That's good

Eve – Erm, I think his relationship with other people have improved, he's talking about cycling again, erm he's joined a Ju-Jitsu club

Phoebe – Right!

Eve – I think it was something that he thought he wanted to do for himself

Phoebe – Mmm

Eve – It's quite a big step for him, to actually do something really new, and go along and meet new people, and do something, a new activity when he usually can be a bit nervous about doing these things

Phoebe – Yes. A lot more motivated then?

Eve – Yes, really, and he was really proud of reflecting that he'd done that, and he was going to carry on with that as well

Phoebe – Sounds great! Erm the question about how you'd rate the clinical degree of significance of change --- I suppose that links to the Glasgow Depression Scale you used?

Eve – Yeah –

Phoebe – And you said that you'd noticed a change with that?

Eve – Yes, a really significant change – it was way above the threshold level when we started and hardly rated at all on the repeat

Phoebe – Right. And what did you find were the best, or most successful aspects, of the therapeutic process with SM?

Eve – Erm... (pause)... it feels like there are lots of different parts..erm..I think the relationship was really central, in building that with him

Phoebe – Mmm

Eve – Erm, the educational parts of it were useful in explaining that it wasn't just him –

Phoebe – Mmm

Eve – In terms of how we all are

Phoebe – Being a person?

Eve – Yeah, just normal life things, rather than him having to think that there was something wrong with him

Phoebe – Mmm

Eve – And the idea that we're all – strange creatures as human beings, her actually said that himself in a session, and that felt like the relationship was equal, it felt like he was talking about us all, that we're all human beings and that we're all ok and that you know, we have our ups and downs

Phoebe – Yes

Eve – And that we're not perfect and he said, "we're really strange creatures aren't we?" and it felt like a really mutual point you know, in the therapy.

Phoebe – Mmm

Eve – And we had that agreement that yes, we are all strange, but that's how we are -

Phoebe – Able to reflect on life -

Eve – Yeah, yeah.

Phoebe – Um, what were the worst and least successful aspects?

Eve – Erm... (pause)

Phoebe – …If there were any?

Eve – (long pause)

Phoebe – You said it was difficult at the beginning when he didn't turn up...

Eve – Yeah, that was difficult, to know why... I think that was just his anxiety about doing something different and not knowing what to expect... and finding turning up to the first session really hard...

Phoebe – Mmm

Eve – Very difficult, but he overcame that, when he met up, he felt a bit more reassured

Phoebe - Yeah, and built up the relationship?

Eve – Yeah, and he had bit more understanding about what the process might involve...

Phoebe – Mmm

Eve - ...He was fine with that

Phoebe – Erm...

Eve – It was difficult to find a place to meet! (laughed) The practicalities, but yeah, he did want to meet at his workplace but we were sometimes interrupted even though we put a sign on the door, so that private place was sometimes quite difficult to get, for him

Phoebe – Mmm

Eve – And there were also some difficulties that he referred to in his relationship as well

Phoebe – Mmm

Eve – And that was quite difficult, we often felt quite stuck with that…because I wasn't sure whether that was something to do with his mood, or to do with his relationship. And we had a talk about things that he could do to improve the relationship

Phoebe – Mmm

Eve – But I was working with him and not his partner, so it felt a bit one-sided

Phoebe – Mmm

Eve – So that felt a bit strange and it was a bit of a challenge to know how to deal with that

Phoebe – Mmm.. Ok…The next question is how did you feel at the end of the therapy? You're not quite there, yet are you?

Eve - No, we're not there yet, I think we'll probably have a few more sessions…(pause)..but it actually feels really positive, where I enjoy the sessions and I enjoy seeing him and hearing about his improved mood, and hearing about how well he's doing

Phoebe – Mmm

Eve – He still needs a lot of reassurance that the anxiety that he's suddenly going to wake up and be pulled back into that depressive state, erm, it's just sort of normalising that – you know, everybody has that sometimes, you know we all feel a bit low in mood, or a bit worried about things at times, but he just needs to carry on with what he's doing, cos what he's doing is really working

Phoebe – Mmm

Eve – So..

Phoebe – Right. So, were there any lessons learned, or practise development issues that came out of the therapy?

Eve – Erm... (pause)

Phoebe – Sounds like a really interesting approach that you used –

Eve – Yeah, I... it was quite a difficult – well it wasn't difficult – there are a lot of visual resources out there – to explain the model,

Phoebe – Mmm

Eve – I used a lot of pictures, erm resources so without those it would have been quite a challenge and also SM couldn't read or write, so I was quite anxious about…. I had to make sure that any information was really accessible and didn't just reinforce any anxieties he already had about his own abilities

Phoebe – Yeah

Eve – And yet it was helpful to do sort of picture prompts, for different things that he needed to do in between sessions, so for example, we did some work on the inner self critic, erm, and the inner compassionate person,

Phoebe – Mmm

Eve - So he came up with this compassionate owl, so I printed out a picture of that and he came up with some phrases about that that he could use when he was being self-critical

Phoebe – Yes

Eve – So I wrote those down in a really simple form so that he could use those, and I put them on a card for him

Phoebe – Mmm

Eve – So I think that was quite helpful to adapt the materials for him, yep.

Phoebe – Great. And in terms of the therapeutic relationship in learning disabilities, can you tell me about your own experience of what it's like to develop a therapeutic relationship with someone who has a learning disability?

Eve – Erm... (pause)... I feel like I was gauging the pace all the time, because SM was quite anxious to start with. It's hard to describe really, it was just feeling the way really, erm...

Phoebe – Mmm

Eve – Like, I was trying to walk next to him

Phoebe – Mmm

Eve – All the time – so not pushing him too far, or lagging behind – making sure I was really there with him, in the sessions

Phoebe – Mmm

Eve – Erm, so… at the same time as working with him, I was doing my own like, Mindfulness practise, so being really present with him, in the sessions, was helpful

Phoebe – Mmm

Eve – Erm...

Phoebe – Yeah. Did it make any difference, working with someone with a learning disability? Or would you have still, used the same approach?

Eve – Erm... I wasn't really sure, it was the first time I'd used the approach with someone with a learning disability

Phoebe – Mmm

Eve – And I wasn't sure how well I could adapt it

Phoebe – Mmm

Eve – And there isn't a lot, well there's no research that I could find, on anybody who'd used it…but I found in making things really visual and relating the model back to things that he was saying within the session,

Phoebe – Yeah

Eve – To you know, his experiences and the model – rather than just presenting the model itself - it was like weaving it into the sessions, on an ongoing basis as we were working together

Phoebe – Mmm, yeah.

Eve – And that worked really well, cos it made it relevant to him, and then it wasn't just a lot of information for him to take on all in one go

Phoebe – No…personalised?

Eve – Yeah.

Phoebe – Mmm. And what do you feel is important in terms of the role of the therapeutic relationship, when providing psychological therapy to an individual with a learning disability?

Eve – Erm (pause) For me it's a key thing – you know, that relationship is... the vehicle for which you – the process happens – and within sessions I was quite aware of our relationship and what I was feeling and what that might have meant

Phoebe – Yeah

Eve – In terms of what he might have been experiencing

Phoebe – Mmm

Eve – So it was, you know, again weaved into the sessions,

Phoebe – Mmm

Eve – That was part of what we were doing – I don't know if that makes any sense?

Phoebe – Yes it sounds really interesting, especially with the visual references

Eve – (laughs)

Phoebe – So the question continues with what was most helpful and important for SM? - You've probably answered that?

Eve – In terms of...?

Phoebe – The therapeutic relationship.

Eve – The relationship? –

Phoebe – Yes, you said that you worked alongside him, and walked next to him

Eve – Yeah, I think I mentioned before that he hadn't felt like he'd been able to.. sort of talk about the experiences that he'd had – he'd been through some quite difficult early experiences

Phoebe – Mmm,

Eve – And... he didn’t feel like people really listened to him, so actually having somebody that would actually listen and validate what he had been through,

Phoebe – Mmm

Eve – And to help him understand, you know, why he might be feeling that way at the moment – that it p’raps does relate to these different things that have happened and then to more recent events that have triggered his mood

Phoebe – Yeah

Eve – And I think listening in that non-judgemental way – cos he always felt very criticised by other people, like he wasn’t good enough, as well,

Phoebe – Felt judged?

Eve – Mmm, yeah.

Phoebe – Great. Moving onto ‘empowerment’; erm, what’s your idea about the meaning of empowerment, and how is it relevant or important in your work?

Eve – Erm... (pause) ... I think it’s working with somebody in a way, that enables them to, have some..I suppose - control? – A means of making changes that are really important to them...

Phoebe – Mmm. Things they want?

Eve – Mmm

Phoebe – And is that... important throughout your work generally?

Eve – Yeah... I think it’s something that I’m really aware of when I’m working with somebody. Again, it’s another kind of, what happens throughout the process – yeah, I had to do a lot of reflection

Phoebe – Mmm

Eve – Particularly as it was a new approach, on how sessions have gone and thinking about them in between

Phoebe – Mmm

Eve – And having supervision...

Phoebe – Mmm. And what does empowerment mean to you, in terms of working in the area of providing psychological therapy to people with learning disabilities?

Eve – I think it’s a really key theme... so many of our clients have... don’t experience you know having choices and control,

Phoebe – Mmm

Eve – So being able to experience that within a therapeutic relationship is .. is really key to the work that we do I think… erm...

Phoebe – So less choice and control within... learning disabilities, or if someone does have a learning disability?

Eve – Yeah, if someone does have a learning disability, it’s difficult… their social situation

Phoebe – Mmm

Eve – Or the circumstances that they’re living in... so it’s often associated with the learning disability, whereas it amazes me how resilient many of our clients are, that they can actually cope with the difficulties that they deal with on a day to day basis

Phoebe – Mmm

Eve – Erm... so I think the empowerment work works against that, in helping them to maintain that resilience – to understand that it isn't them, a fault within them -

Phoebe – Mmm, mmm… Were there any factors affecting SM, causing disempowerment in his life?

Eve – Erm I think a key thing for him… I think, was that he'd gone to a special school

Phoebe – Mmm

Eve – He felt that he hadn't had any opportunities to take exams and the right support in school… erm, he'd experienced quite a bit of bullying...

Phoebe – Mmm

Eve – Within different contexts… I suppose that had been quite disempowering for him and impacted on how he felt about himself

Phoebe – Yeah

Eve - And socially, erm...he does a job that he very much enjoys, but it's on a voluntary basis and that's very limiting

Phoebe – Yeah

Eve – So he's very limited in the things that he can do

Phoebe – Mmm

Eve – So when we were thinking about things that he wanted to do with his life that were important to him, I was always aware that he didn't have much money and things that he could do with his partner... were very limited

Phoebe – Mmm

Eve – He didn't have any spare money to spend

Phoebe – Financial restrictions –

Eve – Mmm, that was quite a key thing for him… and again he was limited in his social networks, as well… he couldn't, he hadn't got a job that gave him access to a lot of people or didn't have the money to go out and you know, meet people at different activities

Phoebe - Mmm

Eve – Yeah, so a lot of you know, social constraints... which he probably found disempowering for him

Phoebe – Mmm, restrictions...

Eve – And I think that I was quite aware of that in working with him, in that I was very wary of suggesting something that would cost money, or something that I might consider doing, then...it was probably not attainable for him, in his social situation...

Phoebe – Yeah, mmm. That's a good point (pause) And you feel there's any benefit in having an empowerment focus within therapy?

Eve – (Pause)… Yeah... I think all therapy…should be empowering…(laughs)…it's a really essential part of working with somebody...

Phoebe – Mmm

Eve – And working with what's valuable to them, and how the changes that they want to make…

Phoebe… Yeah, yeah. And do feel there's - are there any barriers, or challenges, to empowerment in this group – with psychological therapy?

Eve – (Pause)...

Phoebe – I suppose ones that you've already mentioned are somebody's social and financial situation…(pause)…any other challenges....

Eve – Erm… (long pause) … I can't really think of any…

Phoebe – Ok erm, the next question – in terms of your experience and understanding of empowerment in the therapeutic relationship, with individuals with learning disabilities, is there anything else that you'd like to add, or think that we've missed talking about?

Eve - … (long pause) … erm, I think that only that with SM, I worked very much on an individual basis with him,

Phoebe – Mmm

Eve – In learning disability services there tend to be quite a large number of multi-disciplinary team – so I felt like, I was working very much just with him, so there wasn't really any need to share, or to talk to carers

Phoebe – Mmm

Eve – Which suited the way that we were working together…whereas with other clients, there are often carers and other professionals, wanting to know information...

Phoebe – Mmm

Eve – And that can often cause conflict really - you know – how, when and what level of information to give people...

Phoebe – Mmm, so he didn't have lots of other professionals involved?

Eve – No, he just had the people that he works with... and obviously they were aware that we were meeting for therapy, because we used their premises – but there wasn't any expectation or any pressure to share things – which I think was really helpful to SM

Phoebe – Yeah

Eve – Because it made him feel like there was you know, that true sense of confidentiality, there wasn't any need to share anything...

Phoebe – Yeah. That's good... So, there's just two additional questions: can you comment on your involvement with other therapists or professionals, also working with Sid – well you've just said that he doesn't have a lot of other people involved? –

Eve – No! There is just obviously, he's got a boss who he works with... Adult Care … and on a couple of times he was a bit unhappy with how they'd spoken to him – but we'd kind of talked through, you know, relating that to us all being human,

Phoebe – Yes

Eve – So relating that back to the model – and actually on reflection, he felt that those situations he'd dealt with in a really appropriate and assertive way. So, I think that was helpful for him, to reflect on how well he'd dealt with those situations

Phoebe – Mmm

Eve – Erm...

Phoebe – And did he not have any other significant health needs – sometimes our clients have other health needs -

Eve – Yeah, he was involved with his GP, who was prescribing the medication, but he didn’t have any liaisons with his GP, so if it’s ok with Sid I’ll write a summary for his GP when we finish

Phoebe – Mmm. Ok. So finally, do you have any other comments about these questions or this research?

Eve – Erm... It was interesting to think about aspects of empowerment in the work… I’ll probably think about others after the interview! (laughs)… But yeah to reflect on whether it had been empowering for him…

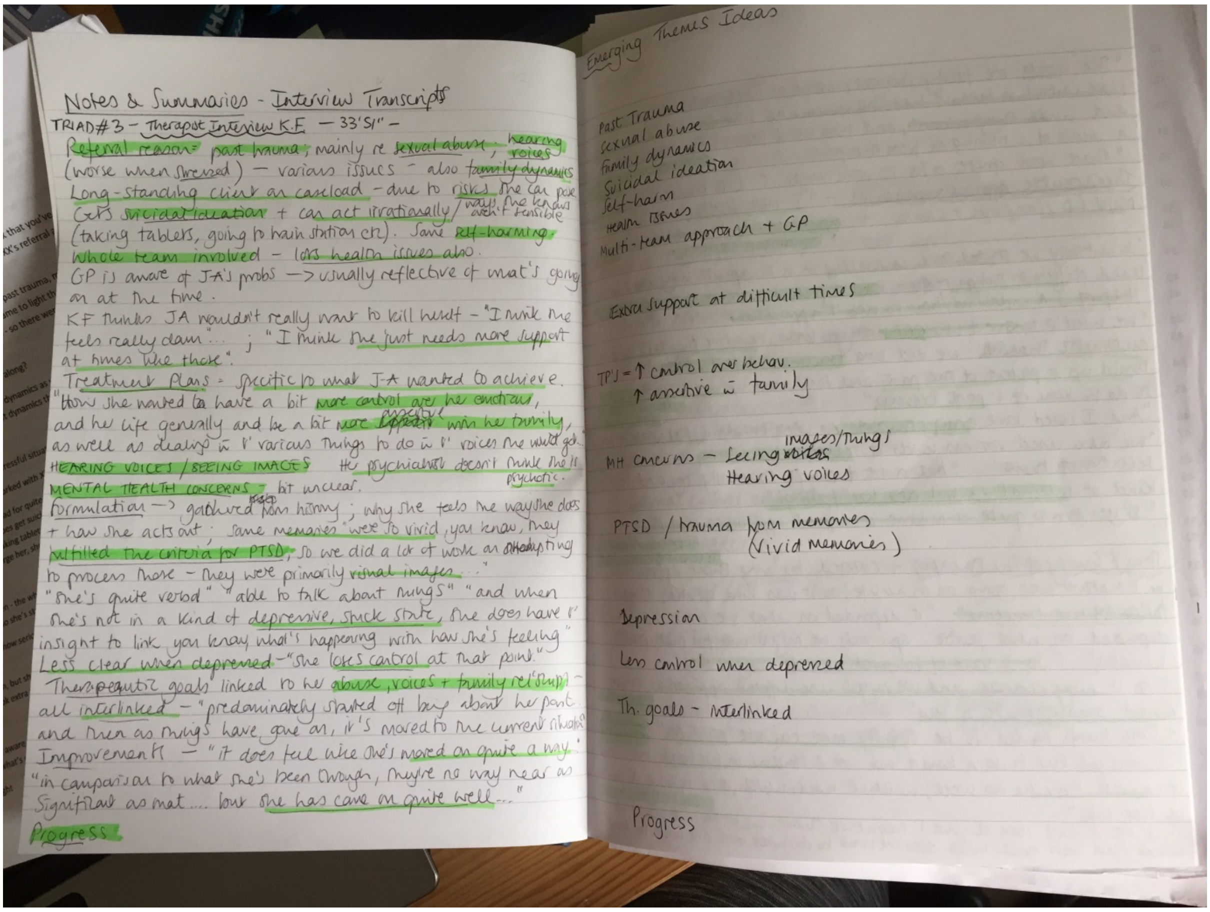
Phoebe – Great

Eve – Yeah, and to know whether he’d experienced it as empowering or not… (laughing)

Phoebe – Mmm. Ok, lovely. Thank you very much.

Eve – Ok!

APPENDIX L: EXAMPLE PHOTOGRAPH OF INITIAL NOTES & ANALYSIS FROM A TRANSCRIPT



Notes & Summaries - Interview Transcripts

TRIAD#3 – Therapist Interview K.F. – 33'51" –

Referral reason = past trauma; mainly re sexual abuse; hearing voices (worse when stressed) – various issues – also family dynamics

Long-standing client on caseload – due to risks she can pose

Gets suicidal ideation + can act irrationally / ways she knows aren't sensible (taking tablets, going to train station etc). Some self-harming.

Whole team involved – lots health issues also.

GP is aware of JA's probs –> usually reflective of what's going on at the time.

KF thinks JA wouldn't really want to kill herself – "I think she feels really down"... ; "I think she just needs more support at times like those".

Treatment Plans = specific to what J-A wanted to achieve.

"How she wanted to have a bit more control over her emotions, and her life generally and be a bit more assertive with her family, as well as dealing w/ the various things to do w/ the voices she would get..

HEARING VOICES / SEEING IMAGES – the psychiatrist doesn't think she is psychotic.

MENTAL HEALTH CONCERNS – bit unclear.

Formulation –> gathered from history; why she feels the way she does + how she acts out; some memories "were so vivid, you know, they fulfilled the criteria for PTSD, so we did a lot of work on adapting to process those – they were primarily visual images..."

"She's quite verbal" "able to talk about things" "and when she's not in a kind of depressive, stuck state, she does have the insight to link you know, what's happening with how she's feeling"

Less clear when depressed – "she loses control at that point."

Therapeutic goals linked to her abuse, voices + family rel'ship – all interlinked – "predominately started off being about her past and then as things have gone on, it's moved to the current situation"

Improvements – "it does feel like she's moved on quite a way." "in comparison to what she's been through, they're no way near as significant as that.... but she has come on quite well..."

Progress

Emerging Themes Ideas

Past Trauma
Sexual abuse
Family dynamics
Suicidal ideation
Self-harm
Health Issues
Multi-team approach + GP

Extra support at difficult times

TP'S = ↑ control over behav.
↑ assertive w/ family

MH concerns – Seeing ~~voices~~ images/things
Hearing voices

PTSD / trauma from memories
(Vivid memories)

Depression

Less control when depressed

Th. goals – interlinked

Progress

APPENDIX M: EXAMPLE OF ANALYSIS PROCESS

(exploratory comments, key words & emerging themes)

LD Client (Abbey) Themes	**Page & Line Number of Extract**	**Key words**	**Exploratory Comments** **(C) = Conceptual** **(D) = Descriptive** **(L) = Linguistic**
Experience of LD vs non-specialist LD counselling services & signposting for appropriate services	1.11	I went through some different services beforehand, someone referred me on to this one, cos I was under Mental Health …and they referred me on for counselling.	Finding the right (LD specialised) service Abbey started at her GP and had generic counselling and accessed the Mental Health service – eventually she was referred to the LD service (D)
	1.14	after so many sessions they did turn ‘round and say they would have to refer me on – so it came ‘round and they referred me on… and I started coming here – to see Penny	
	2.36	I’m not sure if it was my doctor or not, at this one, or if it was the other counsellor I was seeing – that did the referral for further counselling sessions – I received a letter and made a phone call	
	2.38	I phoned up and that’s when I found out it was Penny	
Counselling for past relationship traumas - Past bad memories - Impact upon current relationship	2.33	I phoned up and said I needed help and the person I saw before had arranged the referral	Abbey had counselling for past traumas, relationship problems and the effect upon her – “a lot of things since have really come to light that have helped me remember what happened and to move on from it”
	2.51	a lot of things since have really come to light, that’ve helped me remember what happened and to move on from it…	
	3.57	I had a bit of bad luck… and it was affecting me - my husband couldn’t get close, he couldn’t cuddle me or anything – I kept pushing him away … it reminded me of my ex, how he was approaching me…	(Abbey felt the counselling helped her process and understand things, and “move on” from them) – therefore, it was useful (C)
	4.88	Kevin first noticed it was about how my ex was and that it really brought back a lot of bad memories and at first I wasn’t doing any washing and Kevin was saying ‘I think you better do this’, ‘you better do that’ – all in all it was affecting us and I didn’t realise what I was doing at the time…	Abbey’s current relationship brought back memories of previous ones, so she needed help (in order to this time have a safe, successful relationship) (C)
Housework difficulties & differing expectations between partners	3.70	At one stage I couldn’t care less – tidying up – Kevin had to say, ‘I think you better do	Different expectations and abilities between the two partners –

	4.90 3.97 8.209	this’ and it was like I wasn’t taking much notice at first – at first, I wasn’t doing any washing and Kevin was saying ‘I think you better do this’, ‘you better do that’ – all in all it was affecting us and I didn’t realise what I was doing at the time… I do tend to forget sometimes, but it does take a little hint, and then I just do it... And stepping up to the mark, I’m still going through the process still… realising when to do it and things [cleaning] I am getting in that direction, of making improvements	-> house work -> Abbey “wasn’t doing any washing” / her share of the domestic tasks? –she would “tend to forget sometimes” and needed “a little hint” ➔ she began “stepping up to the mark” and “realising when to do it” (D/C)
Language repetition & emphasis of meaning	3.69 9.243	Definitely, definitely, it’s really helped me My past, from my past – yes. I’ve come to terms with that.	Abbey was definite about the positive effect of the therapy, “Definitely, definitely, it’s really helps me” (L)
Improvements taking time, working through things	2.48 2.50	I’ve made a bit of improvement It took a long time… cos I couldn’t remember… but a lot of things since have really come to light, that’ve helped me remember what happened and to move on from it…	“I’ve made a bit of improvement” (D/C)
Dependence upon husband/carer – becoming more independent	8.218 9.222 9.225 10.273	It’s like, my husband would say – ‘it don’t stop you from going out’, I still do my own things, but at the same time, it’s like – ‘I’m just on the phone’… or cos that’s how I wasn’t… and that’s how… I was with all my other partners, I was just too… and I’ve got to get over that… You were quite dependent on them, were you? /Yeah but it’s like he says, ‘you don’t need to call me – let me know when you arrive at your destination when you’re on the bus, but in between, there’s no need to’… for me to do that…/To keep ringing? /Mmm I haven’t talked much about my mum – a bit – but not a great deal, it’s mostly Kevin and Penny who’s helped me, with the encouragement –	Abbey was quite dependent upon her husband / carers, “My husband would say”, “it’s like he says” (L/C/D) She agrees that she would like to be more independent (eg going places and not needing to phone him on the way) (D/C)

	10.277	And have you talked with Kevin about the counselling sessions? /Yeah. Certain ones yeah and certain ones, no. I've told him a majority of stuff, but… not everything - /Some of it you want to keep to yourself? /Yeah.	Abbey has shared some part of the therapy with Kevin, "Certain ones, yeah, and certain ones, no" – "I've told him a majority of stuff, but not everything" (they are Abbey's sessions and she enjoys having them just for her (C/D)
Problems/ worries caused by ex-wife & response/vigilance	8.198 8.200 8.203 9.245 10.251 10.252 10.255 10.258	Kevin's ex-wife was giving him some hassle… that didn't help things… that made it… it made it more tense… when she was being awkward but since he's took the injunction out and she's backed off, it's … helped the situation – It's made him calmer and it's made me calmer at the same time, it's like that weight's been lifted off us – But Kevin's ex-wife – she's still being – we're keeping our guard up at the moment – yes, she's gone quiet, but we're just waiting – we're on guard, as you call it! cos what she's thrown at him at the moment, we're just waiting – everything depends on that… even I got… I was asleep and I had a vision or a feeling that very shortly it's going to come on my side – like he's got an injunction against her, but that's only on his side, not mine - /Right… so you're still a bit nervous about the situation? /Yeah. I mean, I know she'll probably not do anything to me, in all fairness, cos the amount of times that I've bumped into her – she's frightened of me (laughs) she's frightened, she'll not kick off on me, cos she knows what she'll get from me – she knows if she starts on me… I'm just going to be… right in her face and just give her home truths – and she does not like home truths!	Dealing with Kevin's ex-wife – - "since he's took the injection out and she's backed off, it's helped the situation"– - "Kevin's ex-wife was giving him some hassle that didn't help things, that made it more tense when she was being awkward" (impact on their relationship – of ex) - "We're keeping our guard up at the moment" – "we're on guard, as you call it!" (D) Abbey is nervous of the ex-wife giving her 'hassle' also, although she is 'on guard' and prepared – to "be right in her face and just give her home truths – and she does not like home truths!" (support / advice needed for how to deal with this – threat or reality and avoid conflict, confrontation etc (C)
Counselling benefits/evidence of improvements	3.69	Definitely, definitely, it's really helped me, come to terms with	Improvements from the therapy –

- Increased motivation with house jobs - Thinking more clearly - Exploration of feelings, processing behaviours & memories		what's happened and making steps in the right direction, in making improvements.	- "It's really helped me, come to terms with what's happened and making steps in the right direction, in making improvements" –
	3.70	At one stage I couldn't care less – tidying up – Kevin had to say, 'I think you better do this' and it was like I wasn't taking much notice at first –	
	3.74	But now I'm stepping up to the mark and doing more things, realising things,	- "But now I'm stepping up to the work and doing more things, realising things"
	3.75	a lot of things have been sinking in and I've been taking more on board... and realising …	- "A lot of things have been sinking in and I've been taking more on board, and realising ..."
	3.81	Helping me with what I was doing wrong and making – improving myself	- "Helping me with what I was doing wrong and ... improving myself"
	4.101	It's really helped… made me release everything… realise what I couldn't' see and I felt so weak… I just didn't know what to do and now I feel so much more stronger –	- "It's really helped ...made me release everything"
	4.105	I feel so much more stronger from it now	- "Now I feel so much more stronger"
	5.114	If anything, it's really helped – it's really helped me move on –	- "If anything, it's really helped – it's really helped me move on ..."
	5.117	And turn 'round and say, 'Goodbye past – moving on!'	
	7.179	sometimes it does work, sometimes it doesn't, and I know I'll not do anything but probably what I'm sorting out in my own mind through the day… I could be calm but at the same time… I could retaliate or I don't retaliate…	- "I'm making improvements, communicating more" - "I'm moving on and making improvements"
	7.185	Yes, it does vary on me. It varies how I'm processing things in my mind, I tell myself, 'don't do it, don't do it' … I would retaliate…	(a lot of positive feedback for the therapy and beneficial impact on her) (C/D)
	7.186	I'm trying to find a way of thinking, of just – not thinking 'don't do it, don't do it' but by not thinking that way …	
	7.195	I'm making improvements, communicating more	
	7.195	I'm getting over that fear, where I was holding back –	

	 8.209	I'm moving on and making improvements – And stepping up to the mark, I'm still going through the process still… realising when to do it and things [cleaning] I am getting in that direction, of making improvements	
Perceiving the interview as 'fun!'	1.4	Thanks very much Abbey for coming/Fun!	
Appreciation of the counselling & counsellor - Feeling listened to - Being able to talk - Releasing built-up tension - Clarifying/highlighting	4.101 4.105 5.114	It's really helped… made me release everything… realise what I couldn't' see and I felt so weak… I just didn't know what to do and now I feel so much more stronger – I feel so much more stronger from it now If anything, it's really helped – it's really helped me move on –	Releasing aspect of the therapy: "It's really helped, made me release everything" (and strengthening – "now I feel so much more stronger") and helped her "move on"
Counselling processes & strategies - Sleep diary, recording triggers, - Practical goals & strategies	5.125 5.126 7.167	she did ask me to keep a diary – at first, I did…. for my sleeping habits – to keep a diary and try out techniques before I go to bed, to keep myself calm so I don't kick out at Kevin in my sleep – I tried out all different techniques before I went to bed – is that why you kept a diary? /Yeah! Mmm, of me actions, just so I could see what was triggering it.	Extra strategies Penny suggested in the therapy – "She did ask me to keep a diary" – "For my sleeping habits" – "And try out techniques before I go to bed, to keep myself calm so I don't kick out at K in my sleep"
Story of cat talking & protecting Abbey	6.141 6.142 6.147 6.151	At the time we had a cat and her name was Rapid – even she could tell if I was sleep-walking – she could go into the bedroom, jump on the bed and say to Kevin, 'wake up, wake up!' and then as soon as he realised, she went flying out the back door, running down the road, she was walking, just following me…. She always – woke him up to say 'mum's gone out of the door' She was quite a good guard-cat!	Interesting story of Abbey's cat / protecting her and communicating with Kevin – "At the time we had a cat and her name was Rapid – even she could feel if I was sleep-walking" "She always – woke him up to say, 'mum's gone out of the door'" "She was quite a good guard cat!" "She was protecting me" "Letting her dad know, saying 'Dad, she's down here, meow, meow!'" (in part what Abbey would

	6.153	Yeah. She was protecting me, following me down the road, like I say, making sure where I was, letting her dad know, saying ‘Dad, she’s down here, meow, meow!’	like? – to be protected? And the cat is communicating instead of her?) (C)
Sleepwalking, hitting out in her sleep & unconscious behaviours	.126 5.132 6.137 6.157 6.161 6.163 7.172	for my sleeping habits – to keep a diary and try out techniques before I go to bed, to keep myself calm so I don’t kick out at K in my sleep – I tried out all different techniques before I went to bed – sometimes I’d go to bed and I’d be calm before I went to bed and still lash out at K, but the trouble was… with all that happened in the past, when I went to sleep, subconsciously, I was unaware of what I was doing – if I wasn’t lashing out, I was sleep-walking – walking out of the bedroom, into the living room, into the kitchen and out the back door, and walking down the street, towards the road – I didn’t even know, to be honest – cos I was sleeping – that’s the one thing, when I do these things – I don’t realise I’m doing them – cos it’s always subconsciously I might add. People tell me next day and they can see the bruise from what I’ve done to him. And I say, ‘I’m sorry, I don’t realise!’ Even he realises I don’t mean to do it. That’s what we’re trying to get my brain to think – to realise and… before going to bed – to keep calm and try … so I don’t do these things I think last time I sleep-walked according to my husband would’ve been probably 3 or 4 months back now – if anything I’m still hitting him, cos it’s …... cos I really do not want to hurt him	Sleep behaviours - sleep-walking - hitting out in sleep (trying to rationalise and explain the behaviours - Abbey is articulate about “the subconscious” to an extent (C/L) “When I do these things – I don’t realise I’m doing them – cos it’s always subconsciously I might add” - To what extent does she use this to blame the bruises etc. on Kevin? “I say I’m sorry, I don’t realise!” (She says she does not want to hurt him, and it is getting less) (D/C)
Dreams & processing	10.252	I was asleep and I had a vision or a feeling that very shortly it’s going to come on my side –	Discussing dreams in therapy – processing daytime fears and anxieties

		like he’s got an injunction against her, but that’s only on his side, not mine - /Right… so you’re still a bit nervous about the situation? /Yeah.	(same as triad #4)
Determination to changes & searching for alternative strategies	5.117 5.126 6.163 8.209	And turn ‘round and say, ‘Goodbye past – moving on!’ for my sleeping habits – to keep a diary and try out techniques before I go to bed, to keep myself calm so I don’t kick out at Kevin in my sleep – I tried out all different techniques before I went to bed – That’s what we’re trying to get my brain to think – to realise and… before going to bed – to keep calm and try … so I don’t do these things And stepping up to the mark, I’m still going through the process still… realising when to do it and things [cleaning] I am getting in that direction, of making improvements	Determination and acceptance of responsibility to make changes – “And turn ‘round and say, ‘Goodbye past – moving on!’” “Stepping up to the mark” (D)
Use of metaphors and linguistic phrases – quite able verbally (mild LD)	8.203 8.209 9.246 10.255 10.259	it’s like that weight’s been lifted off us – stepping up to the mark we’re on guard, as you call it! ..in all fairness, I’m just going to be… right in her face and just give her home truths – and she does not like home truths!	Abbey used a lot of phrases & clichés – - do they make her seem more ‘able’ than she really is? - or useful linguistic devices, descriptions? (so maybe she is more capable verbally than some LD clients, despite her speech impediment?) - “stepping up to the mark” - “on guard” - “home truths” - “in all fairness” - “I might add” - “goodbye past – moving on” (L)
Increased interviewer input for LD participants? - Paraphrasing, checking, helping, suggestions	3.73 4.108 5.117	You didn’t feel like doing jobs round the house? /No. But now I’m stepping up to the mark and doing more things, Right, so by being able to talk to Penny, it’ released all that that was making you feel weak and now you feel stronger as a person, more confident in yourself?/Yeah. Definitely. “Goodbye past – moving on!”/(PA)Yeah. Time to move forward! /Yeah.	More interviewer input – checking, summarising etc – for LD participants? (across all triads?) (C)

	6.147 6.163 7.181 11.278	Woke him up to say ‘mum’s gone out of the door’ - /(PA)Right, so she woke Kevin and let him know and she came with you? /Yeah! That’s what we’re trying to get my brain to think - /(PA)To process? /To realise and…before going to bed – to keep calm I could retaliate or I don’t retaliate, it’s trying to find - /(PA) It varies? It sounds like overall it is helping, but in general it varies doesn’t it? /Yes, it does vary on me. It varies how I’m processing things in my mind, I’ve told him a majority of stuff, but … not everything - /(PA) Some of it you want to keep to yourself? /Yeah. /(PA) Mmm. So just when you feel like it, when there’s some issues that might be relevant for him? /Yeah.	
No other professionals involved	10.273	Not really…. It’s mostly Kevin and Penny who’s helped me	Abbey didn’t have a lot of MDT input (some LD P’s/triads have more than others – e.g. Triads #2, #4 and #5 it was less needed – more emphasis on the counselling? Although all had a GP and occasionally saw their doctor) (C/D) No meds needed for Abbey/ (at least 3 of the triads mentioned meds at some point) (C/D)
DISC/CRIT ANAL – if I’d used a different approach to IPA I could have focused more on words, language, emphasis, meanings etc			

APPENDIX N: ANALYSIS PROCESS STEPS

Table N.1 - Showing IPA data analysis process

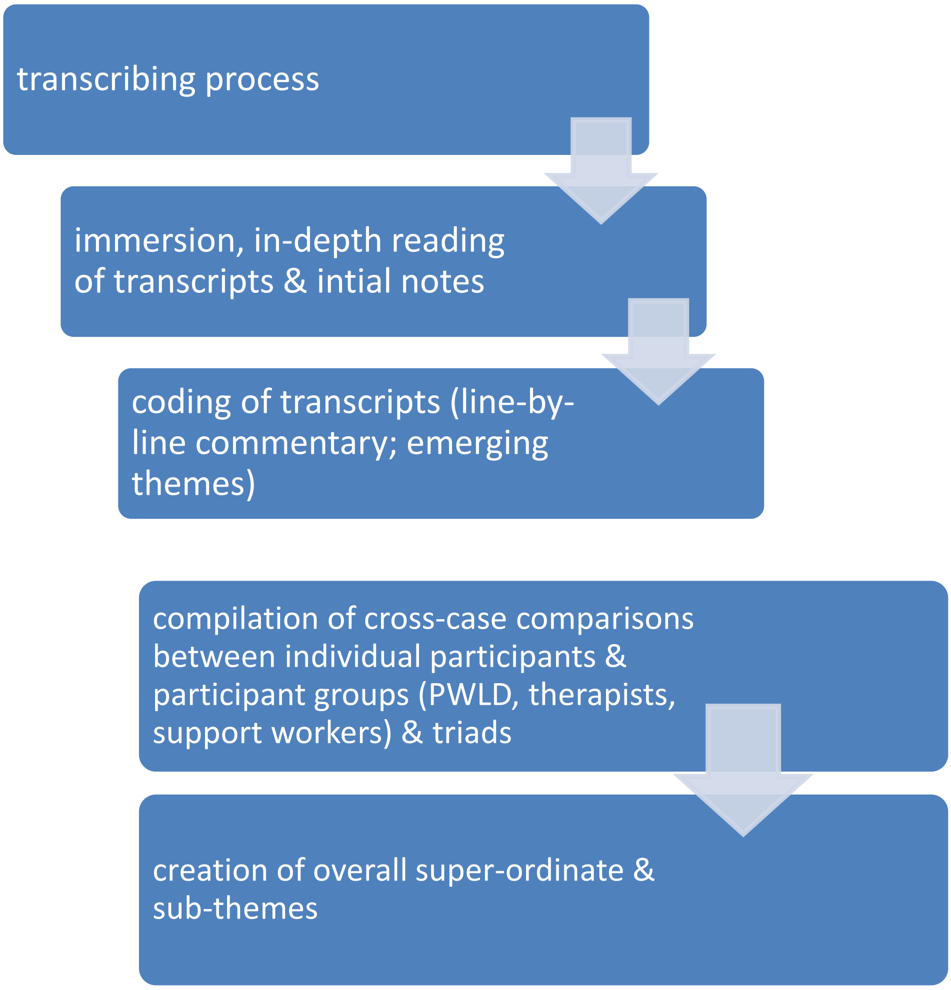
Developing line-by-line coding, staying close to data; generating possible interpretations	Transcript excerpt	Checking/clarifying core content
• Jacky was willing to work with her support worker Malcolm although he was male – "I don't usually like working with man cos of what I've been through" • She trusted Malcolm and didn't mind working with him	4.90: *I've worked with Malcolm* [support worker] *as well, he's taken me places and come to my house* *4.95: I don't usually like working with men cos of what I've been through… but Malcolm seemed really nice, I knew he wouldn't do anything, so I thought, "right, I'll work with him" –*	Referrals & support by different professionals What approach did Malcolm use? Why?

Box N.2 - Keeping Track of the Emerging Themes

LD Client (Jacky) Themes	**Page & Line Number of Extract**	**Key words**	**Exploratory Comments** **(C) = Conceptual** **(D) = Descriptive** **(L) = Linguistic**
Referral issues - Self-harm - Past abuse/rape	1.4 1.6 1.12	*Because I was doing harm to myself.* *I got raped when I was 5 years old.* *I used to cut my arms and … I was in a lot of pain, so I used to cut my arms, thinking it would release the pain - the pain'd be coming out of me*	Serious abuse, causing emotional and problems – manifesting in cutting arms harm "I used to cut my arms, thinking i release the pain" LD degree of self-aw (as a result of the therapy?) (C/D)
Physical detail of self-harm	1.15 1.17 1.19 1.23 1.25 3.62 3.64 3.66	*I did me wrists in…/(PA)That's a nasty scar* *I don't do it now, I just do… with me finger… I pick the scabs…* *See there's a couple of scars but not a lot…* *I've done my fingers…* *I nearly cut me fingers off* *I've promised my family, I'm not going to hurt myself.* *But sometimes… I will tip tablets on the table - my other tablets and paracetamols -* *To take them, and then I think sometimes, "why am I doing it for? I'm not gonna get nowhere, I'm just gonna kill meself" … and then I put*	Graphic detail – in words and shown p (gruesome / unpleasant) "I did me wris that's a nasty scar" "I nearly cut me fingers off" "I pick the scabs" (D/L) Jacky questioning why she does it – "Then I think sometimes 'why am I doi – able to engage in reflection and ques her actions (useful in therapy) – theref candidate? – wanting support, attentio

		them back		
Interviewer summaries & paraphrasing /trying to make sense of client trying to make sense!	1.26 3.70 3.76 8.218	*so, you came to see Nichole… so that she could help you talk about those things that you were having … about the self-harming and about your childhood/Yeh* *So sometimes, you feel like taking tablets and then put them on the table, but then you think better of it? /Yeh.* *Right - a lady's voice in your head telling you not to do it -/Yeh.* *Right? Sometimes you think there's voices in your head, but you're not sure - you think it might be other people? Around you? /Yeh.*	Meta processing? Interviewer checking the correct understanding and reasons behind the behaviour – questions, reflecting, summarising (link to skills used / needed as a therapist) Extra need to clarify with LD clients (C)	

Diagram N.3 – The IPA process



APPENDIX O: INITIAL LISTS OF MAIN THEMES PER PARTICIPANT GROUPS

List of Main Themes for each Participant Group – 1st draft

A. Participants with Learning Disabilities

- Concern/awareness of stigma, labelling, not 'fitting-in' or being 'normal' & other people's judgements/treatment of them
  - Some experienced bullying & victimisation
  - Social anxiety
- Appreciation towards therapists & support workers
  - Gratitude, wanting more/to continue
  - Stated progress/improvements made
- Progress & changes as a result of the therapy
  -all showed increased confidence, increased independence, improved mood
- Being able to trust therapist was important
  (& not being patronised – which some had experienced from non-LD counsellors or other professionals)
- Trust, privacy & confidentiality = important before making any disclosures or being able to engage
- Struggling with dealing with their emotions/life events/referral issues
  (all had experienced difficult life events & strong, challenging emotions that they could not resolve alone/without support – very strong feelings)

B. Therapist Participants

- Adaptations needed in LD therapy work
- Limitations, challenges & barriers in/to LD work
- Achievements, positives, opportunities, rewards/satisfaction
- Working alongside others – family/carers/MDTS's (in most cases)
- Importance of the therapeutic relationship – especially trust & rapport
- Approach used – according to client needs/situation/disposition
- Client-led/co-operative approach

C. Support Worker Participants

- Joint/MDT working, liaising, consulting, sharing – generally very helpful
- Improvements/progress/achievements/changes
- Appreciation of therapist/value of the therapy
- Job/work satisfaction
- The Helping Role – variation, but focused on client/helping/supporting
- Awareness of client's needs/issues/triggers
  (genuine care & support/concern for clients)
- Adaptations/working effectively with the client
- Treating LD people equally/same as everyone else/as individuals
- Unanimous agreement re the importance of empowerment for LD clients

APPENDIX P: TABLE SHOWING CROSS CASE COMPARISON OF PARTICIPANT GROUP THEMES

Participants with Learning Disabilities	**Therapist Participants**	**Support Worker Participants**
Concern/awareness of stigma, labelling, not 'fitting-in' or being 'normal' & other people's judgements/treatment of them	(Limitations, challenges & barriers to/in LD work)?	Treating LD people equally/same as everyone else/as individuals
	(Approach used = according to client needs/situation/disposition)?	
Being able to trust therapist was important (& not being patronised – which some felt they had experienced from non LD Counsellors or other professionals)	Importance of the therapeutic relationship – especially trust & rapport	The helping role – variations, but focused on client/helping/supporting
Struggling with dealing with their emotions/life events/referral issues (all had experienced difficult life events & strong, challenging emotions that they could not resolve alone/without support – very strong feelings)	Adaptations needed in/for LD therapy work	Adaptations/working effectively with the client
	Limitations, challenges & barriers to/in LD work	
Trust, privacy & confidentiality = important before making any disclosures or being able to engage	Client-led/co-operative approach	Awareness of client's needs/issues/triggers (genuine care & support/concern for clients)
Appreciation towards therapist & support workers -gratitude, wanting to continue -Stated progress/improvement made	Working alongside others – family/carers/MDT's (in most cases)	Appreciation of therapist/value of the therapy
		Joint/MDT working, liaising , consulting, sharing – generally very helpful
Progress & changes as a result of the therapy – all showed increased confidence, increased independence, improved mood	Achievements, positives, opportunities, rewards/satisfaction	Improvements/progress/achievements/changes
		Unanimous agreement re importance of empowerment with LD clients
	Approach used = according to client needs/situation/disposition	

APPENDIX Q: INTERVIEW SUMMARIES

The following in-depth information in this appendix contains early drafts of data analysis explorations, in the form of summaries from the semi-structured interviews for the following individuals, groups and in terms of overall information obtained and general emerging themes:

INDIVIDUAL PARTICIPANTS; TRIAD GROUPS; OVERALL SUMMARY & GENERAL THEMES

i) Interview Summaries – Individuals

LD Participants

1) Sid

- (History of recurrent depression = reason for referral)
- Sid said Eve came to see him for counselling as he was depressed. ("depressed and I was fed up", "I couldn't get out of it…. just constantly, constantly, constantly -") Sid had plaguing and pervasive negative thoughts, life felt hard.
- He said he had to force himself to work (volunteer placement).
- Sid spoke about being quiet/withdrawn.
- The counselling sessions involved talking about how Sid was feeling, relaxation exercises, and exploring physical sensations in different parts of the body (CFT approach).
- Sid spoke about having been bullied in and after school (discussed in the counselling).
- Sid also had not seen his daughter since she was a child and felt very guilty and down about that – they reunited recently, and he wanted "to be a good dad" to her.
- Sid spoke about the bad times, ups and downs, "dragged" "through hell".
- Negative self-concept, putting himself down, thinking people didn't like him.
- Eve helped Sid to think 'good things' instead of 'bad' ones.
- Sid still on medication (anti-depressants).
- Sid spoke about frustration from different professionals giving different answers – he wanted "one answer and that's it" (re his problems and solutions).
- Relaxation was an element of the sessions.
- Improvements since the counselling included "I can do more things". ("I've passed my chain saw course, so that's made me feel better", and his daughter "coming into my life again"). Also doing Ju-Jitsu now.
- Sid spoke a lot about enjoying the work and wishing he could have paid employment there (Sid described the work "It is interesting. It's never boring", Different wood/land related activities/work at different times of the year. "Keep saying I want a job down 'ere").
- Sid said he now has some goals (e.g. to get to brown belt in Ju-Jitsu)
- Sid spoke very positively about both Eve and Robert.
- Support worker support – "he is there if I need him, he's helped me out a lot…. He's a good 'un, Robert is".

Emerging Themes List (Sid):

- Depression.
- Constant low mood and suicidal thoughts.
- Forcing himself to keep going.
- Past problems – bullied.
- Separated from daughter/sadness.
- Experiential/practical elements of therapy.

- Lots of ups and downs in the counselling.
- Importance of talking/therapy.
- Exploring/changing the constant negative thoughts.
- Extreme depression and suicidal thoughts.
- Metaphors and use of descriptive imagery.
- Vivid language – strong feelings/self-critical.
- Long difficult process.
- Habitual thinking – negative thought patterns.
- Changing ‘bad’ to ‘good’ thinking habits.
- Hard to put into words/describe what it was that helped exactly.
- Use of medication and upped dose (not effective at first).
- Homework – being nice to self; positive self-talk; relaxation.
- Battling with negative thoughts.
- Blame/criticism.
- Grappling with causes of depression.
- Desire for one definitive answer/frustration at different perspectives.
- Researcher’s opinion/IPA/Interview rapport.
- Links to empowerment – doing more – feeling better – practical achievements.
- Life changes – passed chain-saw course – starting Ju-Jitsu – reunited with daughter (wanting to be a good dad).
- Desire to continue counselling vs. awareness of endings.
- Empowerment and work placement.
- Would like to work (paid) there/enjoyment of work.
- Goals and future plans/achievements.
- Low self-esteem and lack of confidence prior to therapy.
- Impact of others helping - gratitude and appreciation.
- Off-topic conversation outdoor based wood-placement, practical work and skills.

Main Themes (1st Draft)

- Severity of referral presenting problem
  - Metaphors and vivid language emphasised
  – Battle with negative thoughts and low mood
  – Extreme depression/suicidal thoughts.

- Long difficult process with ups and downs
  – Not easy
  – Ups and downs
  – Medication reviews.

- Empowerment and Improvements since the therapy
  – Mood (improved in several ways)
  – Reunited with daughter
  – Achievements (chain saw exam)
  – Motivation and setting goals/targets (Ju-Jitsu).

- Sid’s work placement/Importance of work and contribution
  – Feeling valued, pride, respect
  – Being part of a team
  – Wishes he could have a ‘proper’/paid job there
  – Contribution and normality?

- Gratitude and appreciation of helpers/support (feeling listened to and supported)
  – Towards his therapist Eve
  – Towards his support worker Robert.

- Frustration at uncertainty and desire for definitive answers

– Why he has had the problems
– Guilt re daughter/past.

2) Jacky

- Explained reason for having counselling = self-harm (cutting arms and wrists, picking scabs) and past trauma (rape/sexual abuse).
- Various professionals were involved/referred Jacky to Psychology/Nichole.
- Ups and downs; various issues and physical symptoms.
- Jacky discussed self-harm and taking tablets – plus her self-talk and asking herself what's the point of it/rationalising/exploring meaning behind the behaviours.
- Jacky spoke about hearing voices and seeing things/people (some confusion about whose voices they were – relatives? ghosts?).
- Jacky said Nichole had "got a lot of stuff out of me" – helpful sessions.
- Jacky spoke about the travel training on buses and support from Malcolm, (she felt stupid going on bus with great nephew (aged 8), Malcolm has helped).
- Jacky spoke about social anxiety on bus/public and worrying about what others think of her – feeling panic, vulnerable, sick and very anxious.
- Long term counselling input from Nichole – valued. "She were just there for me".
- Jacky described Nichole as "she's just a nice person" and was able to open up.
- Jacky feels 'safe' when with Nichole – trusts her.
- Lots of talking and exploration of past/present ("we talked through loads and loads of stuff… it was really good").
- Jacky spoke about getting tired, her brain hurting, not sleeping, getting headaches (from banging head before?).
- Jacky said she "just shot up!" speaking to Nichole – it really helped.
- Before counselling Jacky felt, "I had nothing to live for" (despite having 3 children etc).
- "She just opened me" (Nichole allowed Jacky to open up and express herself).
- Nichole gave Jacky relaxation tapes – enjoyed listening to the man "really sexy voice!".
- Jacky mentioned changes since the counselling (e.g. now walks to the shops on her own – more confidence.
- Jacky still hears things but can **deal** with it better now (since seeing Nichole), "but I know they're not there. And they could be people on the other side talking to each other…. but it sounds like they're saying things about me" – ghosts/spirits of dead people.
- Some small changes and improvements, re: more independence (walks to shops alone, cut down from 40 to 60 cigarettes to 10, etc) "just a little bit".
- Jacky's sister does the housework, ("I don't like doing houses, I just like doing the garden a bit") & Jacky likes "sitting down watching TV or going to sleep" – room for further growth?? Could get more out of life?
- Jacky still finds it difficult to stand up for herself ("I can't do that") (family/financial abuse still).
- Jacky would like further help /support/sessions (Nichole and Malcolm mainly).
- Jacky doesn't like all her (agency) support workers – they make her feel uncomfortable, are nosey ("I can see their eyes moving around… I'm not that stupid") – Jacky is sensitive to others' opinions or judgements of her – and they "Just sit down, have a coffee" (she feels some aren't very helpful).
- Jacky spoke about being "no good with money", needing help organising her finances and being on "sick money".
- Limited financial means – "It's only £40. And it's all gone now till next fortnight".
- LD NHS team arrange Jacky's GP/medical appointments ("If I need something, I ring XX or ZZ and they just get me in – so I leave it to them to do") – room for further development/empowerment?
- Jacky spoke about finding it difficult to **trust** people ("I can't trust people") – including her support workers.
- Jacky said Malcolm has made her walk when she wanted a taxi ("No you're walking!") – used humour, cajoled, encouraged her (good approach) and she trusts Malcolm (not most males).

Emerging Themes List (Jacky):

- Referral issues – self harm – past abuse/rape.
- Physical detail of self-harm (graphic).
- Interviewer summaries and paraphrasing (trying to make sense of client trying to make sense!)
- Long-term/ongoing work.
- Referrals and support by different professionals.
- Ups and downs.
- Self-control and responsibility.
- Hearing voices and seeing things (trying to make sense of internal dialogue ESP and unusual phenomena).
- Trust and being listened to.
- Value of the therapeutic relationship (and appreciation of therapist).
- Social anxiety – fear of travelling on bus/alone/public.
- Physical symptoms and sensations.
- Confusion and exhaustion.
- Trauma and long-lasting effects of past/rape.
- Improvements and benefits of the therapy.
- Health improvements.
- Feelings of disempowerment, financial inability and low self-esteem.
- Coping strategies and homework tasks.
- Confidentiality, sharing info and nosey agency/support workers.
- Support making appointments.
- Appreciation of the LD team (NHS team).

Main Themes (1st Draft)

- Severity and complexity of the referral/presenting problems
  – Physical detail/elements of the trauma and self-harm (vivid language)
  – Impact of the severe sexual/emotional/physical abuse –> PTSD.

- Valuing the therapeutic relationship/support work (and appreciation of LD team)
  – Impact on progress/physical health improvements.

- Feelings of disempowerment and pessimism
  – feeling hopeless/worthless/low self-esteem
  – not able to be assertive
  – no money/financial inability
  – exhaustion and confusion – physical, mental and emotional.

- Importance of confidentiality and trust
  – feeling safe with Nicole and Malcolm
  – being able to open up and disclose
  – not trusting some agency workers
  – being careful who she tells things to/boxes and roles.

- Seeing/hearing things/ESP.
  Impact of self-control/confidence
  – use of strategies to help
  – more homework in the therapy.

- Social anxiety
  – difficulties travelling alone by bus
  – fearful and untrusting/suspicious of people and their motives.

3) Edward

- Work-related referral issues originally – Bullying (more than 1 occasion - workplace, from manager/"bosses") and "going over my past and everything".
- Long-term/ongoing counselling (over 10 years involvement), "It took a long time to get me right".
- "Covered everything from my childhood, to everything really".
- Including past memories/events from an old LD hospital/institution.
- Made a lot of progress, but still some bumps, ups and downs.
- Treats parents better now (they come to the sessions).
- Discussed the LD work placements, exploitation, bullying (he felt his supervisors "rubbed it into me" – re his LD or not keeping up. "They were saying "Oh you're behind" – but he was doing a lot).
- "They said if you can't keep up, we'll put you back in the disabled area".
- Financial exploitation – "I was on less pay than the others, but I was doing a better job than they were."
- Felt unable to use his union – "can't talk about the union, cos one talk about the union and you're sacked, really" (felt threatened – real or perceived).
- Very appreciative of his counsellor Tim ("helped me get through it", "I'm a better person – to this day, thanks to him…") "He's a good friend... he's really helped me…".
- Also grateful to parents and support workers.
- More stable now – "he's keeping me on an even balance".
- Preferred Tim to past counsellors – "They didn't understand me" (felt understood by Tim).
- Severe state before the counselling – felt "terrible" – "me mum was at wit's end".
- Took a while to get into it – "It took ages to break into me really".
- Spoke about taking things out on his family "since birth, I've always took it out on me mum and me dad".
- Spoke about smiley talk mood chart Tim had worked on with him and traffic lights (measuring Edward's mood – communicating to staff), "so as soon as they come through the door they see, Edward's upset and…. they know what's happening" – but dubious about impact on him, "I don't think it's any good for me really".
- Communicates more better/more effectively to others now. ("If I'm in a mood over something, I kind of tell people…").
- Staff team encourage frank discussion of feelings ("they hammer me to say what's wrong… and as soon as I've said what's wrong with me, it's all alright… it's no bother"). Edward feels understood by his staff team and care genuinely about Edward – good support team.
- Edward felt Tim helped him feel more empowered – "he's been interested in me and helpful".
- Edward enjoyed his jobs and felt proud – e.g. being a Brewster (described his coffee making – "I could do the designs", "I was good at that", "And I know when it's good coffee or bad coffee"). "I did a course on it" – proud of his achievements.
- Being in his flat 5 years = part of feeling empowered ("I do me own cooking and I do … tidy up… tidy up… tidy isn't it?!") -> attributes mainly to Tim – "I couldn't have done that without Tim's help and me mum and dads help".
- Spoke about various support staff and their help – his gratitude.
- Spoke about family and Tim, "Kept me on the straight and narrow really" **–** needed their support.
- Bad past memories still unable to lose – "It's still there… I can't get rid of them", "didn't see my mum for 24 years", "that will stay with me all my life, I'm sure it will…".
- Importance of church – "I've been a Christian for about 12 years", and "friends at church" – "they help me, Ray's helped me in a big way".
- Africa trip via church – positive experience – "I worked out there for 10 days, I really enjoyed it", "I met a lot of people with AIDS and HIV", "I took some chocolates, frogs as well – they went down a treat! Them Cadbury's frogs that you get? They went down like they were hot cakes they did!", "we went over the border to Lisutu, a poor country, very poor", "they said I was rich, cos I was a big lad – I just said I was 20 years pregnant!!" (good sense of humour).
- Support workers help with domestic tasks – housework, gardening, cooking, share conversations and experiences (e.g. XX Hall DVD and counselling discussions).

- Spoke about extreme treatments at XX Hall (LD Hospital/Institution) in his past ("electric treatments, electric shocks, everything, a lot worse….") - now flats and houses.
- Support workers available after counselling sessions to support and discuss the sessions/de-brief (2 stages of discussion – i) counselling – ii) discuss the counselling).

<u>Emerging Themes List</u> (Edward):

- Workplace bullying, intimidation and institutional abuse.
- Exploring past memories and trauma.
- Long term therapy work.
- Choices about disclosure/choosing to disclose to Tim (therapist).
- Ups and downs.
- Improvements – parental relationships – feeling better – more independent/own flat.
- Helpfulness of the therapy – facilitating healing.
- Segregation, labelling and pay inequalities – link to LD.
- Joint work – creating a mood chart together and helpful strategies.
- Appreciation of therapist.
- Use of humour and metaphors.
- Practical and emotional support from support workers.
- Importance of support network.
- Relationship/importance of parents.

<u>Main Themes</u> (1st Draft):

- Workplace bullying and Institutional abuse
  – long-lasting effects/trauma
  – labelling, segregation, and pay inequalities – due to LD.

- Appreciation of & gratitude for therapist and supporters
  – Felt understood by Tim – other non-LD counsellors didn't
  – Keeps him on "an even balance"/helpfulness of therapy
  – feels supported and appreciated, safe.

- Importance of support networks
  – Tim, Ray and Support workers
  – Parents and brother
  – Church.

- Pride at achievements and progress
  – Africa charity work trip
  – Brewster (courses and skills)
  – Better person
  – Impact on parents

- Long-term therapy work of past issues
  – gradual disclosures – choosing to disclose for 1st time
  – trust
  – Reliability/safety.

- Range of improvements
  – mood and feeling better
  – own flat and doing domestic chores
  – parental relationship.

4) Abbey

- Had previous counselling and other services (non-LD) and Mental Health service input (was referred to LD service by GP or another counsellor).
- Counselling with Penny about 1 year – feels she's "made a bit of improvement".
- Discussed with Penny impact of past bad relationships and experiences impacting on current one – "I've never really come to terms with it", "my husband couldn't get close, I kept pushing him away", "it reminded me of my ex".
- Found the sessions helpful ("Definitely, definitely, it's really helped me").
- Impact on housework/jobs – "at one stage I couldn't care less" – "but now I'm stepping up to the mark and doing more things, realising things".
- Relationship and communication are better and Abbey doing her share of jobs at home.
- Counselling helped release, analyse and process – "made me realise everything – realise what I couldn't have, and I felt so weak. I just didn't know what to do and now I feel so much stronger".
- Counselling helped release the past and move on – "it's really helped me move on", "and turn around and say, "Goodbye past – moving on!"".
- Spoke about keeping a diary (Penny's idea) – "for my sleeping habits"- ("try out techniques before I go to bed to keep myself calm so I don't kick Kevin in my sleep") – and look to triggers, record ideas and events.
- Issue of hitting/kicking partner when asleep in bed! – causing bruising.
- Sleepwalking and support of J's cat 'Rapid'! – 'Telling' Kevin/waking him up to warn him! ('woke him up to say, "Mum's gone out of the door", "She was quite a good guard cat!").
- 'Subconscious' sleeping behaviours ("it's always subconsciously I might add"), ("I say "I'm sorry I don't realise!" – is this true?") – not done it for 3 to 4 months (some improvement/ups and downs).
- Problems with ex-wife – Kevin took out an injunction (she was stalking them), ("since he's took the injunction out and she's backed off, it's helped the situation") – "it's like a weight's been lifted off us" – they feel calmer somewhat.
- Abbey mentioned improvements with housework and "stepping up the mark".
- Abbey agreed/said empowerment was important to her – "yeah definitely. It's like, my husband would say – it don't stop you from going out; I still do my own things." (how empowered? Talking through husband? Room for improvement?).
- Abbey spoke about always having been dependent on past partners (pattern of behaviour/relationship).
- Abbey aware she could be more independent? – "It's like he says, you don't have to call me – let me know when you arrive at your destination when you're on the bus, but in between, there's no need to".
- Abbey feels she's "come to terms" "from my past" and moved on.
- Ongoing concerns/fears about ex-wife – "we're keeping our guard up at the moment – yes, she's gone quiet, but we're just waiting – we're on guard as you call it!" – had a dream worrying about ex's reappearance/ongoing threat.
- Abbey feels able to protect and assert herself with ex-wife/not scared – "She's frightened of me", "I know she'll probably not do anything" – "She knows if she starts on me… I'm just going to be right in her face and just give her some home truths" (defensive/jealous/anticipatory/aggressive herself?).
- No other health professionals involved.
- Abbey chooses to share some session info/content with Kevin (husband and carer/support worker), but also chooses not to sometimes ("certain ones yeah and certain ones, no. I've told him the majority of stuff, but not everything").

Emerging Themes List (Abbey):

- Experience of LD vs non-specialist LD counselling services and signposting for appropriate services.
- Counselling for past relationship traumas – past bad memories – impact upon current relationship.
- Housework difficulties/differing expectations between partners.
- Language repetition and emphasis of meaning.
- Improvements taking time, working through things.
- Dependence upon husband/carer – becoming more independent.
- Problems/worries caused by ex-wife and response/vigilance.
- Counselling benefits/evidence of improvements – increased motivation with house jobs – thinking more clearly – exploration of feelings, processing behaviours and memories.
- Perceiving the interview as “fun!”
- Appreciation of the counselling and counsellor – feeling listened to – being able to talk – releasing built up tension – clarifying/highlighting.
- Counselling processes and strategies – sleep diary, recording triggers – practical goals & strategies.
- Story of cat ‘talking’ and protecting Abbey.
- Sleep-walking, hitting out in her sleep and “unconscious” behaviours.
- Dreams and processing.
- Determination to change and searching for alternative strategies.
- Use of metaphors and linguistic phrases (quite able verbally/mild LD).
- Increased interviewer input for LD participants? – paraphrasing, checking, helping, suggestions.
- No other professionals involved.

Main Themes (1st Draft)

- Embracing the therapy and opportunity of empowerment!
  - released past, moving forward
  – making improvements
  – feels stronger
  – enthusiasm for the process/change!

- Dealing with ex-wife (obstacles?), feeling vigilant/defensive
  – improvements since police injunction taken out
  – on their guard still
  – feel calmer
  – ex-wife stalked and caused hassle (not peculiar to LD).

- The counselling has been helpful (made lots of improvements)
  – Enabled processing more mental clarity, explore thoughts
  – doing and thinking more
  – making changes at home
  – feels stronger, more optimistic, energised
  – communicating more/better.

- Sleep behaviours and increasing self-awareness
  – anger management –> hitting out at Kevin in sleep
  – homework and sleep diary – strategies and goals
  – sleep walking (and cat story!)
  – learning about herself.

- Learning (insights) from past and current relationships
  – Moving on, “Goodbye past”
  – processing/reflecting on how past relationships affected her and impact on current one

– exploring and reflecting on current relationship
– learning how to become more dependent.

- Housework and marriage
  – Differing expectations (LD and non-LD)
  – “Stepping up to the mark” and making changes/improvements
  – becoming more independent
  – being more assertive and communicating better.

5) Neil

- PDA/High-functioning Autism/OCD.
- Feels threatened and sensitive to these labels and others’ perceptions of him.
- Uses humour to mask this (“I’m a crazy person!”).
- His mum works for NHS service and contacted Janice.
- Janice was present in the interview at Neil’s flat (he referred to her a few times and she confirmed things).
- Disputed why he had accessed the service and said he’d never had an IQ of below 70 – was a little indignant/suspicious as to why his mum had referred him (Janice had to explain “We had to make a clinical judgement. You were going through a rough time.”).
- Spoke about the counselling sessions being “quite depressing actually” (but laughed) – “talking about depression is quite a depressing thing” – used humour, sarcasm; witty. “I had many weird conversations!” –> not used to such self-exploration?
- Neil acknowledged his defensiveness – “Every person – “stop asking questions, fuck off! Oh, fucking leave me alone!” (is his reaction to others questioning him) “You know, hood up, head on the table….”
- Neil said his mum thought he needed counselling – “Mum thought I was depressed, and I needed help”.
- Neil stated the main difference /result of the counselling is how he now deals with things. He felt life hadn’t got any easier – got more difficult.
- Neil felt counselling had its limits/not sure how it would change things in his external world (e.g. bad neighbours/bullying).
- Neil agreed being more independent was important to him (joked “But obviously it’s not happening because I’ve got a trained counsellor doing my washing up!”).
- Neil said being independent also has it disadvantages (complained about vacuuming, tidying, washing-up – before people visit!). Also said he needed people to nag him to do it!
- Chatted about Dysons!
- Neil also said empowerment could be boring – on his own in the flat all day.
- Neil said he felt bad about “life in general” before the counselling. He now feels “just…pissed off”- rather than depressed (improvement/change). (“But I don’t tend to feel so much – depressed”).
- Spoke about his mum being “a parent”, “And be really annoying”.
- Neil said Paul had somewhat taken over his mum’s role – “He’s kind of taken over mum’s role”. (Checking on him – making sure he washes up, etc).
- Discussed Neil’s repetitive/obsessive checking and washing up (OCD).
- Paul’s role was more to help and support Neil – not involved in the counselling sessions or any homework.
- Neil spoke about feeling expectations to give specific answers (both to Janice/IQ testing and this interview) – felt same pressure (PDA?).
- Neil spoke about his “crazy drug addicts” neighbours and feeling vulnerable. (*Importance of his environment/social situation/limited finances/social-economic factors*), “no amount of therapy sessions is going to make me **like** the neighbours” (difficulties living with/near others/society).
- Neil worried about losing his temper if local teenagers/neighbours continue to cause trouble - “If it does, I’m probably going to end up beating the shit out of them!”.

Emerging Themes List (Neil):

- Concern about LD and ‘Autism’ label.
- Service provision/meeting service criteria/ ‘IQ of 70’.
- Neil perception of therapy sessions.
- Neil’s attitude towards ‘professionals’.
- Client vs. Mum’s perceptions (of him/progress)
- Mum’s role.
- Support worker’s role.
- Self-insight and reflection on therapeutic progress – evidence of empowerment?
- Neil’s use of humour, irony, sarcasm, wittiness.
- Empowerment and independence – Neil’s views.
- Same difficulty staying on track/uncomfortable discussing feelings (PDA?).
- Avoidance of some Q’s/link with PDA.
- Neil’s perception of interview/Qs.
- Neil’s feelings of vulnerability in his neighbourhood.

Main Themes (1st draft)

- Concern about LD and ‘Autism’ label
  – with link to service provision/meeting service criteria ‘IQ of 70’.

- Disadvantages of independence and empowerment
  – Feeling vulnerable in neighbourhood
  – boredom/on his own in his flat.

- Attitude/thoughts towards professionals/ helpers, people’s roles and putting people in boxes.

- Client’s perception vs mum’s perception of the therapy
  – improvements in mood vs improvements in coping skills
  – including use of humour and sarcasm/irony (humour to mask difficulties)

- Client’s insights and self-awareness of therapy and interview processes – denial?

*Neil & Sid both referred due to depression – but expressed differently & very different personalities.

Interview Summaries - Individuals

Therapist Participants

1) Eve

- Sid's referral = history of recurrent depression (referred by GP).
- GP also prescribed anti-depressant medication (and counselling request).
- Joint work on treatment plan and formulations – simple versions.
- Compassion-focussed therapeutic model chosen – Eve thought it would helpful.
- Eve explained CFT approach to Sid whilst gaining background history (quite a complex model, different components – adapted to Sid at different times).
- The approach "Just fell into place at the time" – flowed well.
- Eve checked with Sid what would be useful as they went along/joint work.
- Initially Sid didn't turn up/difficult to see him (he was nervous). Eve visited informally to say hello, introduce herself.
- 6-7 months' work so far (near end of sessions/journey).
- Importance of the therapeutic relationship developing and Sid utilising it well – central to the therapy (talking about his experiences, feeling valued, listened to, and feelings validated.
- Sid's confidence increased and mood improved.
- Initial impressions – Sid had a 'dark cloud' over him.
- Strong sense of Sid's negative mood, physical sense, heaviness (Eve aware of/felt it).
- Sid had felt people couldn't understand the depths of his depression (pressure to "pull yourself out of that" by others and felt criticised and judged).
- Sid and Eve felt disappointment at one point as he felt he wasn't improving fast/enough – worried he wasn't moving out of the depression (felt/voiced/visited GP for more meds).
- Eve stuck by Sid, supported and reassured him – explained it might take a while till he felt/saw things differently.
- Sid was very self-critical and expected he should get over it quickly.
- Discussed we are all human (all "strange creatures") OK to be imperfect, (CFT model helped), (Eve also felt better/reassured – applied it to the therapy too).
- Eve used baseline measures/assessment (Glasgow Depression Scale - useful objective measure – showed Sid his mood had improved after a few months – score decreased).
- Sid had stopped engaging with work/life and before therapy his presenting problems were quite severe (isolating himself, snappy/out of character, lack of energy, affected relationships).
- Sid now enjoying work and proud of achievements (chain saw qualification) and started Ju-Jitsu club – meeting new people (big step) – Lots of improvements.
- Practicalities – finding somewhere to meet, privacy and quiet! (Had to put a sign on the door, to stop people interrupting the session).
- Talking about Sid's partner without her being there felt a bit strange.
- Therapist satisfaction (Eve pleased to see Sid's improvements and better mood).
- Still work to be done/improvements to make.
- GAP in research/little resources and info re CFT and LD clients (Eve had to make adaptations and simplify resources as Sid couldn't read or write – used more pictures ("that was quite helpful to adapt the materials for him").
- Eve constantly "gauging the pace all the time", "feeling the way", "trying to walk next to him".
- Eve also doing her own Mindfulness practice whilst working with Sid (helped her him being present with Sid).
- 1st time Eve had used CFT approach with someone with an LD – learning as she went along ("weaving it into sessions", "made it relevant to him").
- Relationship = The "vehicle" via which "the process happens" – Eve very aware ("within sessions I was quite aware of our relationship and what I was feeling and what that might have meant" – in terms of what he might have been experiencing).
- Importance of non-judgmental listening (very important to/for Sid - enabling him "to make changes that are really important to them").
- Importance of supervision and reflection between sessions.

- Empowerment – A key theme in LD work due to limited choice and control (Eve thought).
- LD population – restrictions in social situation, “the circumstances they’re living in”, “I think the empowerment work works against that, in helping them to maintain the resilience” – “to understand that it isn’t a fault within them”.
- Impact of Sid’s going into a special school – Eve said he felt he hadn’t had the opportunities to take exams, or the right support in school. Also, he had a lot of bullying (due to the LD/label?) – All very disempowering for Sid.
- Social and financial constraints experienced by Sid (“he’s very limited in things he can do”, “I was always aware that he didn’t have much money and things he could do with his partner – were very limited”, “he didn’t have any spare money to spend”).
- Sid’s job “he very much enjoys” – “but it’s on a voluntary basis, and that’s limiting”. (Not paid/formally employed) – he also mentions this.
- Limited Social Networks – No paid job/access to people/no money/couldn’t go out to meet people (vicious circle – diagram?) – all very disempowering for Sid.
- Eve thought “*all* therapy should be empowering. It’s a really essential part of working with somebody”.
- Eve worked “very much on an individual basis with him” – “there wasn’t really any need to share or talk to carers” – “when suited the way we were working together”. (Other clients often have “carers and other professionals wanting to know information”, “there wasn’t any pressure or expectation to share things” – helpful to Sid).
- Less sharing of information or conflict of interests (different to some clients).
- Sid didn’t have a big team of professionals/carers working with him (quite able/independent – mild LD).
- Confidentiality was important – beneficial to Sid - no need to share with anyone.
- Sid explored with Eve how his boss had spoken to him and how he’d felt and his need to assert himself – he reflected and thought he’d dealt well with the situations. (authority/power/relationships).
- Eve was interested to know whether Sid found the therapy empowering or not.

<u>Emerging Themes List</u> (Eve):

- Referral = History of recurrent depression.
- Counselling alongside medication.
- Service eligibility criteria/access.
- Joint work (treatment plan and formulation, therapist/client).
- Use of CFT model – rationale/why chosen – complex model: adaptations.
- Educating the client/informing of the therapeutic model.
- Simplification/adaptations needed for the LD clients.
- Applying CFT principles and experimentation.
- Therapist reflection and supervision.
- Research gap identified (CFT and LD).
- Successful therapy/it went well.
- Therapist satisfaction.
- Client motivation with homework.
- Working co-operatively/checking in with the client.
- Gauging the pace.
- Client nerves/anxiety about therapy.
- Client-led sessions and flexibility.
- Developing the therapeutic relationship.
- Importance of the therapeutic relationship and feeling valued.
- Feeling listened to.
- Not being judged.
- Improvements and maintenance.
- Metaphors and imagery (depression/isolation).
- Using the CFT approach.
- Therapeutic relationship as a vehicle.
- Physicality and sensing negativity/therapist sensitivity – reflective process.

- Going at client's own pace.
- Importance of being taken seriously and depth of feelings acknowledged.
- Frustration at slow progress and fears not progressing fast enough.
- Client self-critical.
- Support and acceptance (acknowledging difficult times and help making difficult decisions).
- Linking the process to the CFT model.
- Difficulties explaining the therapy model to the client.
- We are all human.
- Methodological issues (CFT).
- Use of formal assessments (Glasgow Depression Inventory).
- Severity of the depression – signs and symptoms.
- Signs of improvement.
- "we're all strange creatures", equals/mutuality/shared experience.
- Logistics/practical issues.
- Reassurance and relapse - prevention.
- Normalising feelings (LD person feelings same as non-LD).
- Empowerment – Choice and control, over life
  – importance of resilience
  – link to social/living circumstances
  – Schooling (special vs mainstream)
  – "All therapy should be empowering".
  – via/facilitated by therapeutic relationship
  – not their 'fault'
  – lack of money impacts – financial restrictions
- Social and financial barriers.
- Conflict of interest with large MDT's and sharing information vs. confidentiality/working autonomously with client (pros and cons).

Main Themes (1st Draft):

- Importance of CFT model/approach
  – Applying principles and experimentation
  – Research gap identified/methodological issues
  – Educating client/explaining approach
  – Suitability for referral/presenting problems.

- Client-led and joint therapy work/working together co-operatively
  – Going at Sid's own pace
  – Therapist sensitivity/reflexivity
  – Physicality, senses and emotions (using them in the therapy)
  – Joint treatment plans and homework ideas
  – Shared experience ("We are all strange creatures")

- Importance of the therapeutic relationship
  – Developing the relationship
  – Feeling listened to/understood/at ease/taken seriously
  – Initial client nerves
  – Reassurance and relapse (prevention)
  – Need for therapist reflection and supervision.

- The depression vs the client
  – Severity/depths of feelings
  – Improvements
  – Normalising feelings
  – Self-acceptance (from self-criticism).

- "All therapy should be empowering!"
  – Successes and improvements
  – "we are all human"
  – Therapist satisfaction and client motivation
  – Use of formal assessments was useful

  - – Choice and control
  - – Resilience.

- Barriers, limitations and conflicts
  - – Frustration at slow initial improvements
  - – Practical issues, logistics/finding a quiet space/place
  - – Need for medication reviews
  - – Social and financial barriers
  - – MDT working and sharing information (confidentiality).

- Adaptations
  - – Need to adapt and simplify resources/model/therapy
  - – Flexibility/Informality.

2) <u>Nichole</u>

- Jacky referred due to past trauma, sexual abuse. Quite complex case. Also, Jacky was hearing voices/seeing things – so various issues involved. Family dynamics and financial abuse also involved.
- Long-standing/still on Nichole's caseload due to sporadic risks, self-harm and suicidal ideation. (ideas to take tablets or jump in front of a train etc); whole team involved.
- Self-harm risks etc = reflective of what going off at the time. GP aware. (Feels desperate, needs more support at those times when mental health low).
- Treatment plans around specific issues more control over her life, more assertive with family, dealing with hearing voices/seeing people (not thought to be psychotic by psychiatrist – genuine internal stimuli?).
- PTSD (memories so vivid, fulfilled criteria for PTSD).
- Therapy can be more difficult when Jacky is depressed - less clear/loses control.
- Therapeutic goals linked to abuse (voices linked to abuse) – interlinked. ("There's a sense of moving on from the past.") – a lot to work through and many events.
- Mixture of therapeutic approaches (counselling to build relationship), CBT for negative and automatic thoughts, time line and story work (build up picture of past), NLP (work on past traumas), EFT/Energy therapies (down state of own self), Relaxation techniques (more internal control with rest).
- Nichole followed Jacky's life story (verbal and visual methods/more concrete), looked at negatives and positives from Jacky's experiences in life.
- Sessions "led by her really". Not always a linear process (might go back and review).
- Need to simplify approaches due to LD and regular reviews and checking shared understanding.
- Use of creativity.
- Rewarding/satisfaction – seeing improvements (overcoming trauma) and Jacky managing her state.
- Tendency to flip from adult to child mode –Nichole tried to keep Jacky in adult.
- Nichole found Jacky likeable "you can't help but like her".
- Health problems (CN also involved) – but some improvements (gave up/reduced smoking).
- Need for practical help and support (e.g. finances – avoid family getting her money).
- Trauma was very severe – variety of abuse from a young age.
- Difficult to rate overall clinical significance of change – worked on all different specific issues (Nichole used SUD's to score before and after working on different areas).
- Timeline worked well (Jacky – quite 'visual').
- Frustration re lack of assertiveness with family (Nichole "can't make her be more assertive") – financial abuse still goes on (Jacky agrees can't say no); manipulation/family "all know what buttons to press".
- Therapy still ongoing, Nichole feels Jacky has come on a long way.
- Therapy in LD takes much **longer** – Nichole said – to develop rapport.
- Importance to be careful with boundaries in LD work and clear what your role is.

- Importance of rapport and trust (often lots of distressing history in LD – can take longer to disclose distressing info/new experience to trust someone - very sad to think of higher exploitation in LD population).
- Important for Nichole that Jacky feels empowered – “manage situations as they occur” and feel in “**control** over what they do and how they feel” and give “responsibilities for things”.
- LD and lack of control – Care Providers and treatment plans can help.
- Issue of over vs under protection of LD people – 2 ends of a continuum (both prevent empowerment, independence).
- Empowering focus – “part of the therapeutic process in a way isn’t it?”.
- Nichole felt there are “rather a lot” of barriers/challenges to empowering this therapy more (e.g. can assertiveness be taught? – putting it into practice!!).
- Some involvement with other support workers – “Just occasionally where something needed to be discussed” – e.g. “strategies about how they were helping her – one of them was helping with finances”.
- Support Workers not involved with housework tasks (“they’re mainly doing the practical things, so they come in and do shopping with her and all that sort of thing”).
- Putting people in boxes – Nichole said Jacky does this and chooses who to speak to about different things.

<u>Emerging Themes List</u> (Nichole):

- Referral – long term work/development/journey of the therapy – past trauma – abuse (sexual, physical, emotional, financial) – self-harm and suicidal ideation – Family dynamics – hearing voices/seeing things.
- Impact of family – control/assertiveness – exploitation and manipulation.
- MDT approach (health team, care providers and support staff).
- Mental health concerns – hearing voices – ESP – seeing images – suicidal risks – depression – anxiety.
- PTSD, Trauma and Abuse.
- Working on a lack of control in life (precipitative symptoms and self-harm).
- Inter-linked goals.
- Extra support need at difficult times/time of struggle (including Respite).
- Importance of trust and building rapport.
- Mild LD and self-insight.
- Client-focused/led approach.
- Progress and positives – moving on from the past – looking at positives – managing state better – good use of timeline.
- Need for a flexible approach and long-term work.
- Working creatively.
- LD adaptations and reasonable adjustments – concrete approach – accessibility – Simplification.
- Coping strategies and the need to review or re-cover them.
- Mixed therapeutic approaches – how, when and why?
- Therapist satisfaction/rewarding work.
- Adult/Child roles – switching/swapping.
- Ups and downs.
- Physical health problems (drinking, smoking, mobility).
- Practical and financial issues.
- Monitoring changes (specific vs general outcomes) – LD meaningful way.
- Limitations to the work and other challenges – family/lack of assertiveness – ongoing financial abuse – impact of environment, setting, government policies, culture, society.
- Overprotection vs lack of protection (2 ends of a continuum).
- Staff roles, boundaries, putting people in ‘boxes’.
- Empowerment – control over life – “part of the therapeutic process” – helping role of a therapist.
- Disempowerment – lifestyle – lack of control: engage in negative behaviours – a lot of work to do for LD group in society.

Main Themes (1st Draft):

- Need for Adaptations
  – Flexibility – Creativity
  – Simplification – Concrete approach
  – Longer sessions/more/regular reviews and checks

- Mixed Approaches for complex issues
  – PTSD and significant trauma – Abuse and self-harm
  – MH issues requesting MDT support – Extra support needed at difficult times

- Limitations to the work and other challenges
  – Lifestyle, background, environment
  – Family (abuse, control, manipulation)
  – Over/under protection from others/carers
  – Lack of choice and control – experience/background
  – obstacles preventing
  - Support in care setting, society, culture (insufficient/inappropriate?)

- Practical, physical and financial Issues
  – Poor physical health
  – Financial difficulty/mobility and abuse

- Impact of family background and environment/lack of choice and control.

- Importance of trust, building rapport and the therapeutic relationship
  – Client-led work
  – Important to allow disclosures and support
  – Enabled improvements/progress
  – Mutual satisfaction.

3) Tim

- Referral for Edward was due to workplace bullying and subsequent nervous breakdown.
- Initial treatment plan = around sharing info and consent (in other health and adult care people).
- Edward wanted a chaperone – his parent (Tim found this unusual) – they still attend all sessions.
- Tim discussed formulation – including differences for R managing strong emotions; monitoring long-term relationships; narcissistic attitude; PTSD type symptoms (mood disturbance, flashbacks - intrusive images from work place); difficulty coping with change or loss, some long standing behaviours; possibly formed form the nurturing process; self-harming behaviours – Edward said taking **control** of the situation makes him feel better. History of aggression and violence aimed at parents; 2 x abuse at work (factory and café run by church).
- Institutional abuse from past (30 years ago) also mentioned – went their safeguarding (inconclusive as not possible to locate medical records and people had died/moved on and hospital had been demolished); Edward got a sense of closure; watched DVD of the old hospital and worked with Edward's emotional desensitisation.
- Therapeutic approach – initially PCA/Rogerian - to build up therapeutic relationship; the Gestalt - to help with therapeutic challenge and create change; Transactional Analysis – to look at interactions with others and more self-awareness/had Edward presenting (approaches also helped Tim with report writing).
- Tim used some metaphors and imagery in his description of the process (e.g. old comfy slippers).

- Therapist satisfaction – especially from building the relationship and gaining trust (fondest memories – silly talking – and getting to know Edward).
- Difficulties – including therapeutic challenge phase (more aggressive behaviours and volatile self-harming). "Healing crisis" and overwhelming emotions coming up – "Edward did sort of rise out of that and become a lot more self-aware".
- Dreams reported mirrored R's process/journey (lots of snakes trying to bite him during therapeutic challenge; occasionally they still reappear if Edward feeling vulnerable); (Tim discusses this with Edward in sessions – symbolic, relating to thoughts and emotion).
- Tim now on "maintenance" phase ("as opposed to that intense therapeutic engagement").
- Outcomes = big improvement (from nervous breakdown and losing job and girlfriend; differences communicating - to now having good relationships with family and community, now lives independently with minimal support, valued member of his church – now "a fully functioning individual".
- 10 years for this transformation - big improvement and he sees big success (from 2/10, to 7/10, to 10/10).
- Edward no longer medicated (was on benzodiazepines and serotonin uptakes).
- Previously very severe behaviours, self-harming – "there was consideration for him to become an inpatient".
- Impact on family and others around Edward – now big improvement for all involved.
- Phase of therapeutic challenge – most difficult and most successful (most self-awareness).
- Physical symptoms "sort of tracked around his body as we were working through these emotions", (psychosomatic presentations – throughout challenge phase).
- Ongoing work ("I still feel as though work's unfinished really. I don't feel as though "job done" you know".) – (scope for further development).
- Tim said he'd underestimated the impact of the therapy – "I underestimated how powerful the therapy could be". ("The sort of intense, psychosomatic presentations, that sort of developed").
- Tim would've liked to have seen "more support for Edward in between (our) sessions".
- Family struggled as elderly and own health problems – more help needed at the time ("I think things could have gone a little bit more smoother, if Edward had had some support at that time, some staff support" – "rather than parents having to try to support their son through that process".
- Tim finds/feels it "an honour and a privilege" to work with LD clients as a therapist.
- Tim thinks LD clients "respond really positively to the therapeutic engagement", (reflects upon/discussed their background – "Individuals who've been labelled, segregated" – "they welcome and cherish that focused one to one engagement".
- Tim mentioned importance of applying reasonable adjustments through sessions, "being very open, very transparent", "explaining everything as you go along".
- Tim thinks the therapeutic relationship – "it's the core, it's absolutely core" – "without the relationship you wouldn't be able to progress onto the other phases", "absolutely critical".
- Tim thinks "it's critical for the client to feel safe, comfortable", "to trust you".
- Importance of revisiting the therapeutic relationship and relationship building skills. (Revisiting the therapeutic contract, rechecking where they are now, how both feel, how the therapy is going, "checking things out").
- Tim thinks empowerment = "absolutely crucial", and "I think it's the goal which all therapists aim to achieve in new clients", "critical".
- Tim finds it fulfilling to see transformation in clients (from "meek and mild", to "confident", "lots of self-esteem", etc).
- For Tim empowerment – "about somebody having the confidence to be totally self-governing and speak up for what they think's right and wrong, and to express their need without feeling embarrassed or feeling as though they are no able to do so".
- Tim felt empowerment affected Edward by transforming him from a "very poorly man" into a relatively healthy man, who's able to have a say in his life and steer his own boat" and "form healthy relationships within his local community".

- Impact on parents (“It’s freed them up, they’ve now got a little holiday home”) and carers (“massive systemic benefit”/also improved “the working life of his carers”).
- Disempowerment for came from the workplace bullying (“totally disempowering”; “he had no self-confidence, no self-worth, didn’t have an opinion on his capabilities”, “massively damaging effect upon Edward” – now a “very proud man” – at 1st refused to get a mobility scooter and doesn’t like to claim benefits).
- “Massive transformation”.
- Tim considered himself “just there as a sort of conduit”, “Edward’s done all the hard work”. “he’s been incredibly courageous and brave”. (Tim admires Edward and his progress).
- Tim warns about therapy with “forensic type clients” – importance of guarding against making “the client, more proficient at being an offender” – “by the very native of engagement – it can make the person more comfortable in feelings and emotions that they may experience while committing a crime, or offending”, (Tim warns about “applying certain models, as in models that are based from the field of Humanism” – Do I agree??). need for boundaries and awareness of pro/anti-social (or harmful) behaviour -Discuss with client? What wrong? – “That’s something to be mindful of – sort of a paradox”.
- Tim think the therapy should be “offered more widely” to LD client group and to hold onto clients for longer (time pressure to discharge - early discharges and short-term work “from an economic point of view, I don’t see it as being viable”).
- Other professionals involved (SALT, OT, CN, Police – Vulnerable persons unit [Police do weekly checks “call and see R, have a drink of tea with him”]. (Helpful to have MDT working).
- This research = “Under studied environment and I can only see good coming out of it”.

Emerging Themes List (Tim):

- Referral themes – mental health concerns – working through strong emotions – self-harming behaviours – historical aggression towards parents.
- Workplace bullying, institutional abuse, and victimisation from employer.
- Including parents in sessions/Impact of therapy on family.
- Trauma, PTSD symptoms and behaviours.
- Importance of building trust and therapeutic relationship.
- Coping with change/stability and control over life situations.
- Mixed therapeutic approaches.
- Use of dreams and symbolism in therapy.
- Ups and downs.
- Long-term therapy (not short-term fix)/process and benefits/demand in LD service/pressure to discharge.
- Limitations and challenges to the therapy – therapeutic challenge – Narcissism.
- Use of metaphors.
- Phases of therapy – relationship building – therapeutic challenge – maintenance and stability.
- Unfinished work/need to continue/scope for further improvements.
- Therapist satisfaction (Edward and LD work generally) – seeing developments, therapeutic relationship, feeling privileged – sharing the process/journey.
- Positive impact of therapy – improvements and transformation – mood, behaviour, communication, life style, relationships – no longer medicated – own flat/independence.
- LD segregation and labelling (Importance of therapy and empowerment).
- Other disempowering factors.
- Body-emotion link (“psychosomatic presentations”).
- Need for more support staff – Impact on client and carers – funding/financial and government policy implications.
- Reasonable adjustments.
- Creating and revisiting the therapeutic contract/treatment plan and sharing information.

- Empowerment – Important /”crucial” – “The goal which all therapists aim to achieve with their clients” – self-governing – confident – able to express needs and rights/wrongs (able to speak up).
- Therapist as “conduit”.
- Warning about dangers of therapy with forensic clients.
- MDT working – useful links and referrals work – sharing info and liaising – helpful for report writing.
- Positive feedback for this research.
- Demand for more therapy provision in LD services.

Main Themes (1st Draft):

- Impact of workplace bullying and Institutional abuse
  – Labelling, segregation, abuse
  – Financial inequalities/importance of equality and opportunities
  – Safeguarding
  – Caused significant mental health harm/breakdown, challenging behaviour and need for medication.

- Positive impacts of therapy/importance of therapeutic relationship, Improvements and Empowerment
  – more confidence, better mental health, better communication, off medication.
  – positive relationships and accessing community
  – sense of pride and self-worth, more choice and control
  – positive impact for family, carers and others
  – scope for further improvements
  – therapist as conduit
  – therapist/client/mutual satisfaction.

- Mixed Approaches and phases of the therapy
  – relationship building phase = “Rogerian”
  – Challenge phase = Gestalt and TA
  – Maintenance phase (ongoing, including mood charts and reviews).

- Limitations, challenges, barriers for therapy and LD population
  – Therapeutic challenge
  – Narcissism/personality issues
  – Dealing with change
  – Segregation and labelling in LD population generally
  – Dangers of therapy with forensic clients.

- Including the family and support networks
  – Edward wanted his parents to be part of the sessions
  – Support workers sharing in the process too
  – Systemic benefits for all involved (parents can go on holiday, easier for all)
  – Importance of communication and appropriate sharing of information.

- Need for more support at difficult time (would have helped)
  – More staff support in between sessions would’ve helped
  – Pressure on elderly parents/family
  – Financial and service benefits with more support and more therapy
  – Include reasonable adjustments/LD adaptations
  – MDT working/referrals can be helpful in NHS.

4) Penny

- Abbey's referral was for anger management and mental health issues (Referred by GP).
- Treatment plan – managing her anger and mental health; then relationship issues also emerged – so treatment plan changed/evolved – "it's been reviewed at times, yeah".
- Therapeutic model = Person-Centred Approach – "it works for me!". (Penny values building the relationship and focussing on /using the 3 Core Conditions).
- Penny often said in LD work "we don't get that feedback" – so you "hope for the best, you know", (I fed back positive comments from Abbey).
- Abbey started out "quite broken" and "very fragile" and "had a lot of issues from the past". (But very nice and wanting to engage/change).
- Impact of carer/husband ("trying to be supportive" but Abbey "felt under pressure"); (Penny felt "it just made things worse, forcing her to open up, etc", "Abbey going to bed and taking out her anger on him while in her sleep").
- Issue of anger/violence toward Kevin at night (kicking, biting, punching him in bed) – Penny provided information for Kevin on domestic violence.
- Info on domestic violence/sign-posting to other services for husband (non-LD).
- Husband's approach exacerbated problems at time – Penny had to work with him as well/ex-army very rigid? /sometimes not very encouraging!
- Help with doing household chore (e.g. tick list and housework tasks); (Abbey forgetful, rushing, has to re-do things – impact of LD).
- Disagreement over punch bag (Kevin's idea, Penny and Abbey not sure about it!) – to release tension!
- Frustration for Penny trying to work with Kevin as well as Abbey (difficult to maintain non-judgmental approach!).
- Satisfaction for Penny, re Abbey's desire to engage and make changes- ("don't always get that").
- Penny supporting Abbey – "taking only a few steps behind", "cos it's her journey".
- Positive feedback from Kevin/carer to Penny (pleasing for her) – (both Abbey and Kevin made positive changes).
- Having to educate Kevin about Abbey's LD – "there's some things that will not change, it's about adapting to that", (sessions useful for him too).
- Problems before therapy = "quite severe" – Abbey had "quite a few violent relationships" (aggression and insults), "the referral came in when she had a glass bottle at Kevin's neck".
- Penny felt Kevin had some responsibility ("then again half way down the road, I realised if he's in her face, telling her to what's if…") (winding Abbey up).
- Abbey wanted to change – "She's even discussed leaving him – because she doesn't want to be that person".
- Therapist satisfaction – "it's nice seeing her transform in front of your eyes".
- Penny felt Abbey has more self-insight (Improvement).
- Impact of Kevin's ex-wife/stalking them and causing trouble – Injunction to content with. ("She's been pretty cool about it", "dealing with it really well") – helpful for Abbey to "sound off" to Penny about it. (Is she? exaggeration??)
- Most successful aspect of the process – to "self-actualise".
- Abbey very determined ("I'm going to change! I'm not going back to the way I was anymore…. I'm not going to let anyone stop me").
- Penny impressed at Abbey's determination/going to CAB to find out what her rights were if she did leave Kevin ("that was a bombshell", "I didn't see that coming at all" - surprises in the therapy).
- Penny not 100% sure if Abbey hitting Kevin at night was subconscious/unaware (not telling Penny whole story and then Kevin appearing in bruises – "I could see her face looking very you know, sheepish" – Penny explored it with them (direct/honest?).
- Penny unsure about confronting/challenging Abbey – worried if she'd built the relationship up enough to test/"gamble with it". ("Are we at a place where we can open up and discuss this?" – careful re-challenging – but it was ok).
- Penny wanting to decrease sessions/taper them off – querying how to do it? (hoping to present it as a positive – I've done a lot and doesn't need her so much now?).

- Practise development issues – not getting a review confused with a counselling session! (Boundaries merged at time – Penny blamed herself "entirely my fault" – Kevin wanted to talk about his issues too). *Kevin = husband/partner as well as support worker (different to other support worker interviewees).
- Penny keen to "look beyond the behaviour" (impact of staff, parents, etc); (not attributing the whole problem/referral to the individual/client) – can be wider things going on. "Trying the find the person amidst all these other things".
- Frustration – "You feel a bit lost", "sometimes it can be pretty hard too".
- Penny keen to stay person-centred and loyal to the PCA – finding it difficult in service/institutional/medical setting?
- Importance of PCA to Penny – "for me it's having these care conditions", "I get tested, quite a lot", "and the boundaries can come down, and then they have to go back up again".
- Empowerment – "It's who you are really, you don't know what you're capable of doing…without empowerment"; "I just feel… you have to go out there and get it!"; "for me it's a biggie, to actually believe in yourself, you have a right to do things…".
- Penny encouraging clients "to help them to do whatever they want to do", "give it a go, you know! Or Oh, ok, we'll find something else!".
- Penny likes her "sessions to be practical" and may give clients goals (e.g. look in the mirror and tell self something positive – client did it and now travelling on buses etc).
- Penny sympathetic/empathetic to feeling in a minority group or feeling "at a disadvantage, so I can relate to that" [ethnic group].
- Penny said Abbey "now feels empowered that she can actually challenge [Kevin]", (Abbey reminding Kevin of Penny's advice to him etc!).
- Abbey now going out more on her own – was "quite confined to the home" (not following Kevin around as much).
- Penny wishes there was more time to go "a bit deeper than we normally do". Frustration – wanting to be fully person-centred and offer more sessions (service restrictions).
- PCA minority group? – "I feel you know, it is unique, and there's only a few of us left! That do work this way" (PCA in LD/NHS).
- Preciousness of external PCA supervisor "he's got to stay there", (keeping the PCA alive, time and not getting dragged into medical/other models? – unique).

Emerging Themes List (Penny):

- Referral Issues – anger management and mental health concerns.
- Past relationship traumas – impact on present relationship.
- Current relationship issues.
- Coping with ex-partner, difficult situation, injunction and stalking.
- PCA – Importance of 3 core conditions – following client's journey/empathy – non-directive approach/challenges? – creating tasks?
- Adaptations for LD work – practical exercises – breaking tasks into smaller steps – allowing extra time – 'Levels' of LD.
- Impact of husband's/carer's approach – differing opinions around support and anger management – encouragement and support for him also.
- Supporting the non-LD husband/carer – the domestic abuse issues and sign-posting for information – LD education, guidance and support.
- Physical expression and verbal descriptions of anger and violence.
- Therapist's interview (impact on transcribing); verbal style and NVC.
- Use of humour (laughter in interview).
- Changes to initial formulation and treatment plans.
- Improvements and client determination to make changes – Increased self-insight/'self-actualising' – practical steps/actions.
- Therapist satisfaction – client engagement – good use of the sessions – transformation.
- Challenges to/in the therapy – PCA/having to be directive – testing the relationship (confrontational Q's) – joint sessions/relationship issues and conflict – time/discharge pressures vs desire to "go deeper".

- Therapy in an LD service can be hard – frustrating – awareness of limitations – More complicated – looking beyond/behind the behaviour – less self-awareness – Importance of close monitoring and reviews – importance of ‘stages’/’bit by bit’.
- Therapist sensitivity – participation in the therapeutic process – addressing difficult topics – personal understanding of minority groups.
- Positive changes for both partners.
- Opportunities for client self-reflection, exploration and to “sound off” and be “real”.
- Increased independence – finding out about rights – more pro-active – going out alone more – better communication.
- Therapist encouragement of empowerment in therapy – must be appropriate – Understanding of client potential and limitations.
- Surprises in therapy.
- Sleep issues, subconscious and anger.
- Determining truth? Hiding information? (Importance of asking questions skilfully).
- How to taper off sessions in a positive way.
- ‘Switching’ professional roles in therapy – reviewing/counselling – controlling the sessions.
- Niche role of PCA LD Counsellors – importance of outside supervisors – maintaining PCA ‘identity’ – special unique group.
- Importance of further LD research.

Main Themes (1st Draft):

- Working with and supporting the carer/husband also
  – Impact of differing approaches/opinions
  – Supporting husband/needs also
  – Training/education/info-sharing and sign-posting provision for husband/carer.

- Challenges of providing therapy in an LD service
  – More complicated/can be hard
  – Frustrating
  – Looking beyond/behind the behaviour (what else is going on – where/who?)
  – Less self-awareness – importance of close monitoring and reviews – importance of stages/bit by bit.

- Using PCA in LD Therapy
  – Importance of 3 Core Conditions
  – Following client’s journey/client-led
  – Difficulty using pure PCA in NHS setting (emphasis on medical model/service requirements and constraints – time limitations and service expectations (would like to go deeper) – need to direct/suggest/give tasks at times!)
  – Niche role of PCA LD Counsellors (importance of outside supervision – maintaining PCA Identity – special unique group).

- Importance of therapist sensitivity in LD work
  - Dealing with strong emotions and difficult situations (incl. anger and challenging behaviours)
  – Determining truth? (e.g. ‘subconscious’ behaviours – hitting partner in sleep)
  – Challenging Q’s?
  – How to taper off sessions/endings
  – Noticing subtleties in client, how to deal with and communicate
  – Personal understanding of minority groups and motivation to help empower
  – Guiding, allowing, enabling
  – Understanding, supporting, sharing.

- Adaptations for LD work
  – Allow extra time
  – Break into smaller steps
  – Acknowledge different levels and differences

– Often a need for practical exercises/explanations/demonstrations.

- Positives and opportunities from therapy
  – Opportunities for empowerment and positive surprises
  – Mutual satisfaction from engagement and progress
  – Progress, improvements, developments (rewarding to see client embrace new opportunities)
  – Enabling client to move on/leave past behind
  - Transformation.

5) Janice

- Referral = re: Neil's mental – depression and threatening/feeling suicidal; mum very worried he might harm himself.
- He was 18 then and still at school (special school for people with Autism - new client known to LD Transition Nurses).
- Janice initially wanted to test Neil's ability (IQ) and screening (ascertain if he met service criteria?).
- Janice talked to Neil about his problems – PDA and Asperger's.
- 1st Treatment plan = screening assessment (but Neil refused to comply). (His mum completed ABAS assessment and NW came within service range –> Janice felt this more to do with his PDA though, than his intelligence).
- Huge anxieties (linked to PDA) - Janice changed treatment plan –> to build relationship and help Neil trust Janice. Encourage his confidence.
- Neil was refusing to leave the house, "he wouldn't step over the threshold and he was terrified of everything", (locking himself away/isolating himself, "he was locking himself away upstairs for hours on end").
- Big impact of PDA on Neil's life.
- Janice was flexible with sessions – started at 3 hours – 1 hour = to come downstairs and feel confident to start speaking, 1 hour = him avoiding any issues, 1 hour = more productive. -> This developed over 3 years – now onto 1 hour. (More productive and time effective now; starts and finishes at same time now).
- Janice used the PCA mainly (going at Neil's pace – he blocked any demands), (allowed NW to lead sessions – otherwise he got angry and defensive) Relaxed approach.
- Janice "gradually eased in topics that were difficult for him", (self-harm; behaviour towards mum and family; his strategies) – Janice approached indirectly and sensitively, "we'd have to talk about them as though they were things I was thinking about, rather than saying "you do this" and "your mum told me that".
- Neil's mum initially sat in on sessions too – until he was confident on his own.
- Neil also had OCD as well as PDA – caused anxiety and issues re personal hygiene (e.g. took ages showering – had to wash every part of his body over and over). Also, re: washing-up and household tasks.
- Neil also had fears re his own aggression – fear of attacking others (losing temper – used to happen when he was a child).
- Differences between mainstream and Special Needs school – Special Needs catered better for Neil's 'disability'.
- Difficulty adapting to change – including new school/college (once needed restraining at school "because he was inappropriate" – how?) -> This then created a negative feedback loop – thinks about it over and over for months. Janice tried to help Neil establish positives and help Neil rationalise what happened and why (he felt out of control, guilty, upset, desperate) "he goes over it and over it to such a point that he says he feel like ending it altogether".
- Positive thinking and rationalisation.
- Janice helped Neil think he'd come up with ideas/strategies himself.
- Neil was anxious about starting college – wanted to go but feared targets.
- Even demands over 'small things' could be challenging for Neil (e.g. putting his signature on a form or describing his disability). Not small for Neil! College form asked about use of

toilet/help in personal care – he felt insulted. Neil refused to sign it – “so it was a long-winded affair, trying to help him understand that that’s what’s needed to go in” – did it at the last minute! (Same with housing benefits form and financial aid – refusing to sign).

- Janice was impressed Neil signed my research form! “I’m sure he felt very comfortable that day, that’s why he did it”.
- Big achievement = moving house/living independently in his own flat (support to achieve this from various agencies/professionals etc).
- Coping better and making progress – “the progressions been amazing”.
- Challenges/negatives of therapy = long 3 hours session initially (draining) and stressful (for Neil and Janice/all involved).
- Improvements in trust/therapeutic relationship (Neil “eventually he got from the bedroom onto the top of the stairs, then he worked his way down and eventually into the lounge… And then eventually answered the door when I knocked”). “I think Neil and I both felt like giving up in the first instant, cos we didn’t know where it was going to end up”.
- Good therapeutic relationship/satisfaction - “It’s been a joy to work with him”, Janice and Neil got on well from the beginning (helpful). (Importance of ‘gelling’ with support staff – “some of the other people I referred him to, he didn’t gel with” - needed to feel comfortable).
- Effectiveness of the therapy – gave Neil confidence, felt relaxed, Janice didn’t ‘impose’ anything on him.
- Neil grew up a lot during the therapy/initially some rebellious teenage behaviour (additional factor on top of Neil’s PDA) – became “more adult”.
- Janice used the TA model also during the therapy (parent-adult-child model). Importance of speaking to Neil like an adult, no matter what he did – “even if he’s throwing things about or smashing his phone, or whatever”, “I always spoke to him like an adult”.
- Mum involved in the sessions too. (“I built up a really good relationship with mum/we do work together and if there’s any issues she will tip me off”).
- Initially Neil waited for his mum to speak for him/now brings up issues himself (more progress).
- Training provided by Janice for staff team and mum (re Neil’s PDA/condition) “What/how PDA means and how it impacts someone’s life”.
- Impact on rest of family (“before the therapy, he was a difficult person – his whole family were in sort of a melt-down”; “it had split his mum and his step-dad’s relationship…. It was quite difficult for them”). “And his sister isolated herself as well”, “when you went into the house, they were all in separate rooms”; “Neil controlled the whole house”.
- Neil found it difficult dealing with people (especially bullies) – getting into arguments and fights. (Getting wound up when goaded) *Another problem in LD? * Copes better than he did with people – more mature.
- Satisfaction for Janice seeing Neil’s achievements (e.g. going to hospital to have knee injury looked at).
- Difficulties for family; mum in tears; tension at home (now better). Things are worse when he’s at home/ “he reverts back to type” –> Family/mum relationship issues?
- Neil had very high expectations (“He’d like to do things that are well out of his scope”, e.g. “like being a director of films in America”).
- Importance of TI (& OT) to promote Neil’s independence.
- Janice learnt a lot about PDA and so did Neil – learning together and coming up with strategies to overcome things.
- Janice focused on LD work, the importance of “seeing a person in their own right” and “not treat them different to anyone else”.
- “Often when we get referrals, the reason they’re referred isn’t the reason they need to see me actually” (underlying reason for referral), “We have to unpick that a lot more in LD’s than you would with the general population”, (harder to understand what’s going on). Communication /cognitive impairments – making therapy more difficult.
- When other professionals/staff aware of conditions (e.g. PDA) it helps – social worker etc.
- Overlapping roles and boundaries (e.g. Janice wrote to housing instead of the social worker doing it”).
- Importance of giving “someone a really safe space”.
- Gauging how to talk to clients “as their level but without patronising them”.
- Humour helps the communication/work/therapy.
- Neil became more trusting of (some) people.

- Empowerment = “trying to get a person to speak up, speak out, and stand up for themselves appropriately and in a way, that doesn’t get them into trouble” (carers/parents can disempower people – sometimes by accident).
- Getting carers involved and supportive of empowering – getting “everybody on board”. (Help to “move on with their lives and feel happier” and “more confident”).
- Neil benefitted from “having fantastic carers and his mum is amazing”.
- Importance of all working together. (Neil had TI, therapist, OT, Support Worker, CN, family etc).
- Neil’s self-sabotage caused him set-backs and difficulties part of PDA).
- Neil had a destructive relationship/girlfriend at one point.
- Importance of the person’s “environment” (and support network).
- Had to be **flexible** (Janice) to see Neil when he was available, (“you really have to be as flexible as you can be”).

Emerging Themes List (Janice):

- Depression and feeling suicidal (referral issues)
- PDA (Pathological Demand Avoidance) and Autism diagnoses.
- Impact of PDA (time, sessions, logistics/venue, engagement).
- Importance of reasonable adjustments and flexibility in LD work.
- LD delayed development vs ‘normal teenage behaviour’?
- Impact of PDA – problems for rest of family.
- Importance of trust and rapport/relationship building, boundaries and roles.
- Importance of multi-agency working, team work with staff and carers.
- Importance of accepting support and ‘gelling’ with staff.
- Service criteria issues and initial treatment plan.
- Going at Neil’s pace.
- Who is the referral about? Who makes the referral and why?
- PCA – easing into difficult topics and helping Neil come up with his own strategies.
- Mum’s presence.
- Flexibility/overlap of staff roles.
- Mainstream vs special school.
- Treating people with LD same as everyone else.
- Wanting to achieve/high expectations despite LD/stigma and labelling?
- Impact of OCD on daily life.
- Reflection on Neil’s interview performance (for this research).
- Achievements, improvement and empowerment.
- Concept/notion of ‘empowerment’ and important caveats (link to aggression and getting parents ‘on board’).
- Disempowerment and barriers to empowerment.
- Ups and downs.
- Adaptations for LD and effort involved (slow process but progress).
- Contribution of Psychology (for people with an LD).
- Degree of change.
- Challenges to the therapy.
- NW’s fear of own aggression.
- NW anger and frustration and difficulty expressing emotions/reacting to other people’s goading and bullying.
- Usefulness of this research.
- Therapist satisfaction.
- Importance of humour.
- TA and importance of speaking to Neil like an adult.
- Impact of environment (re people with LD).
- Importance of staff training.
- Importance of support networks.

Main Themes (1st Draft)

- Impact of the PDA (and OCD)
  - Organisation of sessions
  - Engagement/therapeutic relationship
  - Problems for rest of family.

- Barriers and disempowerment, obstacles as a result of LD label/expectations and stigma
  - LD population generally
    - who is referral for/about?
    - service criteria issues
    - impact of environment.
  - Neil Specifically
    - special school
    - fears of own aggression/reacting to bullying
    - high expectations.

- Key important elements, adaptations to therapy and ‘reasonable adjustments’
  - LD population generally
    - slower pace
    - flexibility of roles
    - normal teenage behaviour or LD behaviour.
  - Neil Specifically
    - going at Neil’s pace
    - use of TA/speaking to as an adult.

- Being person-centred and importance of building up trust and rapport
  - Helping Neil come up with his own strategies
  - Going at Neil’s pace
  - Treating Neil same as everyone else.

- Achievements in the therapy and therapy satisfaction
  - Progress with Neil
  - ‘gelling’
  - use of humour
  - contribution of Psychology in LD work.

- Importance of MDT working and support networks
  - staff training and sharing information
  - flexibility/overlap of roles
  - suitable staff and support.

Interview Summaries - Individuals

Support Worker Participants

1) Robert

- Known Sid for 12-13 years (and also previously when Robert was a social worker).
- Sid attends 3 days a week formally and voluntarily on Friday (4 days per week).
- Work experience placement/work training/working with people/team-work.
- Sid – One of the more able people attending (skilful at joinery/capable).
- Sid referred due to "periods of depression" – due to family/relationship issues ("at times been extremely down, to the point, saying he wanted to end things"). Sid felt suicidal at times.
- GP not very understanding – referral to therapy requested for specialist LD counselling (a Support Worker helped with referral process).
- Robert thought the counselling was to work with the "relationship issues and things that seemed to trigger his depression"; "give him the chance to open up about the difficulties he has".
- Robert aware Eve used "same kind of relaxation techniques to try to get him to calm down"/**limited involvement** with the sessions of Eve (regular weekly sessions and now being phased out).
- Robert not involved in any homework tasks.
- Robert noticed "a bit of a low point", "initially when he started to be working through things", "because it was bringing things to the surface".
- Robert noticed "quite a good gradual improvement" after that.
- Ups and downs.
- Robert said Sid had "commented several times that he just felt Eve was very easy to get on with and talk to"; Robert thought Eve good at helping people feel "at ease with themselves and open up" – importance of Sid being able to talk to Eve (and trust?).
- Robert felt Sid "definitely" benefitted from the therapy. ("he'd said several times about how useful he's found it") – beneficial.
- Therapy = 'offloading' ("it may be 'offloading', but whatever it is, he's just getting a chance to talk things through").
- Therapy = "a snapshot in time" ("but at this point in his life its working for him").
- Robert respected Sid's sessions/confidentiality (between Sid and Eve); ("I just used to ask him about how things had gone, I didn't want to delve too much into it, because that's between him and Eve"); Just checking initially when he was opening up about things and things were coming up to the surface.
- Robert thought Sid found it helpful "just a chance to explore things"; ("some of it from quite a way back, long-standing things that do affect you.").
- Robert felt empowerment = "giving people the chance to be themselves", ("not to feel that they're treated any differently to anyone else.").
- Robert's workplace environment = beneficial – contribution to the community. ("It's all about people feeling they've got a sense of worth… by contribution"); "It's not a job in the strictest sense of the word, but it's a contribution to the community", "I think that means a lot to people who attend here".
- Empowerment for Robert/here – important for him treating people as equals. ("we don't have any hierarchy in particular, I think that's important"). Did Sid perceive this? Called Robert his boss?
- Empowerment for LD people – "people with LD's tend to lack in confidence, people not giving the 'a chance' – "I think it's extremely important, yeah.".
- Empowerment for Sid – Robert said he's one of the more able people there but gets **frustrated** to **communicate** how he feels (helpful having chance to open up to Eve).
- Robert mentioned the impact of medication. ("there were times when he needed his medications upping" – although apparently takes it regularly).
- Robert mentioned Sid's **frustration** about being unable to change the past (past relationships and family issues causing regret/upset/guilt).
- Robert said Sid's confidence better currently.

- Robert unsure about long-lasting effects of therapy/improvements - “I can’t say he’s going to stay like that, but at the moment like, yeah” (improved confidence).
- No other MDT involvement going on (another worker (who knew him)/supported Sid to GP for his referral).

Emerging Themes List (Robert):

- Overlapping roles and capacities of carers/support workers.
- The work placement.
- Only a mild LD (Sid) – very capable/good at joinery.
- Referral for depression due to family relationships.
- Lack of support from GP (Issue of LD knowledge and understanding – training needed).
- ‘The chance to open up’ (purpose of the therapy).
- Limited support worker awareness/involvement of content of the therapy sessions (evidence of confidentiality and respecting privacy).
- Things getting worse before they get better/ups and downs on therapy/temporary improvements?
- Assumptions about therapy – “brings things to the surface”, “chance to off load”.
- Importance of being listened to/heard in therapy (ease/trust between client and therapist).
- Skilfulness of therapist (Sid found Eve easy to talk to).
- Usefulness of the therapy (reported by Sid).
- Staff were worried about Sid (times he didn’t come in/spoke about ending it all).
- Empowerment (via work and contribution)
  – giving people the chance to be themselves
  – not to feel treated differently to anyone else (equal, valued, etc)
  – giving a feeling of self-worth
  – contribution to the community via work.
- Work placement ideals – lack of “hierarchy” – treating people as equals (did Sid agree?) – raising confidence (especially? in LD).
- Disempowerment – less confidence in people with LD’s – Sid’s frustrated can’t change past (relationships and family/daughter).
- Impact of medication upon personal well-being (need for medication reviews).
- Not many other professionals involved in this case (just Eve and GP).

Main Themes (1st Draft):

- Empowerment through contribution (work placement)
  – Important to promote feelings of worth
  – Sid = skilful/capable
  – Contribute to community/local area.

- Confidentiality and respect for privacy
  – Did not delve/pry
  – Already aware of Sid’s background (overlapping roles in local service).

- Value of the therapy
  – Chance to open up/off-load
  – Positive feedback of therapist (skilful and effective)
  – Felt supported at ease and listened to
  – Sid showed improvements.

- Lack of GP support/understanding
  – Counselling requested from LD service
  – Training needs/implications – in NHS? (LD, patient/professional manner).

- Concern for Sid’s wellbeing
  – Genuine care, support, concern

– Especially when absent from work
– Especially when Sid talked of ending things
– Low mood/recurrent depression
– Due to (awareness of) past and relationships.

- LD work placement ideals
  – Not hierarchical (? Did Sid feel this? – referred to "boss"?)
  – To offer support
  – Chance to build confidence
  – Contribute to community.

2) Malcolm

- Involved a couple of years with Jacky – re travelling on buses, (Jacky "had a phobia of getting on buses", thought people were staring/looking at her).
- Malcolm helping Jacky to lower her anxiety, "how to keep her calm, getting her to focus on other things, rather than the people around her".
- Malcolm said the purpose of Jacky's therapy was "to gain her confidence, build up rapport in her" (some confusion here? Didn't answer Q?).
- Malcolm sometimes supported Jacky to/from his sessions and other times me met her at the clinic (sometimes met her at her house).
- Travel training and building up Jacky's confidence = Malcolm's main areas of support.
- Malcolm not involved in homework from Nichole.
- Jacky spoke to Malcolm about some difficult past issues (abuse) and would "start getting tearful" – she trusted and could talk to Malcolm. ("I think it were very important to Jacky, that she could come and talk to me, and off-load and talk about all the things she'd kept inside regarding all the past history, re abuse and not just physical abuse, but money abuse and verbal abuse") - Malcolm continued support during/after Nichole's sessions.
- Imp. of trust – Jacky was able to talk to Malcolm about private things.
- Jacky's original problems = phobia about getting on **buses** and **crowds**, historical issues "she'd held inside herself, regarding **abuse**" and also **hearing voices** (e.g. voices telling her "to jump on the railway line").
- Jacky's problems = very severe; at times she felt suicidal.
- Malcolm was sometimes worried about Jacky (harm/suicide) and would tell Nichole.
- Malcolm felt Jacky benefitted from the therapy ("very much so").
- Malcolm described Jacky's changes – "She's more out coming with all the info, she's quite confident in talking to me about it, even about the female side you know, which females don't usually talk to males about". (Jacky even discussed her body with Malcolm "what they're [females] going through inside their bodies") "Jacky was quite open with me" and able to trust and disclose to Malcolm.
- Malcolm thought the therapy = very successful – "she goes on the bus by herself now, nobody has to be with her" (Is this true? Jacky said her great nephew had to be there?).
- Malcolm sometimes had joint sessions with Jacky and Nichole – chooses who/how much to tell – (Jacky would tell different accounts – sometimes tells 1 more than the other and vice versa).
- "Sometimes I feel it's like a game, with Jacky you know – and she's obviously thinking "well I'll tell him this bit, I'll not say that bit" – which I often find out eventually! (laughter)".
- Malcolm found joint sessions useful (Malcolm and Nichole could fill the gaps/get a fuller picture); ("I could have, with Jacky's consent, to bring anything up that she might have forgot – to tell Nichole, and I'll just prompt and then Jacky' will just come out with it").
- Malcolm thought most helpful part of the therapy for Jacky was the listening ("somebody being there listening to her.", she "felt at that time, that we were listening to her, and taking it on board") – feeling heard/understood/having a voice/being taken seriously ("and how serious the situation was").
- Malcolm felt empowerment = "giving people back everything – what they lack, or lost confidence with, building that confidence up so that when they're not sure about something, reassuring them" – "and they end up taking it on board".

- Malcolm thought empowerment important for Jacky because “it comes down to **confidence**”/realising others can’t/shouldn’t abuse her or be abusive – “and she’s to take **control** back over her own life, which me and Jacky have discussed quite a lot”.
- Malcolm thought disempowering factors in Jacky’s life = her family (at times), (“it still carries on being honest with you” – “Jacky will go through a phase where everything’s good, for so long, and then one of the family will probably want some money, they’ve got bills to pay”, “They always go to Jacky for money”) – financial abuses/pressure from family – ongoing challenge.
- Malcolm said some sessions Jacky was confident – “She came over as quite confident, saying stuff like ‘I’m saying no from now on Malcolm’” (difficult for Jacky to be assertive with her family – needed support).
- Malcolm only worked alongside Nichole/occasionally liaised with community nurses (some MDT involvement, but not much).

<u>Emerging Themes List</u> (Malcolm):

- Travel/bus training and social anxiety – reason for Malcolm’s involvement/support
  – Jacky had phobia of getting on buses
  – Jacky felt people were staring at her/would hurt her.
- Support to increase confidence and independence – practical/emotional.
- Time/memory issues.
- Building rapport/’off-loading’ and gaining trust (especially to a male – given past experiences).
- Feeling heard/listened to.
- Trauma and nature/consequences of past abuse.
- Hearing voices.
- Concerns about self-harm and suicidal issues (liaising with Nichole if Malcolm had any concerns – sharing information).
- Joint working/sessions and liaising with MDT.
- Selective disclosure and sharing of information (choice made by Jacky).
- Improvements and positives
  – More ‘out-coming’ with info.
  – More confident talking to Malcolm about things
  – More independent/re travel (? Jacky said different).
- Assertiveness and regaining control in life/empowerment.
- Empowerment
  – Giving people back what they lack
  – Take control back over life
  – Able to say ‘no’
  – Increasing (lost) confidence.
- Family and financial abuse
  – Still going on
  – Needed support to stand up to it
  – They go to Jacky for money (family).

<u>Main Themes</u> (1st Draft):

- Selective disclosure/sharing of Information
  – Jacky sometimes picked/chose who to tell different bits to
  – Jacky overall felt comfortable talking to Malcolm and Nichole
  – Increased disclosure with time/trust.

- Importance of trust, gaining rapport and relationship building
  – Impacted on disclosure
  – needed in order to off-load/discuss past events and hearing voices etc
  – Jacky sometimes became tearful and expressed emotion to Malcolm, trusted him.

- Progress and Positives

  – Jacky felt able to talk to and trust Malcolm
  – Even about female issues
  – Jacky was more ‘out-coming’ with info than initially
  – Progress/getting on bus/going place alone now (Jacky mentioned Nephew?)
  – Jacky stated determination to be assertive.

- Joint Working
  – Some joint sessions with Nichole and Jacky
  – Supported Nichole’s work/sessions
  – Continuity
  – Helpful when concerned/Jacky disclosed suicidal ideation.

- Financial exploitation by family/difficulties standing up to them
  – Jacky finds it hard to stand up to her family
  – Family still ask her for money to pay their bills (ongoing) – exploitation.

- Practical and emotional support (referral specific/focused work)
  – Bus/travel training due to social anxiety
  – Support to stand up to family
  – Support to increase confidence.

3) <u>Ray</u>

- Known Edward for 5 years; referred approx. 2003/had Tim from 2002.
- Checks Edward is OK, “just making sure that Edward’s alright, he’s got everything he needs, he’s looking after himself … nothing bothering him. Ray also helps with appointments (“just trying to make his life as easy as possible when he’s living on his own”).
- Ray said counselling was due to the difficult time Edward had had at work. (“He felt he were victimised and bullied”, “wasn’t living life to its fulfilment”) Also re Edward’s mood – going back to childhood.
- Ray said after Tim had been, Edward’s flat transformed from a “very hostile” environment to a totally new page”.
- Importance of Edward talking to Tim – “everything comes out and it’s much better when he talks about it”.
- Ray supported Edward to most therapy sessions (only not if on leave/working in another property).
- Ray was involved with homework tasks – e.g. mood charts. (“I helped Edward in whatever had been set at the meeting”) and help in making meals instead of buying them.
- Ups and downs – Edward sometimes “blown things out of proportion” or “sometimes just not been in the mood for it”.
- Ray feels Tim’s therapeutic relationship = important because “it give Edward the opportunity to get a lot off his mind”.
- Ray = comfortable talking to Tim and I will tell him things he can’t talk to his parents or Ray about; “Tim will get it out of him”.
- Tim skilled and persistent – “it could all blow up, but it’ll be resolved, no matter what – we won’t leave the room until it is”.
- Ray = loyal, determined, supportive, helpful, genuine.
- Tim suggested to Edward to start talking to Ray when he’s not there (support worker continuing the work outside of therapy sessions).
- Ray said it was helpful for Edward to leave home “he’s an adult now” (sat down as a family and talked about it). Positive outcome – Independence.
- Disadvantages to independence/own flat = “it’s not always easy though and the stress is twice as bad because everything that goes on in the house is his and his only”.
- Big transformation even in the last 5 years. (Edward shows frustration and stress in his face – “when he couldn’t speak to someone about his problems”) – need to talk/release tension.
- Edward’s parents were clear that if Edward wasn’t nice/spoke nicely to his support workers, they’d have to leave (he used to take stuff out on parents).

- Edward used to take out his feelings on Ray – “there has been times where he just had to get that one thing off his chest and I had to sit there and take it for a good 20 minutes” – “after that I was like… right we can talk about it now can’t we” – Ray very patient and dedicated!
- Ray discussed ongoing work with Tim and Edward – “I think he’ll still be involved for quite a while yet” -still things needing addressing occasionally (“it just needs that little visit from Tim”).
- Ray feel the therapy’s been “very successful. I’d recommend it to anyone”, “it’s a real good thing”.
- Ray commented on the therapeutic relationship – “after certain sessions, a lot comes out, a lot of very private things, nothing leaves this room”, (chance to off-load safely and confidentially and without judgement – “he just sits there blank-faced Tim – he never judges – you can tell him anything in the world and he never judges Edward, and that’s a very good thing as well, cos that makes Edward speak out more about his problems”).
- Ray spoke with Edward about the sessions afterwards – like a de-brief (“have another discussion ourselves about how it was”, “we’ll say it went alright, didn’t it?” – “keeps us all in the know”).
- Importance of communication and info sharing between support workers and others involved with Edward.
- Most important for Edward in therapy = “being able to show his emotions and his feelings to people that actually cared for him and want the best for him” – express emotions/feel cared for/valued.
- Ray explained empowerment for Edward via therapy – “after Tim’s gone Edward’s got his **confidence** back”; more energised and assertive; “stands up and says ‘right, we’re going here today’”; “he’s got his colour back in his face”; (if been low, is back up and can “talk about it”).
- Ray said empowerment = important in LD work – “it’s everything really”; (“you’ve got to feel cared about … wanted… like there’s a purpose that you’re here”; “everyone needs a purpose don’t they”).
- Ray thinks it’s important for Edward to feel supported – “any time he wants, there’s five people that’s always gonna answer the phone to him and hang on his every word”. (Mum, Dad, Tim, Ray and another support worker N); “People he can speak to and relate to, about anything that he’s got a problem with, ever”.
- Genuine care and support - Edward feels trust, safe, valued, cared for.
- Ray said disempowerment for Edward came from the workplace bullying (“when they were treating him horribly” – “They basically treated him like he wasn’t capable of doing the job he was doing – but he was the only one on the machine he used and whenever he went on holiday, they got five other people on the machine”, “the things they were saying, was knocking him back down”, “threatening to put him back on the disabled section”. “Sort of hollow empty threats constantly, to try to get him to do more work” – examples of workplace bullying. “It must’ve been pretty disempowering, when you’ve got a job, you’re going on and you’re doing what they ask you to do, to earn money like everyone else – and then you get knocked back down”. Disempowerment from workplace bullying.
- Ray Said empowerment for Edward evident from “confidence build-up” (“sometimes he’s on top of the world and you can’t get a word in edge ways” – “very talkative, very chatty, very jokey, very polite to everyone” – better mood and confidence – pro-social qualities/behaviour.
- Ray knows Edward and can tell his mood from behaviour (“I can tell Edward’s in a bad mood, from the way he looks when he looks out of the window”) – noticing subtle cues/body language – indicating mood – because knows Edward well. “He doesn’t look at me differently, but I can just tell by his expression and the colour of his face – that something’s wrong”.
- Not many other professionals currently involved (just Tim, occasional GP appts etc supported by Ray and support workers).
- Edward = relatively independent (mild LD).

<u>Emerging Themes List</u> (Ray):

- Support worker helping role
  – Making sure Edward is ok/emotional support
  – Shopping/cleaning/and cooking
  – Help with independent living.

- Referral issues
  – Workplace bullying
  – Institutional abuse
  – Long-term relationship issues/parents
  – Low mood.
- Long term therapy (10 yrs+) and Ray involved approx. 5 years (stability of support?)
- Support during therapy sessions and dedication.
- Ups and downs.
- Transformative impact/presence of counsellor (and releasing frustration)
  – for client – for all involved/concerned.
- Key elements of the therapeutic relationship/experience
  – trust – non-judgmental – private and confidential.
- Allowing/accepting disclosure and selective disclosure (client Edward).
- Improvements and benefits from the therapy
  – Becoming independent
  – Energising effect
  – Increased confidence
  – Mood
  – Communication and social interactions.
- Downsides to independence and disempowering factors
  – Responsible for stress in own home
  – Disempowerment from workplace bullying.
- Staff awareness of triggers – facial expression and body language (sensitivity and skilfulness of Ray/staff).
- Patience and allowing Edward time to calm down.
- Importance of discussion (after therapy/after incidents).
- Support networks and the importance of people who care about or value Edward.
- Importance of having a purpose in life (everyone – including people with LD's).
- Limited MDT involvement currently (only Tim and GP etc).

<u>Main Themes</u> (1st Draft):

- Transformative impact/presence of counsellor
  – Important elements of therapy experience (trust, non-judgmental, private and confidential)
  – Can tell difference before and after therapy sessions (in RS, in the room/environment)
  – Edward can dispel his frustrations/emotion and express himself freely
  – Edward gets his confidence back and feels energised
  – Positive impact on parents and others too.

- Joint sessions/support, during and after the therapy
  – Ray present during sessions
  – Debrief/continue afterwards
  – Dedication and support
  – Privacy – stays in the room (and trust).

- Selective disclosure
  – Edward can tell Tim things he can't tell his parents or anyone else
  – It varies who Edward tells things to (whoever he feels comfortable with)
  – Edward trusts Tim as he is non-judgmental
  – Edward feels able to tell them things, as he knows they **care** about him.

- Sensitivity/knowledge of client and awareness of triggers
  – Notices change in face colour or body posture (linked to different moods)
  – Ray has a very patient approach, allows Edward to 'off-load'
  – Ray very supportive, caring, friendly and genuine.

- Helping role of support worker
  – Checking Edward is ok/make his life as easy as possible

– Help with domestic chores/tasks
– Listening to and supporting/encouraging Edward (aware of past/issues).

- Changes since the therapy
  – **Positives**
  – More independent
  – Energising/mood lifting effect of sessions
  – Boosted confidence
  – Better communication and social interactions (able to say how he feels and express himself)
  – **Negatives**
  – Own house = more responsibility and pressures of home – just his.

4) Kevin

- Kevin = husband/carer/support worker (known Abbey for 9 years).
- "She needs a lot of work" (1st comment!) – "She still needs a little bit of work but will get there eventually".
- Kevin refers to Abbey's LD support needs/difficulties – forgets things – limited concentration – limited understanding. ("She's not streetwise, she needs a lot of looking after").
- Kevin said he'd made the original referral (via GP/Penny?).
- Kevin was aware of Abbey's difficulties – "at beginning of our relationship".
- Kevin said counselling had been very helpful for Abbey. (Ongoing counselling over 2 years – 1 year with Penny).
- Kevin said the purpose of the therapy = "to help J, that's it", "so she could open up", "and not bottle things up inside" – communicating and expressing emotions.
- Kevin said Abbey had been "confused" at start of counselling with Penny – "She didn't know which way to turn, cos we had so many people".
- Kevin very appreciative of Abbey – "I think Penny has done her the world of good", focused attention, stabilising effect – "it's brought her down", "She's done wonders".
- Improvements = "more relaxed", and "thinking a bit more" (more focused/alert/calm?).
- Small steps ("just one step at a time"; "focus on that, and then the next").
- Kevin described his commitment/support for Abbey – "24/7 ball and chain" (not very positive? Joke about it being demanding/hard work for him?). But he said, "it's fine for me" – "I know what I was taking on", "whatever support she wants, I'll give it to her", "no matter how good or bad it is".
- Kevin spoke about him sometimes giving J tasks to do – not Penny's homework though. ("I just let her get on with it. I let her make her own mind up.").
- Kevin spoke about Abbey's anger/past experiences – "She's got a lot of anger in her from the past", ("she had a troubled past").
- Kevin spoke about Abbey taking things out on him/he doesn't take it personally ("she does let it out on me, but I just take it with a pinch of salt").
- Kevin spoke about Abbey's cognitive difficulties – metaphor of disorganised library ("like a library – she can't put them in order").
- Kevin said Abbey has ups and downs ("she has her good days, she has her bad days").
- Effectiveness of Penny's sessions – "She does say, 'hang on a minute – that's what Penny said!'" (processing/using ideas from the therapy – useful). Abbey tells Kevin "Oh Penny said this and I'm going to work on it".
- No criticism or problems with the therapy.
- Kevin highlighted the imp. of the **rapport** between Abbey and Penny – confidence-building ("That's boosted Abbey's self-confidence" – "Abbey might not have noticed, but I've noticed").
- Kevin mentioned imp. of "somebody different … different perspective" (therapy).
- Kevin described Abbey's original problems – anger, mood-swings, not concentrating, lack of focus ("just generally sort of like … she's on another planet sometimes"), "struggling… because she's had 1 or 2 past iffy relationships". Impact of past trauma and bad relationships. Abbey not appearing 'street-wise' to Kevin; difficulty learning.

- Kevin feels Abbey is making progress now (“she is making progress”); “It filters through”, “she’s come on in leaps and bounds”.
- Kevin discussed impact of Abbey’s LD – “finding it difficult to cope”.
- Abbey’s lack of awareness/physical abuse towards Kevin – “She doesn’t know she is doing it”. (“I wake her up sometimes with bruises here and there, from where she lashes out in her sleep”); “it’s her mind soaking things in..”; “when she’s subconscious she does it, subconsciously”.
- Abbey’s problems severe before the therapy (“They was bad”).
  Kevin suggested (and obtained) boxing gloves for Abbey to use = “she takes her anger out on me without hurting me”, “Abbey finds it helpful ... I find it helpful cos she’s taking her anger out on me”; “in a controlled way”.
- Abbey said regarding the relationship – “I just relaxed … just relaxed”.
- Abbey preferred Penny to other counsellors – “I tell you something, 1 or 2 other people that she’s seen – she’s more comfortable with Penny”; “The others … sort of patronising – Penny’s not” - importance of specialised therapists?
- Kevin doesn’t push Abbey to talk about her sessions/respectful towards Abbey; “I let Abbey talk about it when she’s ready”; “I don’t press her”; “I go ‘how’s it gone alright?’”; “If she wants she can talk, she can talk; if she doesn’t want to talk – ok”.
- Imp. of Abbey talking to Penny – “Basically, in a nutshell, talking to Penny” (helpful) and lack of judgment (“without somebody judging”).
- Empowerment – “I’m all for that. That’s what I’ve been working on with Abbey”, “to be more independent” – Abbey was terrified of opening the oven when they 1st met “now she opens the oven door, puts on the grill, she cooks …”; Also, able to use kitchen utensils and knives now. “Once you show her, you just let her get on with it” – “She’s come on in leaps and bounds”.
- Kevin helping empower Abbey – “It’s important to me to get her more independent, not just reliant on people …” (more self-sufficient – Kevin encouraging Abbey).
- Kevin in favour of treating people with LD’s individually “they’ve all got their different quirks and they all need to be treated differently …”, “I treat them on their level”; “as individuals”.
- Kevin said important for Abbey to have “new experiences” – importance of self-confidence (“important for her to experience new ventures, new goals, … and new experiences”; “so she can step up”; “Build her confidence up …and let her be more independent”. Kevin thought Abbey’s past had affected her – “because she’s been knocked”, “probably her trust issue … either trusting myself or trusting anybody else, or trusting herself.”, “It’s just a matter of time till she sorts it out herself” (optimistic/hopeful view).
- Kevin sometimes accompanies/supports Abbey to appointments (“If it’s an area she doesn’t know, she wants me to come”; “one time I said, ‘do you want me to come up to see Penny?’ and she said ‘No, I’m alright!’”).
- Kevin describes himself as Abbey’s “supporter” (positive view?).

Emerging Themes List (Kevin):

- Support worker and husband
  – Kevin’s role and input (big commitment)
  – Kevin’s attitude and feelings about Abbey/providing support.
- Frustration (hard-work/demanding/”24/7”/”ball and chain”).
- Referral reason and Kevin’s opinion about Abbey’s need for therapy (and who referred Abbey)
  – Self-expression
  – Avoid “bottling things up”
  – Need for specialist support
  – Troubled past/impact of social relationships
  – Mental health problems.
- Language repetition and use of metaphors
  – To make a point/emphasise (or limited language?)
  – Interesting library metaphor.
- Impact of physical aggression and subconscious processing (?)
  – Abbey lashing out at Kevin in sleep

  – "She doesn't know she's doing it"
  – "I put up with it"
  – Kevin's strategy = boxing gloves for Abbey.
- Kevin's perception of Abbey's LD and her needs/difficulties
  – Memory and concentration difficulties
  – Need for practical support and demonstrations
  – Limited personal awareness (before the therapy).
- Ongoing/further need (of Abbey).
- Impact of the past relationships on Abbey – creating trust issues and affecting her confidence.
- Previous counselling and support
  – Several people/services (confusing for Abbey)
  – Abbey found some other counsellors (non-LD) patronising – but not Penny.
- Appreciation of Penny's counselling
  – Imp. of therapist rapport and trust
  – Seeing someone with a different perspective
  – Confidence boosting.
- Progress, improvement and positive changes from the counselling
  – Increased confidence
  – Time to talk and off load feelings.
- Ups and downs – good and bad days.
- Interviewer input – summaries, questions, reflection.
- Empowerment via practical support
  – skill development – increased self-reliance – increased independence.
- Perception of LD population and diverse needs (and desire to treat people with LD as "individuals").
- Humour (Kevin's humour in the interview – "ball and chain", "she's still got all her fingers!" – but was it really funny??).

Main Themes (1st Draft):

- Support worker role (husband/carer)
  – His role and input
  – Attitude towards/feelings about support (content/not all complimentary?) -24/7, "ball and chain", encourage and commitment, very involved".

- Improvement (evidence of empowerment and increased independence since the therapy)
  – Improved self-confidence
  – More capable at home (in kitchen – knives, oven, etc)
  – More independence (e.g. catch bus alone)
  – Thinking more clearly.

- Appreciation of counsellor/counselling
  – Penny better than previous/non-LD counselling (not patronising)
  – Importance of therapist rapport and feeling heard and not judged
  – Seeing someone with a different perspective
  – Confidence-boosting and supportive
  – "She's done wonders"
  – "Basically, in a nutshell: talking to Penny".

- Reason for referral
  - "Troubled past"/ past "iffy relationships"
  – Self-expression, avoid bottling things up
  – Mental health problems (anger, mood swings, not concentrating, "on another planet")
  – Need for specialist support.

- Perception of Abbey's LD needs
  – Needs extra help/ "a bit of work"
  – Encouragement and rapport

– Forgets things, limited understanding and concentration
– Difficulties/ "on another planet".

- Impact of physical aggression/subconscious processes
  – Physical description (bruises, lashing out)
  – Abbey does it "subconsciously"
  – Boxing gloves/dealing with/outlet
  – "I'll put up with her".

5) Paul

- Neil was referred to OT dept due to "not going out and not engaging" (Paul was a Therapy Instructor/TI and Support Worker – working alongside OT and other professionals).
- Paul working "to get him out of the house", "he struggled to get off his drive".
- OT first considered using the sensory rooms (Neil was put off by sign), (snoezelen engagement was a bit up and down – only attended 2 or 3 sessions).
- OT briefed Paul on Neil's PDA – not asking too many Q's etc/Paul liaises a lot with OT.
- Neil was talking to Paul, through his mum at first – lived at parent's home then.
- Problems at home "dynamics in the house".
- "Suck it and see" approach at first (Neil nervous and easily put off/puts up obstacles if put off.
- Paul said Neil "had a problem with that as soon as he noticed it" (LD sign), (perceived stigma/labelling) – also upset from Grandma – "he's special and he's going in a special bungalow", "oh, I'm special".
- **Hard work** and lots of time needed for Neil to trust people/Paul.
- Paul described chatting with Neil about things he likes ("technology and all that kind of stuff"); (asking him to help with car radio – asking him to help).
- Paul tried to "make it that it's his idea" (enjoyment, rapport, trust, relaxed approach, casual, friendly, humour).
- Paul said Neil then told him about an incident at college where he'd got in trouble (gone beyond college boundaries – got physical, caused problems, upset him; Then Neil stopped going out and wouldn't go beyond his drive).
- Paul helped Neil leave the house, go for short walks – at his pace* **(going at client's pace – frequently mentioned in support worker and therapist interviews)**.
- Paul used humour and **cajoled** Neil (effective) and very encouraging/supportive.
- Neil used to tell Paul to "stop asking!" (questions – disliked re PDA).
- Gradual, slow pace built up at Neil's pace/comfort level (effective).
- Improvements! Own flat, attending college, goes outside alone, no longer a "prisoner in own home".
- Adaptation of some PDA training – was told "don't praise him", but Paul **praised Neil a lot** (esp. when attacked/going through difficult time) – (effective). Also important = relaxed approach with no pressure (e.g. make things Neil's idea).
- Paul felt mum inadvertently put pressure on Neil and wanted him to make progress/upset if Nel didn't co-operate with Paul (go out in car etc).
- Paul said, "Neil puts people in boxes", "of course Janice is 'serious stuff'".
- Neil dislikes the word 'help' or 'supporting' him – eventually he was ok with 'leisure support' staff going in (higher ability than most LD clients). Imp. of labels, words, LD perception, stigma? Self-esteem; embarrassed teenager.
- Goals = get Neil "back out in the community", "get his self-esteem up".
- Neil struggled with making friends/social media problems – Impact of Autism ("Neil takes things to heart" – "a couple of words from a friend and then he'll not be his friend".
- Paul supported Neil and "try to advise him on different things on Social Media etc".
- Neil refused to go on buses after a driver asked to see his card (bus pass?); ("so he will not go on the buses now.").
- Neil developing ("he knows he can get over that now and he's learnt by himself") – developing his own strategies –
- Paul helped Neil set goals each week – e.g. getting up to the shops (Neil enjoyed achieving things, telling Paul and being praised) – must have had good rapport.

- Paul played tennis with Neil ("he's good - you know, he's good"); (helped get Neil out and enjoying life – as the PDA "stops him doing things that he likes to do").
- Paul supported Neil move on/move out (suggested and discussed getting his own place, during the transition and now at flat) – went well – "the rest is history now he's moved out".
- Neil now more independent (a high/success of the sessions).
- (Unrealistic) high expectations re future career (Paul) – would like "to go to America and do films", but Paul bit frustrated "but you won't even go on the bus. Won't it be hard for you to go there?".
- Paul used a lot of humour – "I think I get a lot of stuff out of him… with jokes", e.g. "if you have it done (IQ), I'll have it done!". (Paul uses it with other clients too) – helping them to have happier lives.
- Paul supported Neil with his domestic tasks/sharing and encouraging him to wash up.
- Neil also has OCD (problems washing pots over and over) Paul used humour – "come on your mum's coming, I'm not getting told off".
- Paul queried normal/age appropriate behaviour – "Did you tidy up every day when you were 20?".
- Low in the sessions = when Neil split with hi g/f (first g/f) – but "he dealt with it quite well".
- Low in the sessions = Neil getting attacked at college.
- Neil got attacked at college – dealt with it well and Paul praised him. ("he just walked away" – Neil was worried he'd lose his temper – "I said that's amazing, you're the bigger man for doing that").
- Neil going to court – Paul supporting him with it and through a police interview ("to be honest I was more frightened than him, but he just – he just killed it"); Neil spoke to the police through Paul - "he were talking to me cos he can't look at people if he doesn't know 'em").
- Paul thought Neil had overcome a lot (that his PDA used to prevent – e.g. taking family dog out for a walk), Neil happier than before.
- Paul determined to help Neil, get him making progress ("we're gonna get through this" attitude).
- Paul also has OCD ("with having OCD I understand him")/could share and relate – helpful to Neil e.g. discuss how to wash up/routine at home (and normalising).
- Transformation – The 1st couple of home visits "you just saw his feet" (kid at the top of the stairs).
- Imp. of teamwork (Paul mentioned a few times) – all working together, professionals, sharing helpful info.
- Paul sympathetic towards Neil's mum ("it must've been hard for mum").
- Successful – "to be honest with you, it's all been successful".
- "Trying different things"/persistence.
- Using subtle/inadvertent tactics ("what do you want to do today? I wouldn't mind getting a bit of chocolate… let's go off to the shop" etc).
- Making things Neil's idea.
- Initially difficult to see Neil/wouldn't engage at first.
- Imp. of prompting and reminders (e.g. house jobs).
- Imp. to take things slowly and have patience.
- Paul optimistic for Neil's future and confident in support team taking over/met them (discussed with Neil Paul taking a "back seat", less sessions).
- Paul sees 'Empowerment' as "a challenge… I do like a challenge" (positive); ("to think I've made a difference", "to achieve stuff in people".
- Paul passionate about work in LD – "I'm not going to treat them any different just cos they've got a learning disability".
- Impact of Neil's autism – "it has had a **major** impact on his life, and his family's life" ("It kept him a prisoner in his own home for a year").
- Paul encouraged NW "I said to him, 'You've got potential'"; ("telling him what he's achieved", "you've done that, you've done that… you've gone out") – positive feedback –
- Paul's LD work approach – "I try and be absolutely personal with everybody" (joke with woman who always said 'bedsocks!') – individual attention, person-centred, genuine enthusiasm.
  "I try and have connections in every person I work with"
  "That person with autism not the same as that person with autism".

- Problem with neighbours/children or teenagers “having a go” at Neil – stopped him going out again (blip).
- Ups and downs – Support and encouragement really needed - advice when to go out (when they’re at school).
- Paul highlighted the importance of learning from each other (“we can always learn from each other”).

Emerging Themes List (Paul):

- Referral issue – refusal to go out or engage with people.
- Therapeutic goals – creation/use of.
- LD label/perceived stigma.
- Mum’s involvement.
- Sympathy for mum.
- Family/home dynamics and working with the family.
- Importance of the flexibility and adaptations.
- Building trust and rapport and getting to know Neil. Using gentle and friendly approach.
- Working creatively – indirect approach – chatting, walking.
- Making strategies client’s idea.
- Supporting Neil with boundaries.
- Challenges, PDA obstacles/blocks and anxiety.
- Small steps and going more slowly – at Neil’s pace.
- Supporting Neil around physical incidents, frustration and aggression (to/from others), college problems.
- Bullying and problems with social situations.
- Consulting with other professionals/MDT Team/working.
- Using humour.
- Support, cajoling and encouragement – the importance of praise.
- Achievements and progress/increased independence.
- Neil putting people/staff in ‘boxes’.
- Client dreams and aspirations (very/too high?).
- ‘Normal’/age appropriate behaviour.
- Others’ expectations of Neil.
- Fears vs confidence about Neil’s future – feelings of responsibility for Neil.
- Service/support gaps (IQ above 70/Asperger’s).
- Job satisfaction/being able to help.
- Sharing information/shared understanding.
- Not treating people with an LD differently/seeing past/overriding the LD.
- Disempowering factors for Neil (Autism, PDA, isolation, family struggling).
- Nerves about supporting Neil at court.

Main Themes (1st Draft):

- Support through a positive relationship
  – Building trust, rapport and getting to know Neil – sharing OCD info – commitment, willing to make effort.
  – Importance of support, encouragement, praise, cajoling – genuine and friendly – seeing past the LD/PDA.

- Practical Support/focused referral work
  – Getting out/accessing community
  – Support with boundaries
  – Support around problems at college (including police interview/court)
  – Setting targets (small and achievable).

- Achievements and satisfaction (progress, more independence)
  – Being able to help and motivate
  – More independence – own flat and domestic tasks (looking after it) – getting out on own etc.

- Consulting/liaising with other professionals (MDT working)
  – PDA advice from experts
  – Sharing information
  – Different roles/flexibility
  – Importance of team work – consistency of approach – support.

- Challenges and obstacles
  – LD label/stigma
  – Family dynamics and problems/support for mum
  – Very high aspirations
  – Fears about future (others' expectations) (not LD – support gaps/service)
  – PDA obstacles – challenges initially with engaging.

- Adaptations
  – Working creatively – Indirect approach – chatting, walking, tennis
  – Making Neil's strategies 'his'
  – Small steps and going slowly/at Neil's pace
  – Using humour
  – Same treatment as anyone else (not adapting?).

ii) TRIAD SUMMARIES

Triad #1 (Sid, Eve, Robert)

- Sid was referred due to recurrent depression.
- Support staff at his work placement recommended/supported him to GP appointment.
- GP made referral to LD service for counselling and gave Sid anti-depressant medication.
- Sid felt depressed due to long-term family issues, relationship issues.
- Sid had low self-esteem/lack of confidence in past due to his LD label, having attended a special school, felt he had ltd opportunities.
- Sid had been bullied at school and afterwards.
- Sid was affected/impacted by financial situation, social restrictions (lack of money or paid work, lack of social opportunities to meet people or do things)- disempowering factors.
- Eve used CFT approach (Humanistic) and adapted it and resources for Sid.
- Sid couldn't read or write so Eve used visual elements – picture/symbols.
- Eve gave Sid relaxation homework exercise.
- Sid found talking to Eve helpful – lack of judgment/criticism of him, encouragement, kindness, support – the therapeutic relationship = important.
- Robert had limited involvement re the therapy – supported Sid at his voluntary work placement (Sid = very capable at joinery etc).
- Sid had only a mild LD and fairly independent (has a bike, own place, relationship, etc).
- All felt Sid made progress – seemed happier, better mood, more relaxed and confident.
- Sid started doing more and achieving things (Ju-Jitsu, chain saw qualification, using his bike),
- Sid happy his daughter had come back into his life – had felt lots of regrets and guilt.
- Robert respected Sid and Eve session/privacy and didn't ask many Q's (noticed improvements and Sid said EK was easy to talk to and helpful).
- Ups and downs; frustration and lack of progress initially (needed to see GP and up meds again).
- Eve and Sid disappointed, but pursued and reflected on need for time and not quick fix.
- Little MDT involvement – Sid preferred privacy, quite independent, focus was counselling.
- Therapist satisfaction – Eve found the sessions rewarding and also used mindfulness herself. Found CFT interesting and enjoyable.
- Gap in research re CFT for people with LD's – Eve had to be creative and adapt resources for Sid (1st time she'd tried it in LD – experimental?).
- Eve used Glasgow Depression Scale to score before and after/show changes and improvements (objective/formal assessment).
- Bullying.

Triad #2 (Jacky, Nichole, Malcolm)

- Quite long-term work with Nichole and Jacky – Several years/kept on caseload for maintenance and risk protection.
- Jacky referral due to past abuse and trauma/PTSD/hearing voices and seeing things (sexual abuse as a child, physical, emotional and financial – from family and other people).
- Jacky had sometimes self-harmed (graphic-showed the scars/scabs) and sometimes felt suicidal.
- MDT team involved and info due to risks involved and health problems.
- Nichole focused on therapeutic counselling, support personal work.
- Malcolm involved to help in travel training, fear of social situations, crowds, anxiety about people staring at her and judging her; (felt threatened/scared people could hurt her/didn't want to travel alone).
- Nichole used mixture of methods and approaches (Counselling, NLP, Energy therapies, TA, Timeline work, CBT, relaxation techniques).
- "Quite a complex case".

- Treatment plans created around specific issues.
- Nichole highlighted imp. of simplifying info, checking and reviewing.
- Sessions led by Jacky/followed her timeline and life story – not always a linear.
- Trauma initially severe – Nichole used SUD's to score before and after.
- Jacky has many improvements in her life – all agreed (more assertiveness sometimes, less traumatised from past memories, able to go out on her own a bit more, mood generally better and self-esteem).
- Still areas for improvement/further development (saying 'no'/assertiveness); Frustration from Nichole different between teaching and putting into practice; family abuse ongoing/"know which buttons to press"/financial abuse – family.
- Jacky needed to be able to trust people – disliked some agency staff as she felt they were nosey and judging her (could see their eyes looking around her home; not very helpful (just drinking coffee) etc).
- Some joint sessions with Malcolm and Nichole – Jacky sometimes disclosed things to one and not the other (Malcolm thought sometimes a bit of a game – that they usually found out about things).
- Mutual liking/positive therapeutic and support relationships (Importance of trust).
- Nichole felt there were many areas creating disempowerment in the lives of people with LD's.
- Imp. of choice and control in the lives of people with LD's.
- Influence of environment and social factors (family can be over or under protective, less empowerment).

Triad #3 (Edward, Tim, Ray)

- Edward was initially referred due to workplace bullying and MH problems.
- Long-term counselling input (approx. 10 yrs) – still seeing Tim occasionally in the maintenance phase.
- Tim spoke of 3 distinct phases of the counselling – relationship building – challenge phase – maintenance phase.
- Ray started working with Edward approx. 5 yrs ago as his support worker.
- Edward experienced 2 x workplace bullying and past trauma from LD/Institutional abuse.
- Tim involved in a safeguarding investigation previously (re institutional abuse – inconclusive?
- Big improvements/transformations (Edward no longer on medication, much better relationships, valued part of community, enjoying life and activities, more independent – own house now.
- Positive impact on family/parents and others – parents can now have holidays (imp. as elderly), all getting on better, less stressful for everybody.
- Tim used a mixture of therapeutic approaches (Humanistic counselling to build relationship/rapport and gain trust; TA and Gestalt (helpful in Tim's report and meetings too) to help challenge.
- Tim also explored Edward's dreams, imagery.
- Tim mentioned imp. of body symptoms/processes mirroring changes for Edward.
- Edward very appreciative of Tim and everyone's support (parents and support workers).
- Tim felt Edward had worked hard and put a lot of effort in himself.
- Edward wanted to feel independent, proud of his work/jobs and skills/abilities (e.g. Brewster, training, skill operating machines) – (resistant initially to having a mobility scooter or claiming benefits).
- Imp. of verbal communication, exploration of concerns – in a safe, trusting environment, where Edward felt confidentiality was respected and he was prized.
- Very supportive team, good MDT work/liaising and genuine care/support for Edward (he benefitted a lot from this and Tim's therapy/relationship) – Can these things be taught?
- Tim warned about Humanistic therapy in some forensic clients/offenders (imp. not to get comfortable with discussing emotions and their actions).
- Talking and support = more imp. to Edward than homework, mood charts etc (expressed reservations re the charts but appreciated Tim's efforts).
- Bullying.

Triad #4 (Abbey, Penny, Kevin)

- Abby referred for help with anger management and MH issues.
- Abbey had received previous (general) counselling/MH service input – but did not find as helpful as Penny (specialist LD counselling).
- Important to Penny not to feel ‘patronised’ or judged – all agreed; she was much happier with Penny
- Counselling received from Penny approx. 1 year (Penny wanted to start to phase it out).
- Penny used PCA – pretty much solely (unlike the other therapists) – although give some homework and didn’t want to be absorbed into medical model/NHS constraints. Also liked her therapy to be ‘practical’ (e.g. minor work with another client, journal work for J).
- PCA identity = very imp. to Penny (and PCA supervision).
- Kevin different kind of support worker as also Abbey’s husband (her ‘supporter’).
- Penny sometimes saw Abbey and Kevin together jointly – caused some issues for Penny re boundaries/review sessions merging into couples counselling or counselling for Kevin.
- Penny had to review/adapt treatment plans as other issues emerged.
- Relationship issues became a priority (originally past traumatic relationships /memories affecting Abbey – Then her relationship with Kevin and physical abuse).
- Penny needed to signpost other services to Kevin and discuss domestic violence.
- Penny didn’t always agree with Kevin’s approach/es (e.g. punch bag/directness/army background and pressuring Abbey to talk when she might not have been ready).
- No other MDT team involved – Abbey happy with Penny just for counselling.
- Noticeable improvements mentioned by all – esp. confidence and self-awareness.
- Abbey appreciated being able to talk to Penny and explore her feelings, experiences and also Penny’s support/encouragement – and sometimes remind Kevin of things Penny had said.
- Abbey hitting out at Kevin at night in bed when ‘asleep’ – Abbey and Kevin thought it was ‘subconscious’ behaviour and Abbey ‘processing things’; Penny not so sure – but it decreased. (Penny surprised and concerned when saw Kevin’s bruises and bite marks).
- Abbey becoming more independent and empowered was very imp. to all 3 (all in agreement). (More confident, more able at home/domestic tasks, thinking/processing more).

Triad #5 (Neil, Janice, Paul)

- Janice was referred as he was depressed, experiencing suicidal ideation, having problems at home/family problems, angry and not “fitting in”.
- Neil’s mum contacted Janice/Dr’s etc (worked there and knew Janice).
- Janice agreed to carry out a screening assessment – not possible for a while.
- Janice adapted Neil’s treatment plan to include developing the relationship/rapport and trust.
- Janice also referred Neil to OT (Paul involved as support worker) – to help Neil get out of his house, build confidence, social interaction.
- Neil had counselling sessions with Janice in his house at first – longer/adapted for him.
- Neil’s Autism/Asperger’s, PDA and OCD mentioned as key factors.
- Neil was very unhappy/resistant about coming to service building due to LD label/sign outside. Very concerned about stigma, others’ perception of him, labelling ‘normality’ etc.
- Neil experience some bullying from peers/teenagers – he reacted angrily and had fights/got into trouble.
- Neil’s gran called him ‘special’.
- Eventually Janice managed to carry out an IQ assessment – Neil scored ‘well’/too high for LD service (didn’t actually have an LD – did have ASD, PDA and OCD).
- NW made lots of progress – esp. moving into his own flat alone.
- Neil’s PDA had stopped him doing many things and made life difficult (e.g. refusing to sign docs at college/hospital/for benefits/to get flat, show his bus pass). All of these reminded him of being ‘different’.
- NW said independence and empowerment has its drawbacks – living in own flat on his own could be boring. (need for further support and life/personal changes).
- Neil diagnoses made relationships with others difficult.

- Janice and Paul felt MDT team working was helpful/sharing info and training (PDA).
- Neil said his mum thought he wasn't depressed anymore – he thought he just deals with things better now (and more self/socially aware? /more social life skills).
- Janice and Paul found the working very rewarding and liked NW.
- Neil said he had "lots of weird conversations" – it had been quite uncomfortable (used humour as a defence mechanism?) and found counselling "depressing".
- Janice and Paul felt Neil's dreams for his future too high/unreasonable (being a director of films in USA).
- Janice and Paul had useful advice re adaptations for LD work.
- Janice used mainly PCA, with some TA.
- Paul tried to give Neil weekly targets (e.g. getting out/walking dog etc).
- Bullying.

iii) Ideas for Overall Summary/General Themes

- Neil and Sid both referred due to depression – but expressed differently and different perspectives.
- Neil, Sid and Jacky all felt suicidal at times.
- Neil, Edward and Abbey all felt angry/violent at times.
- Interesting to see each LD clients' sense of humour – utilised in most sessions.
- Some clients (Edward and Abbey) want to share (or others to share) counselling confidential/personal info with carers and others – some don't (Neil, Sid and Jacky, Abbey?).
- Clients often like to use phrases and metaphors.
- Different views of special schools between LD clients? (and stigma/labelling – e.g. Neil, Sid)
- See cycle of disempowerment diagram in Eve's summary (no job, etc).
- All therapists highlighted/repeatedly mentioned importance of trust and building up the therapeutic relationship.
- Some LD clients moved into own flats – sign of independence/empowerment (via counselling/PCA approach etc) - Edward and Neil.
- All therapists agreed on the importance of empowerment (some see as whole/key point of the therapy – e.g. Nichole, Eve and Tim).
- Stigma felt/highlighted by LD client's (Neil, Edward, Sid, Jacky) – e.g. Edward's pride/scooter/benefits.
- Imp. aspects of Empowerment = "having an opinion on capabilities etc and self-governing (**List** the examples given of empowerment for each client). Interesting to compare each therapists/clients' view of empowerment.
- Treatment plans sometimes changed/evolved – in most cases here (Neil, Robert, Jacky, Abbey).
- Several/all therapists mentioned wider/systemic issues going on – not just client referral (incl. impact of staff, carers, parents, past experiences, environment).
- Penny and Eve mentioned imp. of supervision/reflection.
- Imp. of going at client's pace and/or for client led sessions (and following the client) – frequently mentioned in support worker and therapist interviews.
- High/outstanding level of care and efforts from support workers.
- Dedication from all staff involved.
- Amount of MDT input varied (some LD clients preferred less and were quite able/independent).
- Not all support workers were working alongside therapists (e.g. Robert) as aware of therapy details - some working in specific areas/others more general support (different roles).
- Support worker awareness of client/sensitivity = very imp. (e.g. able to notice changes in appearance – Ray).
- Support workers roles differed (e.g. Kevin was also Abbey's husband).
  appreciation towards most therapists/support workers from clients (Sid, Jacky, Edward, Abbey)
- Improvements taking time/working through things.

- Increased interview input with LD P’s (checking, paraphrasing, suggestions, helping).
- Importance of ‘reasonable adjustments’.
- Importance of Support networks.
- Therapist sensitivity, commitment, skills.
- Bullying/abuse/victimisation/exploitation.

APPENDIX R: ANALYSIS PROCESS & NOTES (INITIAL THEMES)

This appendix contains early draft data analysis information relating to how the information gathered answers the research questions and aims of this study. It includes participant transcript summaries (with pseudonyms) and the table of participant conceptualisations of empowerment used in Chapter 4.

- **TABLE OF PARTICIPANT CONCEPTUALISATIONS OF EMPOWERMENT**
- **EXPLORATION OF RESEARCH AIMS & RESEARCH QUESTIONS OUTCOMES**

APPENDIX R CONTENTS

OVERALL CLIENT SUMMARIES & MAIN THEMES:

OVERALL LD CLIENT SUMMARIES —Sid, Jacky, Edward, Abbey, Neil

MAIN THEMES – LD Participants (1st Draft)

OVERALL THERAPIST SUMMARIES — Eve, Kevin, Tim, Penny, Janice

MAIN THEMES – Therapists (1st Draft)

OVERALL SUPPORT WORKER SUMMARIES — Robert, Malcolm, Ray, Kevin, Paul

MAIN THEMES – Support Workers (1st Draft)

CONCEPTUALISATIONS OF EMPOWERMENT

RESEARCH AIMS:

1. **FACTORS LD CLIENTS FIND HELPFUL & EMPOWERING (in the psychological therapy received from psychological therapists)**
2. **HOW THE THERAPEUTIC RELATIONSHIP AFFECTS PSYCHOLOGICAL WELL-BEING (within an LD population, as facilitated by their therapists & support workers)**

   3.WHAT FACTORS CAUSE

   a) <u>DISEMPOWERMENT</u> AMONGST THE LD POPULATION? &
   b) WHAT HELPS TO BRING ABOUT FEELINGS OF EMPOWERMENT? (with particular focus on psychological therapeutic interventions)

RESEARCH QUESTIONS:

1. **IN WHAT WAYS DO PWLD EXPERIENCE EMPOWERMENT FROM PSYCHOLOGICAL THERAPY AND THE THERAPEUTIC RELATIONSHIP, WITHIN THE NHS?**

2. i) **HOW DO PSYCHOLOGICAL THERAPISTS AND THE CARERS/SUPPORT WORKERS OF PWLD ENABLE CLIENTS WITH LD's TO EXPERIENCE EMPOWERMENT FROM THE PSYCHOLOGICAL THERAPY RECEIVED WITHIN THE NHS?**

2. ii) **DOES CHOICE OF THERAPEUTIC APPROACHES AND METHODS INFLUENCE OR FACILITATE POSITIVE OUTCOMES AND EMPOWERMENT IN PWLD**

OVERALL LD CLIENT SUMMARIES

—Sid, Jacky, Edward, Abbey, Neil,

Neil	–	☐	Depression/suicidal/family problems PDA/autism, OCD. Moved to own flat.	☐
Sid	–	☐	Depression & low self-esteem, guilt. Woodland-based work placement.	☐
Jacky	–	☐	Past abuse – rape & trauma. Mental Health concerns self-harm, seeing/hearing things, family – financial abuse.	☐
Edward	–	☐	Workplace bullying & institutional abuse, family relationship. Moved to own house.	☐
Abbey	–	☐	Anger management & past/current relationship issues, becoming more independent.	☐

Neil & Sid both referred due to depression – expressed differently & different perspectives.

Neil, Sid & Jacky all felt suicidal at times.

All had mental health concerns at times/before (different kinds & intensities).

Neil & Edward moved into own home → improvements.

Some mentioned the importance of not being patronised (and past experience by other professionals).

All had experienced past bullying/abuse/victimisation or exploitation.

Most expressed appreciation towards therapist (Neil may have been embarrassed as Janice present).

Most had a mild LD (Neil actually didn't meet service criteria).

Some had additional physical health problems (Jacky & Edward).

The therapeutic relationship & talking was most important to most (? Neil).

Most had been given some form of practical tasks/activity/homework (even Neil).

None were critical of their therapists or support workers (perhaps Abbey, as hers was her husband?)

Most felt/expressed upset re stigma/LD label, special school. (Neil, Sid & Jacky found the LD label disempowering & stigmatising).

All felt relief (& empowerment?) when they were able to make achievements, 'fit in', or get over some negative feelings & leave traumas behind.

All found the therapy helpful.

All wanted to continue seeing their therapist/support workers for longer (or again).

All had ups & downs, blips, rocky roads/winding journeys.

Some were also helped by/given medication (especially Sid, Jacky, Edward in past).

Most had experienced/having MDT working (especially Neil & Jacky).

Privacy, confidentiality & sharing info were concerns for all, in different ways.

Greater independence, self/life control, ability to make choices, confidence & improved mood — was important to all (& occurred in all).

MAIN THEMES – LD Participants (1st Draft)

- Concern/awareness of stigma, labelling, not “fitting in” or being “normal” & other people’s judgement/treatment of them.
  - Some experienced bullying & victimisation
  - Social anxiety

- Appreciation towards therapists & support workers
  - Gratitude, wanting more, to continue
  - Stated progress/improvements made
  - ? Enjoy the company or getting better?

- Progress & changes as a result of the therapy
  - all showed ↑ confidence, ↑ independence, ↑mood

- Being able to trust therapist was important (& not being patronised – which some had experienced from non-LD counsellors or other professionals).

- Trust, privacy & confidentiality = important before making any disclosures or being able to engage (Key attributes/qualities had to be present).

- Struggling with dealing with their emotions/life events/referral issues (all had experienced difficult life events & strong, challenging emotions that they could not resolve alone/without support – very strong feelings).

OVERALL THERAPIST SUMMARIES

—Eve, Nichole, Tim, Penny, Janice,

Janice	–	☐	Neil’s PDA.	☐	–	PCA (and TA)
Eve	–	☐	Sid's depression.	☐	–	CFT, relaxation exercises.
Nichole	–	☐	Jacky’s complex past, traumas, abuse.	☐	–	Humanistic Counselling, CBT, Timeline, NLP, EFT, relaxation exercises.
Tim	–	☐	Edward’s workplace bullying/institutional abuse.	☐	–	Humanistic counselling, TA, Gestalt, dreams.
Penny	–	☐	Abbey’s anger management & relationship issues.	☐	–	PCA, diary writing.

All therapists expressed satisfaction from the work/with these clients.

All mentioned ‘reasonable adjustments’ or need to simplify/adapt for LD clients.

Most used a mixture of approaches.

Most/all made adaptations with their approach.

Some were involved with MDTs (Janice, Nichole, Tim) & others not really (Eve, Penny).

Most mentioned treatment plans changing & evolving.

All mentioned joint working & client-led work (worked well & more empowering for clients — gives them more choice & control).

Logistical & privacy issues sometimes occurred (Janice, Eve).

All were willing to be flexible around the client’s needs.

All mentioned the importance of trust, rapport & building up the therapeutic relationship.

All involved longer term working (over 6 months) Eve – 6; Janice – 24; Tim – 10; Penny – 12; Nichole – 10

?Relationship & trust = more important than specific technique/approach.

? Relationship & trust = more important than homework tasks.

(But if it aided the therapist, their work in client specific/structured tasks & focused activities helped & were part of the process).

MAIN THEMES – Therapists (1st Draft)

- Adaptations needed in LD therapy work.
- Limitations, challenges & barriers in/to LD work.
- Achievements, positives, opportunities, rewards/satisfaction.
- Working alongside others – families/carers/MDTs (in most cases).
- Importance of the therapeutic relationship – especially trust & rapport.
- Approach used – according to client needs/situation/disposition.
- Client led/co-operative approach.

MAIN THEMES – Support Workers (1st Draft)

- Joint/MDT working, liaising, consulting, sharing – generally very helpful.
- Improvements/progress/achievements/changes.
- Appreciation of therapist/value of therapy.
- Job/work satisfaction.
- The helping role – variation but focused on client/helping/supporting them.
- Awareness of client's needs/issues/triggers
  — Genuine care & support/concern for client

- Selective disclosure.
  Confidentiality & privacy issues.
- Adaptations/working effectively with the client.
- Treating LD people equally/same as everyone else/as individuals.
- Unanimous consensus of opinion/agreement re importance of empowerment with LD clients.

OVERALL SUPPORT WORKER SUMMARIES

—Robert, Malcolm, Ray, Kevin, Paul,

Paul	–	☐	Neil – PDA, OCD, getting out & accessing community.	☐
Robert	–	☐	Sid – depression/work-based placement.	☐
Malcolm	–	☐	Jacky – bus/travel training & social anxiety.	☐
Ray	–	☐	Edward – past bullying; general support ↑ independence.	☐
Kevin	–	☐	Abbey - anger management & relationship issues; carer/husband.	☐

All very dedicated & caring – very high levels of support; genuine concern & interest.

Roles varied.

Some worked alongside therapists (Paul, Malcolm, Ray) others did not (Robert) – awareness of details of therapy varied.

Awareness of client/sensitivity = very important (↑ able to notice changes in appearance/behaviour).

All able to liaise with other professionals/sources of support & get appropriate help for clients.

All expressed/saw improvements.

Able to share info if needed.

All mentioned importance of trust, building rapport/relationship.

All knew their clients well – all had known them over one year.

All aware of referral issues & client background.

PARTICIPANT CONCEPTUALISATIONS OF EMPOWERMENT

LD client participants

1.	Neil	Being independent = important but can be boring (sitting around in flat alone/or hassle getting around to doing house jobs). Therapy won't change the neighbours/environment/worried about losing his temper/Less depressed now – just “pissed off”! Dealing with life better now (life itself no easier/more difficult!)
2.	Sid	Found the sessions helpful (agreed) – “good”; “I think I'm getting better” (improvements in his mood). “Thinking good things – instead of thinking bad things”. Nicer to himself – felt better. “It's helping, yeah. I think it's helping.” Improved life events and successes – passing chainsaw course. Looking better/less miserable. More active/independent – started Ju-Jitsu; got goals in life.
3.	Jacky	Making health improvements (40 – 60 cigarettes to 10); more independent and active (e.g. walking to clinic or shops alone). Knowing who to contact/who can help (even if Jacky still unable in places). Learning how to stay safe. Feeling better/less affected by past and traumas. Less self-harm. More self-awareness. Confidence, trusting herself more. (e.g. question O/D thoughts).
4.	Edward	Being/feeling independent, having jobs, sense of worth/self-esteem. Having skills. Own flat. Having therapist/people who are interested in and care about him “he's been interested in me and helpful”. (Very grateful for help/support – attributes his progress to their help. Respect from others. Able to communicate better and sort out problems faster/easier with carers. Feeling better/mood. Treating people better (especially parents). Interacting in the community.
5.	Abbey	Making improvements, doing more, “stepping up to the mark”. Realising things/↑ awareness; thinking more clearly and calmly. Communicating more/effectively (especially with husband). Feeling stronger and more confident. Doing more independently (e.g. bus travel/to appointments). Able to move on from the past. Getting over fears. Feeling more autonomous. More assertive. Able to stick up for herself (e.g. ex-wife).

Therapist participants

6.	Janice	Trying to help a person to speak up, speak out and stand up for themselves, appropriately and in a way that doesn't get them into trouble (may see empowerment as aggression – so need to explain difference) and trying to empower others as well (carers etc) and using appropriate adult language. Trying to get everyone involved on board. Helping people move on with their lives and feel happier and more confident.
7.	Eve	Working with someone in a way that enables them to have some control. "A means of making changes that are really important to them." Many LD clients don't have experience of having choices and control – so being able to experience that within a therapeutic relationship is key to the work we do.
8.	Nichole	Giving our clients some sort of control over what they do or how they feel. (Some LD clients might exert control over some specific type of behaviour because that's the only thing that they have control over" – so working out how they can have control or working with care providers, how they can help with support in empowering them more) – increasing control and having responsibilities for things.
9.	Tim	Empowerment is "crucial, absolutely crucial and I think it's the goal which all therapists aim to achieve with their clients." "It's about somebody having the confidence to be totally self-governing and to speak up for what they think's right and wrong and to express their need – without feeling embarrassed or feeling as though they're not able to do so." "Able to have a say in his life, to steer his own boat."
10.	Penny	"It's who you are really… you have to go out there and get it!"; "for me… it is a biggie" "To actually believe in yourself, you have a right to do things…" Tries to help clients to do whatever they want to do, "give it a go." "Or, OK, well find something else!"

Support worker participants

11.	Paul	“I like a challenge… and to think I’ve made a difference”; “I like to achieve stuff with people, and I want them to achieve… Thinking about how they feel…”
12.	Robert	“Giving people the chance to be themselves”; Not to feel that they’re treated any differently to anyone else. “It’s all about people feeling they’ve got a sense of worth by contribution.” Treating people as equals. Giving people a chance.
13.	Malcolm	“Giving people back what they lack, or lost confidence with, building that confidence up so that when they’re not sure about something, reassuring them.”
14.	Ray	(Confusion about who the empowerment referred to) “It’s everything really – you’ve got to feel – cared about really, you’ve got to feel wanted”; “You’ve got to feel… like there’s a purpose that you’re here – everyone needs a purpose; don’t they – “
15.	Kevin	(Not sure of the meaning of empowerment) – agreed with my explanation. Encouraging someone to be more independent and confident. Helping people develop. To be independent, not just being reliant on people.

EXPLORATION OF RESEARCH AIMS:

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3. **WHAT FACTORS CAUSE:**
   a) DISEMPOWERMENT AMONGST THE LD POPULATION? &
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RESEARCH AIMS

1. FACTORS LD CLIENTS FIND HELPFUL & EMPOWERING (in the psychological therapy received from psychological therapists)

Neil	Found talking about depression depressing! "Many weird conversations!" Counselling helpful/reassuring to his mum! Reluctantly admitted services were helpful. "My life hasn't got any easier, it's got more difficult"; "The difference is how I'm feeling with things". Glad to have his own flat (counsellor helped with) &? Some pride in looking after place? Less depressed about life in general (Just "pissed off") PDA/reluctant to praise anyone – embarrassed (& teenage?) Counsellor unable to change his neighbours or environment however.
Sid	Sitting down to talk. "Talking and relaxing and keeping my mind away from my thoughts" Learning to be less self-critical – (used to put myself down/"rip hell out of myself") Changing thoughts/thinking patterns "Thinking ... good things – instead of thinking bad things…" Homework to encourage him to be nicer to himself. "She gave me something about being nice to myself." Relaxation exercises. The counselling "it's helping". More independent & motivated – "I can do things more" (chainsaw course passed, started Ju-Jitsu & set goals) "I've actually got a goal that I want to do" (brown/yellow belts)
Jacky	Feeling heard/listened to. Nichole "being there", trustworthy & reliable. KF being "nice person" kind & supportive. Being able/feeling safe to off load. "She's got loads & loads of stuff out of me." "When I'm with Nichole I feel like I'm safe." Feeling she can tell Nichole private details safely. Finding Nichole's approaches helpful. "It was just good" & allowing her to release the past/tension. "We talked through loads & loads of stuff" – having the time/space/ opportunity to talk together. Can now walk to the shops on her own (felt supported, motivated, trusting). Trusting the CLD to help support her – health appointments, referrals, more counselling, etc. Trustworthy LD/NHS team.
Edward	Safely going through past events (family, work, etc) – exploring & resolving traumas & issues. Feeling heard & listened to. Felt understood – other counsellors "didn't understand me". Having a supportive friend/influence. Trusting Tim. "He's been interested in me and helpful". "Tim has been there. Kept me on the straight and narrow." Talking was more important than charts/homework/traffic lights behavioural systems etc. Edward was able to tell Tim things he hadn't disclosed to his parents or anyone else. Felt safe with Tim & parents, support workers – all supporting together, agreeing, sharing the process.
Abbey	Being able to <u>process</u> past events, relationships, traumas, memories, coming to terms with the past. Support in moving on, making improvements. Being able to say, "Goodbye past – moving on!" Enabling Abbey to "release everything", see hidden things ("realise what I couldn't see, and I felt so weak. I just didn't know what to do and now I feel so much stronger").

	Talking to Penny allowed Abbey to release all that was making her feel weak & she began to feel stronger as a person & more confident. Penny helping to raise Abbey's awareness – e.g. of hitting out at husband in sleep (acknowledge, discuss & find ideas/strategies to overcome this too & process/move forward) Penny asked Abbey to keep a diary (for sleeping habits & try out relaxation techniques to help calm). Time to explore life issues, feelings, events & look for solutions herself. Given space to do this. Allowing. Enabling. Providing space. Trusting relationship – able to talk, offload, disclose. Encouragement of Penny – "It's mostly Kevin and is Penny who's helped me, with the encouragement." Support.

RESEARCH AIMS

2. HOW THE THERAPEUTIC RELATIONSHIP AFFECTS PSYCHOLOGICAL WELL-BEING (within an LD population, as facilitated by their therapists & support workers)

Neil – Acknowledged feeling less depressed since the counselling (more “pissed off” – but more independent & mature?)
Accepted help of counsellor & support worker gradually (successful?)
Relaxed attitude towards his counsellor & use of humour
Admitted the counselling had helped (“I suppose”)
Long-term/ongoing sessions → indicated successful/accepting relationship
Neil gradually trusted Janice & was able to talk with her more easily (she persisted & was very flexible, did not force him or ask too many questions! She provided extra time initially).
Neil appreciated Janice not making demands & began to trust her – plus she knew his mum from work!
They got on well in the beginning & used humour helpfully.
“The progression’s been amazing.”
Janice also built up a good relationship in Neil’s mum – all worked together/& explored whole family dynamics)
“It’s been a joy to work with him” – “challenging but in a nice way” – therapist satisfaction (impacting work/outcome?)
Neil tells Janice “serious things” → should he trust/respect her?
(Neil aware of boundaries & who to tell what to) – used the relationship well.
“He really enjoys the company, whereas before he was very suspicious and not trusting of people.”
Going at Neil’s pace allowed him to feel more supported & comfortable.
Use of humour in the support worker relationship helped – as did a casual, friendly, caring approach
Lots of praise & genuine feedback & positive support was appreciated (despite PDA guidelines!)
Encouragement & liking Neil as a person seems to have helped.
Sensitivity to Neil’s personality/conditions & being understanding (e.g. Neil didn’t like words “carer”/”support worker”)
Sharing insights (support worker also had OCD) –? Made the relationship more equal (& less about unequal power/control).

Sid – After the counselling, Sid was less withdrawn/quiet
The therapy included relaxation, stress relief
felt better in himself, thought he was getting better
felt the therapy went “As well as it can, I think.”
Found “just talking” relaxing & keeping my mind away from… From my thoughts”
Improvements from the constant negative thoughts.
Helped him be less self-critical (“always used to put myself down… rip hell out of myself”)
Helpful changing thinking patterns – “thinking good things – instead of thinking bad things”
Homework tasks re being “nice to myself” & “don’t beat yourself up”.
Felt accepted, not judged, encouraged, appreciated, liked, respected, valued → improved his mood and confidence.
“It’s helping, yeah… I think it’s helping” (the counselling)
“I can do things more”; “I’ve passed my chainsaw course, so that’s made me feel better”
Facilitated motivation, confidence; made him feel like/able to do more. Encouraged him to do things.
Sid felt listened, non-judgementally.
“Being able to experience [having choices & control] within a therapeutic setting… is really key to the work that we do” (can be new experience/not used to experiencing

these).
Helping Sid to feel valued – Sid appreciated being able to talk about his experiences.
Eve allowed Sid's feelings to be validated – not always possible to "pull yourself out of that" straightaway.
Honesty, integrity, reflection of feelings – all really helpful & valuable for Sid.
Eve allowed Sid to talk/move on/go at his own pace/rhythm – sensitive & respectful.
Eve practised mindfulness exercises at the same time, doing some of the exercises with him.
Eve acknowledged the relationship building satisfaction.
Eve allowed Sid to recognise that the depression wasn't him – it was "a result of his experiences partly."
Sid & Eve discussed/shared that we're all human beings & none are perfect.
(It made both feel better – was part of the CFT approach & they explored that too).
Eve said "It's great to work with someone who's so motivated" – sharing improvements & progress.
Eve "I think the relationship was really central, in building that [therapeutic change & progress] with him."
Robert "giving people a chance to feel at ease with themselves" (Eve)
Robert respected the privacy & confidential nature of the therapy – was not intrusive.
Robert "for Sid, he commented several times that he just felt Eve was very easy to get on with & talk to."

Jacky – Felt she could trust Nichole & Malcolm – could tell them things about past/release traumas
From the support, Jacky felt safe, calmer & able to release past tensions.
? New experience of trust & being able to talk/offload to Nichole "She's just a nice person"
"When I'm with Nichole I feel safe."
Talking & psychological processes helped Jacky feel better – enabled confidence & progress – mood, confidence, less self-harming
Working alongside Nichole & Malcolm allowed Jacky to experience greater independence, able to travel more easily, overcome fears and live a more "normal" life.
Jacky keen to have further sessions –? More progress or enjoyed the company?
Jacky trusted Malcolm although he was male & even able to make disclosures to him (unusual for her)
Positive new experiences with people – encouraging for future & social interactions
Facilitate hope & optimism? Nice people exist. Learn about right & wrong behaviour.
Limitations – Nichole not able to get Jacky to stand up to family/say no (e.g. to financial abuse) when sometimes needed.
Long-term work was beneficial & needed. Complex case/multifaceted. Nichole highlighted the importance of trust & rapport – if they don't have that "you're not likely to develop a therapeutic relationship that's going to be successful."
Nichole said "a lot of people with "LD tend to have quite a distressing history" – more important re trust & rapport if disclosures to be made.
Jacky hadn't had many people she could trust – "it was probably a fairly new experience" (she trusted Nichole so could make disclosures to her).
Jacky was able to talk to Nichole & Malcolm, give sometimes different info to both, all shared.
Jacky trusted & was able to talk to Malcolm – "Somebody being there listening to her…and taking it on board." Acknowledging the seriousness of her situation.
Malcolm & Nichole believed Jacky & took her seriously, validated her disclosures & experiences. It was important for Jacky that she felt supported – Malcolm felt she experienced this.
Enabling Jacky to take control back, over her own life.

Edward – Was able to make disclosures to Tim he hadn't even told his parents.
Felt safe, supported & trusting of Tim. Able to explore his past, traumatic memories,

workplace bullying & family dynamics – in a safe, protective environment.
Edward = very grateful to Tim and attributed his progress & improvements to Tim. Was able to take a long time exploring issues & developing himself.
Flexibility, consistency & security of ongoing sessions where Edward felt safe to explore. The progress & therapeutic relationship was facilitated by Tim and support staff (& parents) – all present in the sessions at home times. Edward chose & wanted this.
Edward said "it took a few years really… It took a long time really to get me right."
Now problems are resolved "much faster!" – Learnt processes & how to explore his feelings & behaviour – able to communicate & solve issues better now.
Edward reported feeling much better since the counselling – "They were helping", "I'm not… being horrible" (to parents/carers), "I'm on an even scale"
Tim's counselling – "he's keeping me on an even balance" (more stable than before emotionally and behaviourally)
Edward felt "understood" by Tim – unlike other counsellors.
Edward trusts Tim, feels warmth, "he's a good friend – he's really helped me"
"I wouldn't want anybody else" (dependency??)
Edward is able to tell people sooner if he feels bad/needs support.
"Staff… understand me if I'm upset or something" → Also feels understood & supported by his support workers (beneficial)
Acceptance & support felt by Edward ↑ confidence & relaxation
Tim felt LD clients generally "respond really positively to the therapeutic engagement" – due to challenging life circumstances & events, labelling segregation – "they sort of welcome that one-to-one engagement"
Tim said as long as "you're mindful of applying reasonable adjustments, being very open, very transparent, – explaining everything as you go along, I think it's a right positive experience"
Tim – "without the relationship you wouldn't be able to progress onto the other phases, so it's absolutely critical"
Tim aware of the importance of client feeling safe, comfortable, to trust you, "to warm to you"
Important to revisit the therapeutic relationship & check it/things out. Helps promote healing & change
Ray – "It gives Edward the opportunity to get a lot off his mind" "It could blow up, but it will be resolved, no matter what – we won't leave the room until it is."

Abbey – Abbey felt she had made some progress.
The counselling sessions "really helped me to come to terms with what's happened and making steps in the right direction, in making improvements."
The counselling helped Abbey process things & think more clearly – including past relationships and impact on current one.
Penny's sessions helped Abbey "come to terms with what's happened & making steps in the right direction, in making improvements."
Abbey felt more able to do/help with house jobs, do her share, "stepping up to the mark", "a lot of things have been sinking in and I've been taking more on board… and realising" – sharing house tasks with husband – (the sessions helped Abbey think, process, explore, clarify things in her mind).
The counselling helped Abbey "made me realise everything… realise what I couldn't see & I felt so weak – I just didn't know what to do and now I feel so much stronger".
Being able to talk to Penny allowed Abbey to release things that were making her feel weak → so she felt stronger and more confident.
Able to say, "Goodbye past – moving on!"
Penny asked Abbey to keep a sleep diary – the activities also helped.
Because Penny had a good therapeutic relationship with Abbey, she was able to explore issues Abbey hadn't been (wanting to) looking at – hitting partner in sleep "subconsciously". Still ups & downs but better.
Sessions with Penny allowed Abbey "getting over that fear, where I was holding back". Abbey felt "stronger" as a result of the counselling.
(Didn't say much specifically/directly about Jenny or their therapeutic relationship – it was more what she got out of the counselling sessions and her progress.)

“You have to work at a different pace” (LD counselling) – they “clicked, we sort of gelled.” Penny aware of the extra difficulties and factors working with LD – “there’s so many different levels of learning disabilities.” And issues with “awareness”/understanding.
Penny was keen to help the clients find their “core”, consider who they are and what they want – “rather than what other people think they should do, or say, or be…”
Penny hoped to help clients learn to express themselves – can be a new experience. The three core conditions in PCA were vital for Penny in developing the therapeutic relationship. Penny made effort to know and understand and support Abbey – which Abbey appreciated (the “encouragement”).
“She’s [Penny] done wonders. More relaxed and thinking a bit more.”
“With Penny, she is focused on Abbey and Abbey is focused on Penny”; “I think Penny’s done her the world of good.”
Kevin – “The rapport that Penny’s got with Abbey and Abbey’s got with Penny”
Kevin – “It’s somebody different ... different perspective …”
Kevin – “Abbey just relaxed – just relaxed…”

RESEARCH AIMS

3. WHAT FACTORS CAUSE:
a) DISEMPOWERMENT AMONGST THE LD POPULATION? &
b) WHAT HELPS TO BRING ABOUT FEELINGS OF EMPOWERMENT? (with particular focus on psychological therapeutic interventions)

Neil – a) Neighbours/locality/bullying
Boredom/unstructured time alone/lack of support/lack of understanding
Feelings of labelling, stigma, judgement by others/society (IQ score etc)
Lack of understanding of his PDA, OCD, etc
Not achieving/succeeding/performing well at school/college etc (due to LD, IQ, other problems)
Parents/carers not being “on board” or speaking to the person like an adult
Lack of understanding from others – family, carers, society…
Nan called him “special”/”special bungalow” – language insensitivity
Word “carer” or “support worker” → not liked by Neil.
Neil didn’t want to feel patronised or unequal – wanted to feel respected, valued, capable, equal, “normal”.
Attending a “special” school or college.

b) Lack of pressure or questions (three PDA) → understanding of his condition
Supportiveness, genuine interest, encouragement, consistency
Praise and recognition of achievements/progress
Encouragement of independence
Respect, value of him as a person; his interests, hopes, aspirations, abilities, future
Feeling appreciated, valued, treated like an adult
Sharing “banter”, laughter, conversation (not always “on topic”)
Sensitivity to person’s needs, flexibility, adaptability, willingness to try/understand
Educating/training others – carers, society, etc
Working alongside others, sharing supportive approach and info
Equality, fairness; more balanced power dynamics. Treating as an individual.
Genuine and friendly approach/support
Transparency to aid trust (and in communications/sharing info with others)

Sid – a) LD label/segregation and treatment by others – judgements, bullying.
Special school/stigma – lack of opportunities/encouragement
Financial and economic difficulties (no spare money to spend) – impact on social life and lifestyle, limiting what he can do.
Lack of paid employment – feels unequal/unworthy.
Lack of support – unable to see his daughter/didn’t know how to be a better dad.
Past events, circumstances, family background – making him feel worse/causing limitations.
Unable to read/write.
Limited social networks and opportunities.
Social constraints.
Frustration about things that can’t be changed/the past.
Lack of GP understanding/interest or concern/LD awareness.

b) Feeling of contribution to the community – via work (voluntary placement).
Feeling accepted, valued, respected in work place/socially.
Doing things – e.g. new hobbies/activities (Ju-Jitsu) and setting goals/motivation.
Achieving things – e.g. chainsaw qualification (pride).
Making improvements in life – e.g. reunited with daughter.
Improved mood/self-esteem/value/confidence/energy – so more able to do things.
Being listened to/heard/appreciated – helps mood/psychological well-being.

Chance to talk/”offload”, explore past events and impacts on rest of life/activities.
Opportunity to process thoughts, feelings, make sense of things/life/events.
Focus on shifting negative thought patterns to more positive ones – impacts whole life.
Therapeutic relationship was valuable and facilitated change for Sid.
Being able to make choices and have control in life (therapeutic relationship can introduce/include these).
Helping clients understand there isn’t a fault in them (e.g. living circumstances not their fault).
Helps to maintain resilience (encouraged in the positive therapeutic relationship).
Work can bring about a sense of self-worth (or factor in it).
Effective staff/professionals etc – skills, interested, sensitive, aware (LD etc) knowledgeable.

Jacky – a) Family circumstances/social background – limitations and strong impacts/effects.
Financial difficulties of family impacting on Jacky (leaning on her for money).
Past difficulties and restrictions affect confidence, assertiveness and ability to say no.
Training/quality of locum support staff? – Some were nosey and not very caring/capable.
Lifestyle and health habits/learnt behaviour from social group?
(Impacting on physical health, energy, experience of exercise/healthy behaviours).
Lack of awareness of others/society (people staring on bus etc).
Lack of protection from family as a child – from abuse.
Lack of value/respect from family (as child/adult).
Too little or too much control from others over their life (Jacky’s family).
Barriers including difficulty putting assertiveness into practice.

b) Encouraging safe, private, confidential self-exploration, talking and disclosing.
Releasing past traumas, tensions, negative memories, behaviours.
Encouraging new ways of thinking and relating (therapeutic positive relationship – could be new experience).
Trust, rapport, feeling safe. Feeling valued and appreciated as a person/human being.
Kindness, consistency (long-term work, flexibility of sessions).
Appropriate MDT working/referrals when needed/jointly requested.
Joint work between Nichole and Malcolm – safe sharing info, extra exploration and solutions.
Allowing Jacky to feel more choice/control in her life.
Feeling able to trust the therapeutic/support worker.
Even tearfulness and emotions shared. Jacky was expressing herself and trusted Nichole and Malcolm.

Edward – a) Workplace bullying/institutional abuse made Edward feel disempowered and traumatised. “They basically treated him like he wasn’t capable of doing the job he was doing”/”hollow empty threats”.
Family dynamics/difficulties/problems and taking things out on his parents in the past – he felt guilty about.
Edward still finds it difficult/uncomfortable talking about X Hospital.
When at work (factory) Edward wasn’t respected or valued – he felt those in “more powerful positions” “rubbed it in”.
He didn’t feel supported at work (threats to return to the “disabled area”).
– “They said “well, if you can’t keep up, we’ll put you back in the disabled area””.
Edward financially exploited at work either “I was not getting… the right amount of money… I was on less pay than the others… But I was doing a better job than they were.”
Felt intimidated – “I can’t talk about the union, cos one talk about the union and

your sacked, really…”.
Edward needed support as couldn’t fight back/overcome it on his own.
Edward felt some counsellors “didn’t understand me” → also disempowering?
Bullying affected Edward’s confidence and self-esteem.
Edward was too proud to claim benefits or get a mobility scooter at first (own pride).
Tim mentioned segregation, labelling, discrimination.
Also ↑ physical health issues amongst LD population (Tim mentioned Edward’s physical pain/mobility issues) (in PWLD generally and mentioned by Tim).

b) Edward felt empowered by feeling heard, listened to, being able to trust Tim (and divulge info to him he’d previously kept to himself).
Feeling safe/a safe space was helpful for Edward.
Edward said Tim had been helpful and was a “good friend”.
Feeling supported – a good support team around him.
Edward chose his parents to share the sessions – he wanted all his carers involved together.
Edward felt proud about his work/jobs.
(e.g. being a Brewster, doing designs, knowing about good/bad coffee, doing courses).
He was proud of his flat and glad his support workers helped him.
Edward’s church involvement and charity trip to Africa seems enjoyable/ empowering to him.
Knowing Tim has been/is there for him and over a long period of time helpful to Edward.
It seems a relief for Edward to have the support and therapeutic help (improved mood, more stable, better communication with others, etc).
Tim helped Edward improve his self-esteem and confidence.
Caused him to develop better relationships and communication in others.
(Now “able to have a say in his life, to steer his own boat”).
Helped Edward develop confidence to be “self-governing and speak up for what’s right and wrong”.
Edward now looking forward to the future and taking an active part in his life, decision-making etc.
Everyone appreciating Edward.

Abbey – a) Cognitive/processing difficulties – memory, speed of processing (Abbey was forgetful at home, had struggled with doing domestic tasks).
Lack of confidence due to LD and past experiences/less used to being independent. (Abbey had lacked confidence travelling alone independently on buses, attending appointments on her own or going out alone).
Bad past relationships had affected Abbey’s confidence and current relationship (more likely in LD population – as is abuse, bullying, control and violence).
? Less self-awareness therefore less progress and more confusion?
Abbey had mild speech impediment.
Other people’s views about what they (LD person) should do.
Others controlling their lives – can make them lose sight of what they want.
Lose practice expressing wants/needs.
Penny felt the lack of three care conditions by others could be disempowering.
Lack of opportunity to try things out for themselves (“where’s you in all this?”)
Controlling relationships and carers disempowering.
Kevin – “the others [counsellors from LD] sort of like patronising – Penny’s not”.

b) Being able to talk, offload, feel heard and listened to helped Abbey.
Regular sessions with Penny were supportive for Abbey.
Chance to work through past traumas, memories, think about them, process, explore, establish new goals, consider who she is.
Opportunity to release and let go/freeing, reducing stress) – moving on from the past.
Checking things out with another person.

Abbey felt stronger due to being able to leave past behind and have her feelings validated.
Talking to Penny made Abbey feel more confident in herself.
Practical tasks, homework activities and goals set by Penny helped Abbey (focused on exploring/achieving and completing independently of Penny).
Exploring alternative ways of being more effective strategies – together.
Being encouraged to try out new things and find out who they are.
What do they like or dislike? What do they want to do – chance to explore these.
Support to “go for it!”
Talking/educating about people’s human rights (Abbey investigated her legal/civil rights).
Encouragement to be independent, risk doing things alone (park etc).
Kevin – helped show Abbey how to use kitchen knives and utensils – ↑ independence.

EXPLORATION OF INITIAL RESEARCH QUESTIONS:

1. **IN WHAT WAYS DO PWLD EXPERIENCE EMPOWERMENT FROM PSYCHOLOGICAL THERAPY AND THE THERAPEUTIC RELATIONSHIP, WITHIN THE NHS?**

2. i) HOW DO PSYCHOLOGICAL THERAPISTS AND THE CARERS/SUPPORT WORKERS OF PWLD ENABLE CLIENTS WITH LD's TO EXPERIENCE EMPOWERMENT FROM THE PSYCHOLOGICAL THERAPY RECEIVED WITHIN THE NHS?

2. ii) DOES CHOICE OF THERAPEUTIC APPROACHES AND METHODS INFLUENCE OR FACILITATE POSITIVE OUTCOMES AND EMPOWERMENT IN PWLD?

RESEARCH QUESTIONS:

1. IN WHAT WAYS DO PWLD EXPERIENCE EMPOWERMENT FROM PSYCHOLOGICAL THERAPY AND THE THERAPEUTIC RELATIONSHIP, WITHIN THE NHS?

Neil – More independent (own flat and able to look after – with “nagging”!).
More confident, mature (as counsellor and support worker reported).
Less depressed (now only “pissed off” with “life in general”).
Getting out more/accessing community → successful, via counselling and support worker.
Better relationships with others and improvements within family.
Enjoying the conversations and company (initially suspicious or anxious) – more trusting and relaxed.
Support from others/team working consistently, positive approach.
Practice in communicating (more effectively) with others – improving skills and confidence.
NHS provides the opportunities, people, support, expertise to help and empower people.
Sharing info/supporting and helping families and – unclear – not just the client can have a beneficial impact on whole communities
“The one thing we to try to do in unclear is to help people move on with their lives and feel happier.”
Educating.
Feeling the determination, patience, commitment, genuine wish/desire to help – very positive.
New experiences of positive relationships, new ideas, time just for them – to explore, grow, share.
Enjoyed.

Sid – Improved mood and unclear well-being (self-esteem, confidence, less reserved).
Doing more things; more active; new plans, goals, targets (e.g. ju-jitsu).
Achieving things (e.g. passing chainsaw course) therefore feeling better – positive cycle!
Feeling valued, respected, heard, listened to, important, encouraged.
Opportunity to contribute to community fire work placement and support worker (increasing skills, ability, employability?).
Felt heard, listened to, his experiences were validated and not judged.
Shared experience and discussion – “we are all strange creatures!”
Talk about what it is to be human – sharing, inclusive, enjoyable and rewarding.
Choice and control facilitated/experienced through the therapeutic relationship.
Eve helped Sid he wasn’t his depression and it wasn’t his fault (partly due to his life experiences).
Helped lift the judgement, guilt, blame, self-criticism off him – lightening for him.
Supporting self-acceptance, greater peace, ease and starting to feel better about himself.
Eve didn’t rush Sid. She followed him at his pace (allowed him to take his time and be himself).
Found Eve easy to talk to, felt put at ease.
Felt appreciated and valued.

Jacky – Leaving/resolving past traumatic memories – developing a more positive present and future.
Hope. Optimism. Possibilities. New ideas.
Feeling heard, believed, listened to, valued, appreciated.
Experiencing lack of judgement/constraints/criticism.
Feeling safe to be her and freer to walk about in community.

Developing confidence to go to shops/clinic alone/independently.
Practising/learning/considering new behaviours and ways of being.
Learning positive self-help skills (relaxation exercises etc). Didn't do much but light something!
Access to MDT team, NHS resources, other help, adult care.
Support to learn better coping strategies and referrals were difficult times.
A support network Jacky can trust at times of need – giving greater ease, confidence.
Jacky now less likely to take tablets/feel like ending things, as a result of the MDT support and therapy she has received (and still available).
Learning to trust people – "it was probably a fairly new experience".
Now "she can manage situations as they arise" (Nichole thought it important to (give them [LD clients] some sort of control over what they do or how they feel").
Help with travel practising training and becoming more independent.
Tears and emotion = visible signs of release (and trust re Malcolm)
"She's more outcoming with all the information", more confident. "She goes on the bus herself now, by herself, nobody has to be with her" (is this true?)

Edward – Felt more relaxed, more balanced/stable mood and emotions.
Fewer behavioural outbursts – as he felt supported, cared about, heard, listened to, believed/valued and respected as a person.
Calmer and more capable.
Better at communicating his feelings to others and interacting with others in the community (e.g. church); better relationships.
Most of all Edward enjoyed talking with Tim and felt understood.
Specialist LD counselling or non-judgemental therapist = essential for Edwards.
Increased self-esteem and confidence – able to speak up more for himself and make decisions about his own life ("steer his own boat").
Now able to have better relationships and be "totally self-governing".
Edward benefited from feeling supported by Tim and his support team. Now able to look forward to the future.
During the time of therapy, Edward "comes from being a very poorly man into a relatively healthy man, who is able to have a say in his life."
The empowering effects spread to Edward's family/parents and staff all benefited (parents now have a holiday home – "it's freed them up" – not constantly worrying about him now).
"It must feel nice for Edward though, occasionally to know, that any time he wants, there's five people that is always gonna answer the phone to him and [are] hung on every word – his mum and dad and Tim and me and N" – Ray.
Improvements in Edward are visible in his face colour and body language to support workers who know him well – they work well together. Reassuring for Edward.
"And afterwards will say – it went all right, didn't it?" And have another discussion ourselves about how it was, so that's good and it keeps us all in the know" – Ray.
"Tim – never judges – you can tell him anything in the world and he never judges Edward, and that's a very good thing as well. Because that makes Edward speak out more about his problems" – Ray.
"When we're in this environment where we are all in the same room, Tim will get it out of him – that's it then – it could blow up, but it'll be resolved, no matter what – we won't leave the room until it is" – Ray.
Dedication from Ray and Tim → appreciated (and helpful) for Edward.

Abbey – By the opportunity to talk and work through past events and leave them behind, Abbey became stronger, freer ("it made me release everything") and more independent.
Abbey embraced the chance to explore and work through her emotions, behaviour and past.
Abbey felt supported by Penny, it helped her feel stronger, think through

things/more clearly and make decisions more independently.
Abbey was more effective at home, more able to think about and get on with domestic tasks, sometimes travelling independently on the bus to her appointments – learning she didn't need to lean on Kevin her husband all the time – more autonomous.
Some new experiences, ways of being and thinking – all empowering. Abbey mentioned her and Kevin had both benefited.
Abbey felt Penny's "encouragement" and support – to explore, think, be, find out about herself, what she wanted or could try out.
Empowerment was important to Penny due to her background (ethnic minority) so her interest and determination to "go for it" were used in the therapy.
Penny was encouraging Abbey "to go out and do things for herself, because I feel one can be quite confined to the home" (Abbey was thinking of going to the park and the gym).
Supports to explore new ways of being and relating/communicating in her relationship – being more assertive (rather than exploiting and losing her temper).
Penny was a bit like Abbey's cheerleader.
Penny was keen to use the PCA three core conditions to help Abbey find empowerment and make progress in her life.
Penny provided space for Abbey – "I tend to sort of sit back and see where she's going"; "I thought "OK, take it away – it's your hair"".
"Mindful that I'm only taking a few steps behind" – sharing the journey.
Penny's focused attention and mutual rapport – so Abbey felt understood?
Kevin – "basically, in a nutshell, talking to Penny" - (Most helpful for Abbey).
"Without somebody judging."

RESEARCH QUESTIONS

2. i) HOW DO PSYCHOLOGICAL THERAPISTS AND THE CARERS/SUPPORT WORKERS OF PWLD ENABLE CLIENTS WITH LDs TO EXPERIENCE EMPOWERMENT FROM THE PSYCHOLOGICAL THERAPY RECEIVED WITHIN THE NHS?

Neil – Stated the difference is how he now deals with life (life itself got harder).
Admitted the therapy had helped – “I suppose”.
Said no amount of counselling etc would change his neighbours or make them like him.
Patient, genuine, determined, calm, professional approach – as well as person-centred.
Provide an experience of acceptance, value, new, alternative ideas.
Commitment to help and support (positive role models).
Support for family, carers and others, as well as the client.
Providing training and education – new ideas and behaviours/strategies to try out.
Due to being a paid professional/helper – more objective and distance not available to family members.
Specific/set sessions – time to explore and support.
Willing to use humour, conversation. Trying to build rapport and trust.
Treating clients as an adult is important – with respect.
Trying to treat people as individuals, having personal value, whilst no “different” to anyone else.
Working alongside others – MDT teams as with families/carers and sharing info.
“The one thing we do try to do in psychology is to help people move on with their lives and feel happier.” “And more confident”.
Rise out of environment born into/living in → providing more opportunities, ideas and support.
Using reasonable adjustments, making extra effort, going the further mile.
Flexibility and adaptation (e.g. venue/time/session length/pace/sensitivity to client’s needs and personality.
Sense of humour, friendly approach (less threatening).
Promote equality, sharing, more balanced power dynamics.
Sensitivity of Neil’s needs, PDA, personality.
Sharing sessions and tasks – getting involved.

Sid – Support in terms of feeling valued, heard, listen to, appreciated (impacting upon mood and feelings of well-being).
Feeling an important part of society/community.
Enabling Sid to contribute to the community via work/skills.
Acceptance, lack of judgement/criticism.
Helping Sid to change his thinking patterns and therefore impact his life.
Allow time/space to talk; privacy and confidentiality.
Allowing Sid to process life events, explore past and his feelings.
Helping Sid to be nicer to himself, positive human experiences/relationships.
Free NHS service/support = essential (human right/consider government policies and decisions re-funding).
Helping readdress imbalance in society, most not his fault or of his making (power imbalance).
Helping address stigma, labels, LD experience/limitations – help overcome and transform.
Eve helped Sid understand “basically being kind to himself, finding a more helpful way of dealing with the difficulties that he was experiencing”.
Sharing the process, his journey, “making sure I was really there with him in the sessions”; “I was gauging the pace all the time”.
Eve also shared in the mindfulness exercises, using them herself too.
Eve adapted resources (Sid can’t read) – e.g. using a compassionate owl (Sid came

up with phrases he could use when being self-critical).
Lack of hierarchy at work placement/treat as equal; feel “normal”.
Value contribution and skills (to community).
Recognise talents – positive feedback/community care/praise.
Providing opportunities to work and mix with others and feel sense of self-worth.

Jacky – Reliability, consistency, safety, boundaries, clarity – re roles.
Allowing a safe space and regularity to release/offload and disclose private info.
Privacy, confidentiality, clear info protection sharing if appropriate.
Joint working can be very helpful and effective (Nichole and Malcolm discuss first).
Facilitation of MDT referrals, signposting, accessing other useful info and resources.
Professional guidelines, ethics, appropriate liaison in other professionals.
As positive role models, encouraging, motivating, supporting, being a nice person”.
Allowing client to grow, experiment in safe place.
Flexibility and provision of longer-term sessions on NHS = very helpful.
Consistency, trust and rapport = very important.
Nichole felt they were important as Jacky may not have experienced much before (“it was probably a fairly new experience” – someone she could trust).
Nichole allowed Jacky to work through a lot of negative memories and experiences. (“She got a lot of stuff out of me”) – using a range of methods and techniques (timeline work was very helpful and effective, Nichole also used EFT, NLP, relaxation processes – Jacky mentioned enjoying listening to a CD with a “man with sexy voice!”).
Upon developing rapport, trust and a good therapeutic relationship, Nichole was able to utilise, suggest and guide Jacky through a range of helpful processes.
Nichole used TA to explore effective roles, explored in a child/adult coping etc.
Nichole mentioned the need to be a little creative with LD work.
Because of the therapy, Jacky’s flashbacks and experiences of trauma started to dissipate (a success highlighted by Nichole – “overcoming some of the trauma was a high point therapeutically for me”).
Being OK with Jacky being tearful/unclear emotional release/expression.
Malcolm supported Nichole’s therapy and Jacky’s ongoing developments/progress.

Edward – Listening – not judging (respectful, valuing)
Being present – flexible, longer term sessions.
Enabling Edward to feel understood.
Providing the space for Edward to talk, offload, disclose new, very private info. – Allowing Edward to do so at his own pace and choice.
Continuity and trust – Edward said Tim was “a good friend”; supportive and caring about him. Genuine, earnest.
(Humanistic qualities of therapist? Therapy skills?)
Helping Edward feel more in control and calmer about his life and himself.
Showing an interest in Edward “he’s been interested in me and helpful”. “He’s keeping me on an even balance”; “I’m a better person to this day, thanks to him.”
Edward spoke about Tim “breaking into him (like an egg!).
Edward found the counselling “helpful” – able to process past events, reflect on them, himself, changes he wants to make, who he is now.
By encouraging and supporting Edward, Tim enabled his confidence and self-esteem to improve, to make more choices for himself, to speak up.
The improvements rippled out to family and carers also – positive circle.
Edward benefited knowing Tim and others were “walking in [his] footsteps” with him (sharing his journey and road in recovery – all being happy for him).
Regular reviews of the therapeutic relationship and earlier goals and plans.
Tim often checks “things out” and “how we both feel that the therapy is going” (part of the very “transparent” process Tim said was very important).
Appropriate, consensual sharing of information with other carers – to benefit Edward and his progress (Tim taking the lead – directing this at times).
Dedication, staying with Edward in room together until problem is solved.
Tim not judging Edward – “he sits there blank-faced. He never judges Edward… that makes Edward speak out more about his problems” – Ray. “You can tell the

difference when Tim’s been around, you know… It can start off a very hostile environment and nobody wants to really be in the room, but after 25 minutes, it can be a totally new page… It’s much better when he talks about it.”

Abbey – Space and time offered in the sessions – allowing Abbey to offload, talk, explore, discuss. She relished the opportunity and embraced the sessions with gusto.
Abbey acknowledged she’d received the most help from Penny and Kevin (“it’s mostly Kevin and Penny has helped me, with the encouragement”) – importance of feeling encouraged, allowed, valued, appreciated.
Penny allowed Abbey opportunity to talk and use the whole session as she liked.
Penny enabled Abbey to explore and clear the past (releasing).
Penny occasionally sets work/goals/practical activities – to help Abbey focus and continue the “work” without her (also empowering).
Penny was able to question the hitting out at Kevin at night and help Abbey to explore and acknowledge the behaviour – helpful for Abbey and Kevin (due to having built up/a good trusting therapeutic relationship with Abbey).
Penny used the PCA three care conditions to support and follow Abbey “because it’s her journey”.
Penny was keen for Abbey to “go get it”, to believe in herself.
Penny generally offered/gave Abbey the chair “it’s all yours” and “sort of sat back”.
Penny is aware of additional factors to LD clients and willing to work with them/help work around them.
Penny keen for Abbey to find herself and look beyond other people’s opinions.
Penny willing to sensitively challenge Abbey or Kevin (e.g. sleep aggression, Abbey’s LD and limitations).
Penny careful and caring to consider if the relationship built up enough to challenge.
Penny sharing the journey with her/”mindful I’m only taking a few steps behind”).
Sensitivity and care of/about emotions, carefully gauging the way.
Focused attention and rapport (observed by Kevin).
(Effort and understanding – helpful).

RESEARCH QUESTIONS

2. ii) DOES CHOICE OF THERAPEUTIC APPROACHES AND METHODS INFLUENCE OR FACILITATE POSITIVE OUTCOMES AND EMPOWERMENT IN PWLD?

1st Triad (PCA and TA – main approach)

– Janice was careful not to be directive or put pressure on Neil. Also advised other staff re PDA.
– Janice and Paul made it like things were Neil's idea.
– PCA seemed helpful, effective, less threatening, more gradual; comfortable, (or directive, forceful approach may have backfired, so PCA seemed appropriate here and sensitive.)
-Neil may have rebelled at CBT homework tasks/extra pressure?
-TA very helpful in exploring family dynamics, use of adult language, respect and valuing Neil as an equal.
-Short-term blocks of therapy/time-limited sessions would not have worked! Financial and practical implications.
-Need for flexibility, adaptability and use of reasonable adjustments (this itself fits in with PCA).

2nd Triad (CFT – main approach; some homework tasks, relaxation)

– CFT was very suitable and appropriate for Sid/well chosen by Eve (time of use in LD client) experimental.
– Helpful in addressing Sid's self-critical stance and negative thinking.
– Helped Sid feel valued, excepted, OK with himself – perhaps a new experience?
– Enabled/allowed him to make lots of changes as he felt better (mood/activities/achievements).
– The therapeutic relationship was crucial. Equality as humans. Acceptance equals fine critical.
– Eve's lack of judgement, sensitivity and support was very helpful and empowering for Sid. Support worker not really involved but was also supportive and at work placement.
– CFT was very respectful and very clearly linked to the importance of therapeutic relationship.

3rd Triad (Mixture; Humanistic counselling, CBT, NLP, Timeline, EFT, TA, Relaxation)

– Nichole outlines the complex nature of Jacky's case and varied elements involved.
– Timeline very suitable, Jacky responded to this well and both used it successfully together.
– Initial relationship – building, trust and rapport was essential for future building/say foundation.
– Most important to Jacky was being able to trust Nichole and Malcolm and feeling safe to make disclosures.
– This was key for Jacky and enabled her to trust and work with/engage well in with Malcolm also – a male – so another new positive experience.
– Would Jacky have minded using another approach?
– Important that Nichole spent time with Jacky, was flexible, reviewed things, made adaptations and explained things clearly.
– Jacky didn't respond so well to some homework/needed support and focused attention.
– Once trust and rapport were gained, Nichole was in a position to suggest and utilise helpful strategies and other approaches and processes.

4th Triad (Mixture; Humanistic, Gestalt, TA, exploration of dreams)

– Edward appreciated talking and Tim being there consistently, supportively – more than any non-LD counsellor.
– Edward spoke about Tim "getting it out" of him (like delving, mining, surgery – skill required and sensitivity).
– It was crucial Edward could trust Tim (and then disclose things not before disclosed), supported and understood.
– Being able to talk and offload, process is passed = essential.
– Previous counsellors weren't as good – "they didn't understand me" therefore specialist LD therapist = important?

– TR being there was most important (more important than any process/therapeutic approach?) – Or did Tim's skills enable Edward to talk and heal, without him knowing how? Definitely guiding, following, supporting, non-obtrusively and non-judgemental approach.
– Once Tim has built up the therapeutic relationship sufficiently, he could challenge/more directive.
– TA helped self-awareness and examine roles/ways of behaving and being an adult.

5th Triad (PCA = main approach; some goals/targets; some tasks/diary)

– Abbey relished being able to express herself verbally and talk/offload to Penny. The talking and listening element was the most important to/for Abbey.
– Abbey mentions the sleep diary (suggested by Penny) – hence could query was Penny 100% PCA/nondirective? But Abbey liked this, and it was helpful – facilitating positive outcomes.
-Penny had a clear PC approach, gently following Abbey and providing the space/boundaries to explore the issues she so eagerly wanted to talk about. It was important for Abbey to be able to talk and express herself.
-She wanted to change, make progress, leave the past behind – Penny's approach allowed this completely and supported/acknowledged Abbey's LD and difficulties. It was carefully pitched at the right level.
– Penny was passionate about being loyal to the PCA and using the three core conditions to help create change.
Therapeutic relationship was core and the main vehicle for the therapy/progress.