

**SIGNIFICANT THERAPY EVENTS:  
AN INTERPRETATIVE PHENOMENOLOGICAL  
ANALYSIS OF PSYCHOTHERAPY WITH CLIENTS WITH  
INTELLECTUAL DISABILITIES**

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of the West of England, Bristol for the Award of Professional Doctorate in  
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Part 1 Thesis

**SIGNIFICANT THERAPY EVENTS:  
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## 1. Abstract

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**Background:** Gradually, over the years, the type of treatments provided to clients with intellectual disabilities (IDs) has changed, with increasing access to different types of psychotherapy. Given the high prevalence of mental health difficulties of people with IDs, it is key to explore how to make psychotherapy more effective for this client group. There is a growing evidence base of studies investigating the use of psychotherapies for people with IDs, with the level of evidence varying from case studies for less established studies, to small scale randomised controlled trials (RCTs). However, most studies have focused on adapting interventions, and efficacy, rather than exploring the process of psychotherapy, which is in stark contrast to the literature on non-ID populations. Exploring significant events in therapy provides opportunities to gain insight into the therapeutic process; using a video recording of the session to prompt participants' memory of the session enables such insights to be explored. Research exploring significant therapy events involving clients without IDs has shown there to be a link between significant events in therapy and positive therapy outcomes. However, to date, no significant therapy events research could be found involving clients with IDs.

**Aims:** To examine client-identified significant events in psychotherapy and to explore the lived experience of psychotherapy with clients with IDs.

**Methods:** Four therapy dyads of adults with IDs and their therapists were recruited. Semi-structured interviews focused on helpful events in psychotherapy, using videos of particular sessions as a stimulus to help prompt participant recall of that session. A modified version of interpretative phenomenological analysis was used to identify emerging themes.

**Results:** Five super-ordinate themes were identified that related to the research questions. The first four themes described the process leading up to and surrounding the significant therapy events, comprising of: 1) The Uniqueness of the Therapeutic

Relationship; 2) Using Adaptations to Express Emotions; 3) Client Behaviour/Therapist Behaviour; and 4) Hope and Paternalism. The final theme: 5) Meaning Making, depicted how clients and therapists made sense of the identified significant therapy event.

**Implications for counselling psychology:** This study highlights the need for therapists to work in such a way as to facilitate significant events in therapy with their clients through building a strong therapeutic relationship, making appropriate adaptations to ensure their clients can express themselves, being mindful about instilling hope, and adopting a client-led approach. It may be helpful to have more flexibility within therapeutic contracts to enable clients with IDs to have more sessions in order for a strong therapeutic relationship to be built, as well as providing the space for a client-led approach to foster client independence and moments of insight. Furthermore, therapists could use supervision to reflect on balancing empathising, protecting and helping in order to promote the process of empowerment. Indeed, the use of video-recording sessions could be helpful, not only for therapists to reflect on their practice during supervision, but also as a means of training therapists, working in mainstream psychotherapeutic services, to be able to confidently work with clients with IDs. In addition, the research makes an important contribution by demonstrating the feasibility and importance of undertaking process research with clients with IDs in order to explore the process of change.

**Conclusion:** This is the first known study to move the ID research field forward into exploring the process of therapy for clients with IDs rather than utilising the well-rehearsed case study and outcome research methodologies. The current findings suggest that clients with IDs do experience significant therapy events. Furthermore, the research enabled insights to be gained about the process of therapy for this client group and for exploration of therapeutic factors that may be involved in facilitating a significant therapy event. The findings highlight areas where further research is required.

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## 2. LITERATURE REVIEW

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This review will explore the literature pertaining to people with intellectual disabilities, the therapeutic relationship, and significant therapy events. It will begin by defining the term 'intellectual disabilities' and provide a historical context to the development of psychotherapy for people with intellectual disabilities. Research has evidenced the importance of the therapeutic relationship for many psychological approaches and shows it is key for a successful therapy outcome. Given the importance of the therapeutic relationship for all therapy, including therapy with people with intellectual disabilities, this review will then move on to defining the term 'therapeutic relationship', and go on to explore research in this area from both the therapist and client perspectives. One of the ways in which researchers have attempted to gain insight into the change process that occurs in psychotherapy, is to explore significant therapy events; indeed, this has often revealed a focus on building a therapeutic relationship. Therefore, this review will conclude by defining the term 'significant therapy events', and provide an exploration of significant therapy events research.

### 2.1 Defining intellectual disabilities

According to the UK Equality Act 2010, people are defined as disabled if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. Over the past century, considerable change has taken place with regard to the terms used to refer to people with intellectual disabilities. Throughout this review, the term 'Intellectual disabilities' (IDs) will be used; it is widely used in the international scientific community as the term of choice (Harris, 2005) and prevents misunderstandings arising from the use of terms with different definitions in different regions, countries or cultures. There are two core aspects to the term, ID: Firstly, it involves "...a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence) ...(and) a reduced ability to cope independently (impaired social functioning) ..." (Department of Health, 2001, p.14). Secondly, the deficit in intelligence and social functioning "...begins before

adulthood, with a lasting effect on development” (Department of Health, 2001, p.14); this is key in differentiating between people with IDs and people affected by cognitive deficits gained later in life, such as those related to acquired brain injuries and dementias.

## **2.2 Development of psychotherapy for people with intellectual disabilities**

People with a disability face a number of challenges, such as the physical or organic aspects of disability, attitudes from society, and self-stigmatisation (Becket & Taylor, 2016). Furthermore, the Learning Disabilities Mortality Review Annual Report (University of Bristol Norah Fry Centre for Disability Studies, 2018), identified the persistence of health inequalities in relation to people with IDs, highlighting the need for further action in order to meet the health needs of this client group. Additionally, people with IDs experiencing mental health difficulties have historically been excluded from psychotherapies due to their degree of intellectual impairment (Bender, 1993). However, Sinason (1992) made a distinction between cognitive and emotional intelligence, and described how it is possible for an individual’s emotional intelligence to develop age appropriately, whilst having severe deficits in cognitive intelligence. Furthermore, research has shown that individuals with IDs can recognise and experience emotions in a similar way to the non-ID population (Bermejo, Mateos & Sanchez-Mateos, 2014); this indeed suggests that this client group has the ability to gain insight and develop self-awareness, factors that contribute to therapeutic change (Lacewing, 2014). Thus, it is important to not assume that individuals with intellectual impairment do not have the capabilities to engage effectively in psychotherapy (Department of Health, 2001); indeed, they have the right to access psychological therapies (Department of Health, 2015). Furthermore, with the legislative developments that have occurred over the past twenty years (Disability Discrimination Act, 1995; Human Rights Act, 1998; Equality Act, 2010), it is vital that psychotherapeutic services respond by increasing their level of inclusivity to this marginalised group.

It is estimated that between 25 and 40% of people with IDs experience mental health difficulties (The Foundation for People with Learning Disabilities, 2013). Indeed, mental health and emotional difficulties are more prevalent in this client group (Smiley, 2005;

HM Government, 2011). In addition, research suggests that people with IDs may be at greater risk of developing mental health difficulties (Borthwick-Duffy, 1994). An 'increased risk' hypothesis has been proposed due to a higher prevalence of the psychological, biological and social risk factors thought to contribute to mental health difficulties that have been found in this client group (Prosser, 1999). These risk factors include for example, genetic conditions, neurological damage, abuse, poor social skills, lack of social support, moving residence, serious illness or bereavement of a close relative or friend, unemployment and relationship difficulties (Prosser, 1999; Hastings *et al*, 2004). Furthermore, the sense of feeling like an outsider can be thought of as a risk factor; the continuum of 'belonging' (Wilson, 2006) stretches from full membership of the majority group to being an outsider. Most reactions to disability can be thought of as being linked to fear and anxiety within the minority-majority relationship (Wilson, 2006). Indeed, Gilmore and Cuskelly (2014) argue that people with IDs are highly vulnerable to loneliness, and reason that the experience of loneliness is likely to compound mental health problems already associated with ID. There is therefore great need for offering psychological therapies to this client group.

Since the publication of the psychotherapy and learning disability report (Royal College of Psychiatrists Council, 2004), the evidence base has steadily grown, and whilst substantial case study evidence exists for a number of psychotherapeutic approaches, and some randomised clinical trials (RCTs) are beginning to emerge, process research is lacking. Throughout this piece of research, the focus is on individual psychotherapy, and psychotherapy has been taken to refer to all psychological approaches as follows.

Psychodynamic therapy addresses the unconscious content of a client's psyche. By helping clients become aware and bring unconscious feelings into their consciousness, the aim is to alleviate psychological tension. Newman and Beail (2010) found that through looking at the transcripts of psychotherapy sessions with a case series of eight adults with IDs, a range of defence mechanisms were used, suggesting that psychotherapy with this client group is not so dissimilar to psychotherapy with people without IDs; however, in addition, the clients in the study were found to have particular defensive styles, such as, the defence of affiliation containing qualities of dependency and

insecurity. This suggests a possible risk of dependency and increased insecurity after the end of therapy. However, due to the study looking only at sessions one, four and eight, it was not possible to see if change in defences occurs during psychotherapy, or indeed, how the end of therapy is managed for clients who have this defensive style. There are also a number of studies evidencing positive treatment outcomes for people with IDs engaging in psychotherapy. In a study by Beail *et al* (2005), a number of different outcome measures were used to measure the effectiveness of psychodynamic psychotherapy for 20 clients with IDs. Whilst the authors describe some modifications that were necessary to the outcome measures, in terms of minor changes to the wording to be used with people with IDs, they described no modifications to the psychodynamic therapy itself. The results of the study suggest that psychodynamic psychotherapy can significantly reduce psychological distress, as well as improve interpersonal functioning and self-esteem in clients with IDs. However, in a review of the evidence, Beail (2016) found no RCTs; only one further controlled trial conducted by Birchard *et al.* (1996) was identified in which a significant increase in emotional development in the therapy group compared to the control group was found. Skelly *et al.* (2018) conducted an open trial of psychodynamic psychotherapy in which treatment fidelity was checked and cases excluded as appropriate. They found clients did not improve while waiting for therapy and significantly improved while attending therapy; large pre-post effect sizes were reported, and improvements were maintained at six-month follow-up.

Another psychotherapeutic approach adapted for clients with IDs is cognitive behaviour therapy (CBT). CBT aims to help clients manage overwhelming problems by changing the way they think and behave in order to improve their mood (Beck, 2011). A growing number of case studies exist evidencing positive improvements for clients engaging in CBT (Wright, 2013). Willner and Goodey (2006) for example, describe adaptations used in cognitive behavioural treatment of obsessive-compulsive behaviours in a woman with IDs; simple words and short sentences were used, as well as offering more sessions to the client. Adaptations to the cognitive behavioural therapy (CBT) approach were also made, including, constructing a timeline to support the client with the sequencing of events in her lifetime. After of a total of 20 sessions, the client had achieved all of her therapy goals, and had acquired a repertoire of adaptive thoughts that she was able to use in a

range of previously difficult situations (Willner & Goodey, 2006). Furthermore, controlled treatment trials evaluating CBT have found positive outcomes. In a study by McGillivray, McCabe and Kershaw (2008), clients with IDs experiencing depression engaged in CBT; compared to a wait list control, individuals who had attended CBT showed lower depression scores and fewer automatic negative thoughts. Similarly, Lindsay *et al* (2015) conducted a controlled treatment trial with clients engaging in CBT compared to a waiting list control group. Following completion of therapy sessions, clients significantly improved, compared to the control group, on measures of depression. In a review of the available evidence for RCTs, Jahoda (2016) found only one, which was conducted by Willner *et al.* (2013). They conducted a cluster randomised controlled trial investigating CBT therapy for people with IDs experiencing difficulties managing anger. Participants were 179 clients with IDs, who were assigned to either CBT or treatment as usual. However, a self-report measure of anger, based on personally salient triggers, showed no reduction in scores of self-reported anger.

Cognitive analytic therapy (CAT) involves clients exploring the underlying causes of their current difficulties. In doing so patterns of relating to others are identified, enabling the client to move forward by discovering ways of doing things differently. In a review of the evidence base, Beard *et al.* (2016) found over 25 published papers predominantly made up of either case studies or reflective essays. Very few of these papers reported outcome data and none contained pre-post data; however, some did report evidence of client change in revising relational patterns (Wills & Smith, 2010).

Mindfulness and acceptance-based therapies, draw upon meditation and Buddhism. Rather than attempting to change particular thoughts or behaviours, the aim is for clients to change how they experience the world by bringing their awareness to the present moment through being curious and non-judging. In a review of the evidence, Gore and Hastings (2016) found, in addition to case studies, one RCT in which clients were randomised to either meditation intervention or to a waiting list control group (Singh *et al.*, 2013). The authors found that physical and verbal aggression reduced to zero levels at six-month follow-up, with a large effect size reported; although this shows encouraging data, this was conducted at feasibility level, with further research required.

Dialectical behaviour therapy (DBT) provides support for clients who experience intense emotions in certain situations. DBT involves supporting the client to identify and build upon their strengths, as well as learning different ways of thinking. Lippold (2016) reviewed the evidence base and found case studies, with some reporting on outcome data in which improvements were evidenced (Lew *et al.*, 2006). Studies reporting pre-post data are lacking. Morrissey and Ingamells (2011) report preliminary outcomes based on six clients who showed significant reductions in distress; however, the fidelity of the model is questionable with the impact of medication not being separated out.

Compassion focussed therapy (CFT) was developed for people experiencing complex mental health issues linked to shame and self-criticism. The aim of therapy is for the client to develop compassion for themselves, others, and to receive compassion from others in order for emotions associated with calming and wellbeing to be stimulated. Cooper and Frearson (2017) provide an example of adapting psychotherapy for a client with IDs. They described a case study of a client with IDs who engaged in adapted CFT. Little change was found between the client's pre and post therapy scores, however, the authors suggest this could be due to bias; the client's support worker was present during the completion of baseline measures and absent post therapy. The client may have found it difficult to rate certain questions high at baseline, resulting in an inaccurate comparison of these questions post therapy. A criticism of intervention studies is that they rarely explore which parts of therapy were most helpful. Through the use of a qualitative interview, the client described the helpful parts of therapy, such as learning about the 'kindself', discussing multiple selves, and understanding why he was experiencing difficult feelings. Based on these findings, the authors suggest that CFT can be successfully adapted for clients with IDs.

Furthermore, solution-focused brief therapy (SFBT), which involves maintaining a focus on achieving the client's vision of solutions has case study evidence available, with some reporting on outcomes (Rhodes, 2000); however, it is difficult to rule out other factors that may have contributed to reported improvements. Lloyd *et al.* (2016) found one published controlled trial in which a group of clients receiving six sessions of SFBT were compared to a control group receiving care as usual (Roeden *et al.*, 2014); intervention



fidelity was assessed, and cases were excluded as necessary. The SFBT group improved significantly compared to the control group, and improvements were maintained at six-week follow-up.

Thus, it is clear that such psychotherapies have been the focus of investigation, illustrating how they have been adapted in services for people with IDs. There is certainly a growing evidence base, and the level of evidence for psychotherapies varies from case studies for less established studies, to small scale RCTS. There are a few studies that demonstrate ineffectiveness, and the controlled studies that exist suggest that therapy is beneficial compared to waiting list and 'treatment as usual'. However, for many psychotherapy approaches, the evidence is preliminary, and further research spanning a range of designs is required rather than a reliance on case studies.

### **2.3 The therapeutic relationship**

The following sections on the therapeutic relationship illustrate the importance of the therapeutic relationship for many psychological approaches (for example, McDonald *et al*, 2003; Barber *et al*, 2009; Pert *et al*, 2013); indeed the therapeutic relationship is considered key for a successful therapy outcome (Horvath & Symonds, 1991). Given the importance of the therapeutic relationship for all therapy including therapy with people with IDs, it is an important area of research to consider and explore.

According to Rogers (1951), there are three essential aspects to the therapeutic relationship or alliance: empathy, congruence and unconditional positive regard (cited in Rogers, 2003). The therapeutic alliance refers to "...the degree to which the therapy dyad is engaged in collaborative, purposeful work" (Hatcher & Barends, 2006, p.293). Whilst the collaborative nature of the therapeutic relationship is certainly something that could be emphasised during psychotherapy with clients with IDs, it remains uncertain as to the extent to which clients with IDs would recognise or understand the expression of Rogers's (1951) core conditions. Although a study by Siegel (1972) described how children with IDs who received higher levels of the core conditions, made more insightful statements than children who received lower levels, there appears to be some inherent flaws in the

methodology. That is, it is unclear how raters were able to differentiate between low and high levels of communicated genuineness for example. Furthermore, the use of raters is also a rather biased way of measuring just how insightful a statement is when there is no understanding of the individual experience of that moment of insight; that can only be known by the individual making those types of statements.

As proposed by Horvath and Luborsky (1993), the conception of therapeutic alliance grew out of Freud's work on transference. In later publications, Freud changed from taking, what was considered, a negative stance on the subject of transference, to contemplating the development of a beneficial attachment between therapist and client (cited in Ardito & Rabellino, 2011). Bordin (1979) developed a theory of therapeutic alliance. According to Bordin, therapeutic alliance is underpinned by two foundations in the psychoanalytic literature:

One of these stems from such views as those of Sterba (1934) on the alliance between analyst and the rational ego of the patient, and of Menninger (1958) on the central importance of the therapeutic contract. The second draws among others, on Zetzel (1956) and especially on Greenson (1967) for the significance of the real relationship in psychoanalytic work. Fusing these contributions, we can speak of the working alliance as including three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds (Bordin, 1979, p.253).

Within this model, the alliance is initially formed through the therapist and client collaboratively agreeing on the goals for therapy. Together, they then identify the tasks that will enable the client to achieve their goals. This process of agreeing on goals and pledging a shared commitment to the tasks help to build the bond between therapist and client; this bond is based both on trust and the degree of liking for each other (Bordin, 1979). However, it is unlikely that the preceding theories on the therapeutic relationship considered the needs of clients with IDs, since psychotherapy with this client group was not considered to be effective or helpful until much later. Fairbairn (1952) proposed that all humans are primarily object seeking, and this central concept is not thought to be any different when thinking about clients with IDs. Indeed, several case studies have evidenced the usefulness of understanding a client and the issues with which they bring

to psychotherapy within an object-relations framework (Farmery, 2002; Wills, 2014). That being the case, it therefore seems plausible that clients with IDs would be just as motivated to work towards building a therapeutic relationship as clients without IDs, given that we are all object-seeking. Therefore, with regards to therapeutic relationship theory, Bordin's (1979) theory seems to provide a good fit when referring to the therapeutic relationship with clients with IDs, with its reference to the 'development of bonds', providing an apparent connection to an attachment and object-relations perspective, and the concreteness of the concepts, 'agreement on goals' and 'assignment of tasks'.

For many psychological approaches, the alliance between therapist and client is considered key to a successful treatment outcome (Horvath & Symonds, 1991); indeed, the alliance is considered fundamental in counselling psychology (BPS, 2012). In a paper by Jones and Donati (2009), the existing literature relating to the therapeutic relationship in psychotherapy for clients with ID, was explored. The authors note that although the therapeutic relationship is recognised as important in mainstream psychological literature, there is a lack of research on the therapeutic relationship in psychotherapy with clients with IDs. Jones and Donati (2009) found that most of the knowledge in this area is derived from anecdotal accounts from clinicians working in the field of IDs; their views indicate that building a therapeutic relationship with clients with IDs is complex but vital for clinicians to understand.

In a study by Besika, Collard and Coogan (2018), the attitudes of therapists, working in private practice, towards working therapeutically with clients with IDs were investigated. Participants were not required to have experience with clients with IDs, and were instead selected based on the type of approach they practiced within, including, integrative, humanistic, psychoanalytic, psychodynamic, and cognitive therapy. Using Q-Method, a sample of 23 private therapists were presented with a Q-sample, comprising a total of 180 statements gathered from 41 sources. Participants were instructed to rank the statements in order, from 'least agree' to 'mostly agree', based on how pertinent the statements were to their beliefs and values. The study identified four Q-factors that represented the current attitudes of the therapists: 1) therapists are responsible for the

effectiveness of their service; 2) IDs are a type of diversity; 3) lack of knowledge impacts on level of confidence; and 4) there is a need for therapists to undertake relevant training. The authors suggest that therapists working with clients with IDs hold positive attitudes towards this client population; furthermore, they believe that a therapeutic relationship can be built with clients with IDs.

## **2.4 Research on the experience of psychotherapy and the therapeutic relationship: therapist perspective**

Wampold (2015) provided an update of the research on the therapeutic relationship and psychotherapy outcome. Wampold (2015) concludes that decades of research have shown that the provision of therapy is dependent upon common factors, including an interpersonal process, and the therapeutic relationship forms the foundation of therapists' efforts to help their clients. In a study by Misdrahi *et al* (2009), 92 participants meeting criteria for schizophrenia and schizoaffective disorders completed a self-report scale measuring therapeutic relationship. The results of the study showed that the therapeutic relationship can be considered a prerequisite for positive treatment outcome. Furthermore, Barber *et al* (2009) examined the correlations between therapeutic relationship, outcome, and symptom improvement in a cohort of clients experiencing anxiety or depression engaging in a time-limited form of psychodynamic therapy. The findings suggest that although the therapeutic relationship may be influenced by a client's improvement in symptoms, the therapeutic relationship continues to be a significant predictor of subsequent improvement in clients' mood, even when prior improvement in mood is partialled out.

More recently, qualitative research has been employed to explore the therapeutic relationship. In a study by Ryan, Guerin and McEvoy (2016), 91 staff from palliative care and ID services participated in focus groups. The authors found that staff valued their relationships with clients and spoke about how the quality of their relationship seemed to affect therapeutic outcomes. Staff also explored factors they considered fundamental to developing a strong relationship, including trust, continuity of relationship, and

importance of knowing the individual. In contrast, an inability to form an authentic relationship was found to affect the quality of care.

Research has also focussed on interviewing staff on their experience of the therapeutic relationship with clients with an ID. Jones (2013) explored the experiences of counselling psychologists of the nature and role of the therapeutic relationship when working with individuals with an ID. Using interpretative phenomenological analysis (IPA), the study identified the therapeutic relationship as fundamental in providing psychological therapy to individuals with an ID. The study also provides useful insights into some of the practical things that therapists can do to foster a therapeutic relationship whereby the client is better able to trust the therapist by, for example, offering refreshments and using humour. This suggests that the therapeutic relationship may be different with this client group; whilst there is research to suggest that therapist warmth predicts positive outcome (Morris & Suckerman, 1974; Ryan & Moses, 1979), it could be that clients with IDs are more receptive to concrete displays of therapist warmth, such as offering refreshments, and such insight is valuable to bear in mind when working therapeutically with this client group. However, the study by Jones (2013) provided little information on the experience of the deep connectivity between client and therapist, significant points in the relationship, and how the relationship progresses; this may be as a result of asking the participants questions about their work in general with individuals with an ID rather than asking for them to focus on a particular experience between themselves and a client. Furthermore, this research undoubtedly offers a biased perspective since the therapist's is only one perspective and it is unclear what makes them privileged in offering such insight into the psychotherapy process; indeed, the therapists in the research may not have been deeply reflecting on the process of psychotherapy, but rather, their reflections may simply be based on the training they have received, and they may therefore be looking through a particular therapeutic lens.

As part of the researcher's second year research project, therapists were interviewed about their experiences of the therapeutic relationship with clients with IDs (Wills, 2015). By asking participants to focus on specific experiences, this research found seven main themes consisting of: 'Client and nature of diagnosis'; 'Adaptations'; 'Therapist

uncertainty and acceptance'; 'Therapy as challenging'; 'Therapist motivations'; 'Focus on the relationship'; and 'Therapist preparedness'. The study provided insightful accounts as to how the therapeutic relationship is built with this client group, and acknowledges, that whilst this may take time, it is important in order for any meaningful work to be done in the sessions. The study also provided suggestions as to the type of adaptations that may need to be made to therapy, such as providing more sessions and using more practical tools within sessions. Of most relevance, was the sub-theme entitled, 'a significant point in the therapy', which was described as lightbulb moments for clients, suggesting the point at which the therapeutic relationship had been built. Whilst this gives some suggestion that clients may indeed experience such moments of insight during the therapy process, the main limitation of this type of research is that it focuses solely on the therapists' perspective; indeed, it could be that this is the way in which therapists try to make sense of what is going on through their own interpretation.

## **2.5 Research on the experience of psychotherapy and the therapeutic relationship: client perspective**

There has however, been some research exploring the client's perspective. McDonald *et al* (2003) explored the experiences of clients with IDs attending group psychotherapy. Clients were asked about their experiences of therapy, as well as any positive or negative aspects of the sessions, using a semi-structured interview. Three super-ordinate positive themes and four super-ordinate negative themes were identified using IPA. Positive aspects included clients feeling valued by the therapist, enjoying talking, and feeling included in the group. Negative aspects included finding being in the group emotionally painful, and on occasion finding it difficult to identify with other members of the group. McDonald *et al* (2003) suggest the findings add further support to establish the impact of psychodynamic therapy for clients with IDs. Furthermore, Morgan (2011) interviewed seven clients with IDs about their experiences of psychotherapeutic interventions provided within a specialist NHS ID service. Using IPA, two super-ordinate themes were identified: 1) 'seeking help and engaging in the therapeutic process', consisting of the following sub-themes: 'participants' understanding of reasons for therapy' and 'participants' understanding of therapeutic boundaries', and 2) 'relationship factors',

consisting of the following sub-themes: 'the therapeutic value of talking', 'feeling at ease and understood', and 'reluctance to comment on negative aspects of therapy'. This study provides further evidence that people with IDs can engage effectively in psychotherapy, as well as describing how they actively engage in the therapeutic relationship.

In a study by Merriman and Beail (2009), clients were interviewed about their experiences of individual psychotherapy; six participants who had been attending psychotherapy for approximately two years took part in the study. Using IPA, themes about the referral process, the client experience and the outcome emerged. Findings showed that, whilst there was a general understanding about what therapy was, some participants had confused expectations about therapy which contributed to their nervousness. Participants found talking helpful and had a positive view of their relationship with the therapist. Some of the more negative aspects of therapy reported by the participants included the therapist leaving or being absent. That being said, the authors noted that it could be difficult for clients to criticise any aspect of the service for fear of it being taken away from them, suggesting that future research should employ more objective methods of evaluation such as ensuring researchers are external and not related to the service.

Pert *et al* (2013) explored the experiences of clients with IDs who were engaging in individual CBT. Participants experiencing anxiety, depression, or anger took part in two semi-structured interviews between sessions four and nine. IPA was used to analyse the data. Participants found it helpful to talk about their difficulties, with many stating how much they valued the opportunity to talk in confidence. Participants also spoke about how they felt valued and validated during therapy, suggesting there was a strong relational component to the CBT in which they engaged. Positive change in therapy was also identified by participants, however, many felt that they needed more longer-term input and showed concern that any positive changes made may not be maintained beyond discharge. Whilst it is not known what type of long term support the participants would have wanted, it does suggest the importance of thinking about and managing endings with this client group early on in the therapeutic work.

In a recent study by Lewis, Lewis and Davies (2016), clients with IDs were interviewed about their experiences of psychotherapy. They found participants spoke about the helpfulness of the practical aspects of psychotherapy such as creating a timeline, practising breathing exercises and playing a game about the body; this suggests that the use of more concrete techniques and methods to support talking are valuable when engaging in psychotherapy with this client group. The interviews also highlighted the significant impact that the therapy process had on participants; for example, one participant said: "I don't feel trapped anymore because the past is out of my head. I feel like a bird. (P2, 181-182)" (Lewis, Lewis & Davies, 2016, p.451).

Ramsden *et al* (2016) interviewed three clinical psychologists, six clients and six carers on their perceptions of barriers and facilitators to therapeutic change for people with IDs. Using thematic analysis, six themes were found: 'what the client brings'; 'wider system'; 'therapy factors'; 'mental health GP'; 'systemic dependency'; and 'the revolving door'. 'Therapeutic relationship' was identified as a sub-theme of 'therapy factors. Ramsden *et al* (2016) found that all participants noted the importance of having a positive therapeutic relationship; clients in particular, highlighted this as a key facilitator to help them engage in psychotherapy. The authors suggested this research could act as the foundation for further research exploring how psychotherapy can be optimised for clients with IDs. In a study by Roscoe *et al* (2016), the views and experiences about DBT of women with an ID and a diagnosis of personality disorder were explored. Ten women were interviewed using semi-structured interviews; IPA was used to analyse the data. Three super-ordinate themes were identified: 'understanding DBT', 'DBT as helpful and beneficial', and 'engagement with the DBT process'. The therapeutic relationship was found to play an important role in clients' motivation, engagement and participation in DBT. Moreover, participants spoke about the importance of building trust, highlighting the integral need for trust in a strong therapeutic relationship.

In the qualitative studies exploring the therapeutic relationship and participants' experience of psychotherapy, therapists and clients appear to be alluding to something helpful happening during the course of therapy. However, the studies only looked at one perspective each, and using interviews, relied upon participants' memories; by not



exploring the process of therapy, it has not been possible to fully explore specific moments in the therapy. Exploring specific moments in the therapy would provide opportunities to gain more insight into the therapeutic process, and by using a video recording of the session, participants' memory of the session can be prompted.

## **2.6 Defining significant therapy events**

During the course of psychotherapy, there can be many helping and hindering processes perceived by clients and therapists. Precursors to the study of significant therapy events include the exploration of important events reported by adults in group psychotherapy. For example, in a study by Berzon, Pious and Farson (1963), clients in group psychotherapy were asked to write descriptions of important events after every 90-minute session they attended over the course of 15 weeks. The authors categorised events as cognitive, affective, or behavioural. Another precursor to the study of significant therapy events includes studies of therapeutic factors in group therapy. For example, Bloch *et al* (1979) describe a methodology with which clients and therapists were asked at regular intervals to recount those events which they attributed as important. Independent judges were then asked to classify the events by type of therapeutic factor being employed. The authors suggest this type of methodology could be usefully applied to group therapy research as well as training.

The term 'significant therapy events' was first coined by Robert Elliott in the 1980s; these are segments of individual therapy sessions, typically lasting between 4-8 minutes, in which clients experience significant moments of help or change (Elliott & Shapiro, 1988). They are described by Timulak (2007) as the points of the therapy session in which the most fruitful therapeutic work occurs. Significant therapy events are an important area to explore since they can be viewed as a window into the change process that occurs in psychotherapy. Indeed, the occurrence of significant therapy events during the course of psychotherapy are linked to positive therapy outcomes for the client. In a study by Rees *et al* (2001), a client-selected significant therapy event from CBT was analysed using comprehensive process analysis (CPA), a qualitative research method that involves developing an understanding of significant events by taking account of the context, the

event, and the impact of the event. The selected event itself showed the effective management of the process of moving to the specific. The client recalled intense emotions and was self-blaming during the sessions, which the authors noted, was not picked up by the therapist; they suggest this supports the idea that the client may have a range of internal processes going on that are not available to the therapist during the session, which is why this type of research is so important. The authors found that the significant therapy event identified by the client as 'problem clarification', during the course of CBT, instigated a process of client change, therefore resulting in a positive therapy outcome. Moreover, Rees *et al* (2001) highlight the importance of affect in the change process for clients during therapy. Timulak, Belicova and Miler (2010) explored client-identified significant events in a successful case study by examining the presence of a link between significant events and outcome. The authors analysed 59 significant events from one case study, and found 14 types of events. Analysis revealed that events focused either on building a therapeutic relationship or they focused on therapeutic change hypothesised to contribute to therapy outcome.

According to Elliott and Shapiro (1992), examining significant therapy events can be thought of as a type of sampling strategy whereby, rather than selecting random samples from therapy sessions, only the segments of the therapy session in which the most 'action' occurs are viewed. Therefore, significant events can be thought of as representing those general therapeutic factors that are important, such as, alliance and empathy (Wampold, 2015), but in greater levels of concentration. However, this does seem to depend on clients' conscious awareness; clients may not necessarily be aware of some of the significant therapy events that take place in the sessions. This is an important consideration that the current study has taken into account, and has minimised this limitation through also utilising the awareness of the therapist in terms of helping to identify sessions in which helpful moments seem to have happened (see section 3 'Methodology'). Throughout the literature, a significant therapy event has been given several different meanings, however, throughout this review and indeed, this piece of research, the term 'significant therapy event' will be referred to and defined as that segment of a specific therapy session that the client experienced as being the most helpful or important moment.

## 2.7 Significant therapy events research

In the 1980s, an area of process research called significant therapy events research was developed by Elliott (1983-1985). Perspectives from clients and therapists contribute a hugely valuable and privileged wealth of information about the process of therapy (Elliott & Shapiro, 1992). Rather than relying on participants' memories during an interview, a method called Interpersonal Process Recall (IPR) (Kagan, 1975) is often used whereby clients and therapists separately watch a video recording of the therapy session in order to identify and reflect on any significant events during the therapy session. This section discusses the research that has been undertaken in the area of significant therapy events. It should be noted that, rather than being specific to any one type of psychotherapy, significant therapy events have been found to occur whilst clients have engaged in a variety of different psychotherapeutic approaches, for example, CBT (Llewelyn *et al* (1988), emotion-focused therapy (Holowaty & Paivio, 2012), psychodynamic therapy (Elliott *et al*, 1994) and person-centred therapy (Grafanaki & McLeod, 2002).

In a study by Llewelyn *et al* (1988), the impact of helpful and hindering events, as perceived by clients engaging in either relationship orientated therapy or CBT, were compared. Using content analysis, the most prevalently reported helpful events during both types of therapy were 'problem solution', 'awareness', and 'reassurance', whilst, 'unwanted thoughts' was the most prevalently reported hindering event. The study also found that only the prevalence of 'unwanted thoughts' was correlated (negatively) with outcome, suggesting the authors found no evidence that helpful events were associated with positive therapy outcome. However, by using a self-report measure in isolation and quantitative content analysis, clients were perhaps not encouraged to explore the underlying meanings behind some of their identified therapy events, which could result in a lack of richness in the client accounts. In a study by Cahill, Paley and Hardy (2013), client perceptions of the therapeutic impact of CBT and psychodynamic interpersonal therapy were explored. Although the Helpful Aspects of Therapy form was completed in order to identify significant therapy events, clients were not then interviewed; instead content analysis was used to analyse the data. There were minimal differences in the types of significant therapy events reported by the clients engaging in both types of

therapies. The authors suggest these findings support the influence of 'common' rather than 'specific' therapeutic factors. However, given the study was quantitative in nature, there were no rich client descriptions of significant therapy events, nor was there any exploration of the complex therapy process between client and therapist.

Holowaty and Paivio (2012) explored the characteristics of client-identified significant events. Participants were clients attending emotion-focused therapy for child abuse trauma. The Helpful Aspects of Therapy form and post session interviews were used to identify significant events. The findings showed that client-identified events contained more reference to abuse and greater levels of arousal. Furthermore, significant events were found to have deeper levels of experiencing in terms of self-reflection and meaning making. However, this study examined data contributed by the clients only; by not interviewing the therapists themselves, it is difficult to understand the complexities of the therapeutic processes involved.

Elliott *et al* (1994) explored insight events using CPA. They presented the analysis of six client-identified significant insight events from clients engaging in psychodynamic-interpersonal therapy and CBT. One significant event, that was analysed in more detail, identified three factors: 1) the use of therapist interpretations to link different aspects of client experience; 2) the organisation involved in important shared themes or tasks; and 3) the temporary interruption of an important therapeutic task. Furthermore, in both therapies, events involved therapists making interpretations of difficult life events. One of the key findings of this study was the uncovering of the crucial role that therapist key, evocative words have in facilitating client insight during the course of psychodynamic-interpersonal therapy, which is likely to otherwise have been missed in larger quantitative studies; this is an important consideration when designing future research to explore the vast complexities involved in the process of psychotherapy.

In a review of the research conducted in the area of significant events in psychotherapy, Timulak (2010) found that research has focused on types of events, prevalence of events, match between client and therapist perspectives of events, significant events and treatment outcome, as well as significant events and the therapeutic process. The

impacts of client-reported significant events focused on contributions to therapeutic relationship and therapeutic outcomes. Timulak (2010) also found that research has focussed on significant events in different therapies. For instance, research by Elliott (1983) found significant events occurring in psychodynamic therapy, Rees *et al* (2001) found significant events occurring in CBT, and Timulak and Elliott (2003) found significant events occurring in emotion focused therapy. By including all types of psychotherapeutic approaches in its exploration of significant events in psychotherapy with clients with IDs, the current research makes a contribution to resolving this question of whether significant therapy events transcend therapy models.

The review by Timulak (2010) also highlighted differences between the perspectives of clients and therapists on what is a significant event in therapy. For instance, they found that therapists tended to prefer events of therapeutic work such as insight, whereas, clients tended to place a greater emphasis on the relational element of therapy such as reassurance. Moreover, the review revealed the complexity of the process involved in significant events, highlighting the vital need to use a more creative methodology in order to explore the complexities of the therapeutic process.

Timulak, Belicova and Miler (2010) explored significant events occurring in a successful therapy case; they found congruence between the helpful moments in therapy and the reported resolution of the main difficulties brought to therapy. The study identified several implications for practice; the client appreciated the therapist bringing up issues difficult for the client and the client also appreciated the authentic therapeutic relationship and more specifically that the therapist used self-disclosure because it levelled any power imbalances and normalised the client's own difficulties. Indeed, therapist self-disclosure is evidence based, and in a review of the research, there is much support for its use in psychotherapy (Castonguay *et al*, 2006; Stiles & Wolfe, 2006); furthermore, it is thought to foster a deeper and improved relationship between client and therapist.

Wiggins, Elliott and Cooper (2012) investigated relational depth events in psychotherapy. Relational depth refers to the "...state of profound contact and engagement between two

people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level" (Mearns & Cooper, 2005, p.xii). Wiggins, Elliott and Cooper (2012) used an internet-based survey to obtain client and therapist accounts of therapy. They found evidence to suggest that relational depth was present in more than a third of the descriptions of significant therapy events. The authors suggest that relational depth is likely to be a key component in providing an explanation of how client change can occur during therapy; they hypothesise that relational depth could potentially be useful as an upward extension to working alliance or the therapeutic relationship, whereby it is considered a facilitative condition of therapeutic change.

Grafanaki and McLeod (2002) used a multiple case study design to explore how congruence is experienced during significant therapy events. Six cases of person-centred counselling were examined for client and therapist moments of congruence and incongruence. Using narrative analysis, participants were found to experience congruence in a number of ways. For therapists, the following types of congruence during significant events were identified: 'empathic attunement/experiential presence'; 'process directing/focussing'; 'covert use of resolved personal material'; and 'counsellor disclosure of personal material'. For clients, the following types of congruence during significant events were identified: 'sharing meaningful material about self'; reporting simple information about self/others'; 'momentary heightened awareness/realisation'; 'process disclosure'; 'personal contact with therapist'; and 'new ways of being/behaving'. The findings support the idea of the client being an 'active agent' rather than a passive recipient of the therapist's intervention; indeed, the authors suggest that both client and therapist could influence the process of change and the therapeutic climate. This study therefore provides further evidence of the importance of the therapeutic relationship in relation to the presence of the core condition of congruence in significant therapy events.

Balmforth and Elliott (2012) described a case study in which CPA was used to analyse a client-identified significant event involving the disclosure of childhood abuse. They found that the therapist inviting and encouraging the client, and the therapist placing the client's experience in the context of others in the same situation, were both key aspects of the disclosure. The authors found that the helpfulness of the client-identified event

was due to the event enabling the client to form a connection between the earlier abuse and how it had affected her life. The therapist was able to facilitate the event by being sensitive and non-threatening, being alert to the client's hints leading up to the disclosure, recognising the strength of the therapeutic relationship, and remaining attuned to the client's frame of reference.

Because of the importance of the therapeutic relationship, it seems important to consider attachment styles, since these may influence the relationship between client and therapist. An attachment theory framework was used to analyse the influence of client interpersonal styles on the process during therapy (Shapiro *et al*, 1999). In this study, the transcripts of ten client-identified significant therapy events were examined with regard to client attachment styles, client attachment issues, and how responsive the therapist was to client attachment issues. The authors found evidence that a preoccupied attachment style, in which people seek high levels of intimacy, approval and responsiveness, yet worry that others do not value them, was responded to by the therapist reflecting the client's emotions and concerns. By comparison, a dismissing attachment style, whereby, people desire high levels of independence and seek less intimacy with attachments, was responded to by the therapist providing interpretation or challenging the attachment style of the client. This study has therefore shown that therapists' responses to client attachment issues were, as hypothesised, mediated by client attachment styles. Indeed, the clients with a preoccupied attachment style were pulling for more psychodynamic-interpersonal interventions, whereas the clients with a dismissing attachment style were pulling for more cognitive behavioural interventions; this suggests that therapist responsiveness is an important factor in client-identified significant therapy events.

Furthermore, significant therapy events research has been applied to many different areas. Helpful events have been explored within the college student population with regard to career exploration classes. For example, in a study by Gold *et al* (1993), the perceptions of helpful events reported by college students registered on career exploration classes were assessed. Participants were asked to complete written, narrative self-reports, which were coded by type of therapeutic impact. Factor analysis

was used to analyse the codings, with three dimensions being identified: 'affective factors'; 'identifying and coping with problems'; and 'insight gained'. The authors suggest that through identification of similarities and differences of the career exploration process by both students and instructors, both parties could work together to improve the effectiveness of the classes, again suggesting the need for a strong relationship.

In addition, McVea, Gow and Lowe (2011) used CPA to examine significant therapy events during psychodrama group therapy that focused on the resolution of painful emotional experiences. Five meta-processes linked to in-session resolution were identified; one was 'a willingness to engage in psychotherapy', and four were the following therapeutic events: 're-experiencing with insight'; 'activating resourcefulness'; 'social atom repair with emotional release'; and 'integration'. The authors proposed a model that highlights the relationship between inner experiences and interpersonal processes when addressing painful emotional experience during the course of psychodrama.

In a study by O'Halloran *et al* (2016), therapeutic events identified as significant by clients and therapists from community-based treatment programs for perpetrators of sexual abuse were explored; these services offered group-based interventions. Using thematic analysis, the authors developed a model of significant events in therapy, whereby significant events were arranged into the following six domains: 'the process of therapy'; 'making changes and progress in therapy'; 'content and structure of therapy'; 'therapist contributions'; 'negative contributions to therapy'; and 'other factors'. The authors suggest that this study provides evidence for the presence of common therapeutic factors (Wampold, 2015). Furthermore, the authors discuss the importance of exploring client and therapist experiences of therapy for the provision of therapy services; O'Halloran *et al* (2016) suggest therapy service provision can be improved through the development of therapist characteristics.

More recently, McCarthy, Caputi and Grenyer (2017) explored clinical and linguistic elements of helpful events by comparing both human ratings and computerised text analysis. The sample involved transcribed psychotherapy for 20 clients with a diagnosis of depression and personality disorder. The authors found that significant events in



psychodynamic psychotherapy contained emotional and cognitive awareness, and insight, as well as points in which the therapeutic relationship grew. The study highlights the high prevalence of significant therapy events featuring a strong therapeutic alliance. However, a limitation of the study was that significant therapy events were identified using the Helpful Aspects of Therapy form and analysis of therapy session transcripts, rather than interviewing clients specifically about the identified significant events; thus, the study missed some of the rich data that may otherwise have been available.

Through exploration of the literature on significant therapy events research, this review has shown that a qualitative design is preferred over a quantitative design in order to generate the richness in client accounts necessary to examine the process of therapy. Qualitative research has found that significant therapy events contained deeper levels of experiencing in terms of self-reflection and meaning making (Holowaty & Paivio, 2012), a finding likely to have been missed in larger quantitative studies. Research has highlighted the importance of taking both client and therapist perspectives into account, since these perspectives have been shown to differ when describing what participants consider to be a significant therapy event (Timulak, 2010). The use of therapist self-disclosure has been identified as a significant therapy event because it levelled any power imbalances and normalised the client's own difficulties (Timulak, Belicova & Miler, 2010); furthermore, therapist self-disclosure is thought to foster a deeper and improved therapeutic relationship. In addition, relational depth has been found to be present in a high proportion of significant therapy events (Wiggins, Elliott & Cooper, 2012), which seems to confirm the importance of the therapeutic relationship. Many examples have been given regarding the different types of therapy within which significant therapy events occur, including, psychodynamic therapy, CBT, person-centred counselling, and group-based interventions. This therefore seems to provide further evidence for the presence of common factors (Wampold, 2015), whereby significant therapy events can be thought of as representing such common therapeutic factors, but in greater levels of concentration. Given the many benefits of investigating significant therapy events, it seems important to consider how such events may manifest during the course of psychotherapy with clients with IDs, since little is known about the process of psychotherapy with this client group and how positive change occurs.

## **2.8 Significant therapy events research: involvement of clients with intellectual disabilities**

In a study by Lloyd and Dallos (2006; 2008), the experiences of families who have a child with IDs were explored. Seven families took part in the study, all of whom had a child of less than 18 years old with a significant ID. Families engaged in an initial appointment using solution-focused brief therapy (SFBT); in line with the therapy protocol, families could choose who attended the session. Whilst all mothers attended the initial sessions, one father, one grandmother, and two children with IDs attended for part of the sessions. All participants were invited to take part in a research interview to reflect on their experiences of the session, however only mothers agreed to take part. Along with completing the Helpful Aspects of Therapy form, participants were interviewed using structured recall, whereby they listened to those extracts of their therapy session that they had identified as helpful or unhelpful. In the first of two papers, Lloyd and Dallos (2006) explored the perspectives of the therapist. Using thematic analysis, the authors found that SFBT highlighted parents' competencies, goals and achievements. Using the 'miracle question', changes in rapport were found, as well as a shift towards problem solving.

In a separate paper, Lloyd and Dallos (2008) explored the perspectives of the clients. IPA was used to analyse the interview transcripts; the following three super-ordinate themes were identified: 'solution-focused brief therapy brought to mind the idea of 'making the best of it''; 'examination of wishful thinking'; and 'therapeutic relationship'. Of particular relevance is the theme of 'therapeutic relationship'; the authors described the following five sub-themes: 'time to think'; 'hopeful and comfortable feelings'; 'expectations of a directive expert not realised'; 'collaborative relationship'; and 'preferred to use an existing relationship for involvement in research'. This suggests, that even with a one session approach, the therapeutic relationship is a key therapeutic factor, and indeed, seems to be associated with client-identified significant therapy events.

Although Lloyd and Dallos (2006; 2008) employed a methodology that resembled some aspects of significant therapy events research, it did not seek to integrate the

perspectives from the therapist and clients, instead separately analysing them; by not combining these analyses, there may have been missed opportunities for exploring the process of therapy itself. Furthermore, as a limitation of the study, it was the therapist who interviewed clients; although user involvement in the design of the study was not enlisted, participants were asked during the interview and were adamant that they preferred to be interviewed by the therapist rather than a researcher who may misrepresent them. However, this can be problematic, both for the conduct of the interviews and for the analyses, since the therapist may have inadvertently influenced the research, or clients may be reluctant to be critical of the sessions (Merriman & Beail, 2009). Furthermore, whilst some of the initial sessions involved the child with IDs, the research interviews were conducted only with the mothers, and therefore the experiences of clients with IDs were not explored using the significant therapy events research methodology.

In a feasibility study by Burford and Jahoda (2012), clients with IDs engaging in CBT had their therapy sessions video recorded. In a qualitative interview, clients were asked to review tapes of their fourth and ninth CBT sessions. Using thematic analysis, the following three themes were identified: 'how they felt about themselves', 'how they felt the therapist was helping', and 'how CBT was helping'. More specifically, clients reported a number of helpful aspects of their therapy sessions, including: they can express themselves in sessions; they can say how they are feeling; and they feel understood. This research did not specifically follow the significant therapy events methodology, since the interviews focused more generally on clients reviewing their therapy sessions, and therapists themselves were not then interviewed. Nonetheless, it does provide evidence that this approach to interviewing clients with IDs is feasible with regard to clients with IDs providing insights into their feelings and opinions of therapy.

Hence, to date, no research could be found that explores how clients with IDs may experience significant events during psychotherapy. Given the research suggests that individuals with IDs experience emotions in a similar way to individuals without IDs, it is anticipated that this client group also experience significant therapy events. That being the case, it is possible that clients with IDs will be able to identify significant therapy

events, and these events may contain moments of insight, meaning making, and self-reflection. It is also expected that the client-identified significant therapy events may contain some link with the therapeutic relationship, thus, further strengthening the evidence for the importance of the therapeutic relationship. It has become clear from the research that the exploration of significant therapy events has made a vital contribution to furthering our understanding of therapeutic change and positive treatment outcomes for clients engaged in therapy. This creates huge potential in terms of implications for future practice with regard to psychotherapy with people with IDs, given the limited understanding there is at present of the process of therapy for this client group.

## **2.9 Concluding thoughts**

To summarise the preceding sections, the current literature review has highlighted a number of key developments more broadly in the area of IDs. Gradually over the years there has been a shift from a medical model to a social model of disability, whereby the disability is now seen as part of the social environment (Finkelstein, 1980; Oliver, 1990). According to the social model of disability, it is typical for a society to contain people who have mental health and physical differences; disability is a consequence of the failure of society to recognise this and make provision for people in mainstream services (The Foundation for People with Learning Disabilities, 2018). Concurrently, there has been a key shift in the type of treatments provided to clients with IDs, from those that were almost exclusively behavioural in their approach to, very gradually, providing this client group with access to different types of psychotherapy as the research base steadily grows. Moreover, with the legislative developments that have occurred over the past twenty years, now more than ever, it is vital that services respond by increasing their level of inclusivity to this marginalised group.

Research has evidenced the importance of the therapeutic relationship for many psychological approaches and shows it is key for a successful therapy outcome. Given the importance of the therapeutic relationship for all therapy including therapy with people with IDs, it is an important area of research to consider and explore. The therapeutic

relationship has been widely researched in mainstream psychotherapy. However, according to a review of the literature by Jones and Donati (2009), little research exists with regard to the therapeutic relationship built with clients with IDs. Newer research in this area is emerging, however it tends to be limited to case study designs or research that focuses more on the therapist perspective. Despite this, research with a wider remit has been undertaken involving qualitative interviews with clients with IDs and therapists about their experiences of psychotherapy and the therapeutic relationship. A number of considerations that appear key for building a better understanding of optimising psychotherapy for people with IDs have been identified. During research interviews, clients feeling valued, talking about problems, the therapeutic relationship, practical techniques, concrete methods to support talking, having a clear expectation of therapy, and avoiding a change in therapist or an unexpected absence, have all been identified as helpful during psychotherapy for clients with IDs.

Exploring specific moments in the therapy provides opportunities to gain more insight into the therapeutic process, and more specifically, by not relying on participants' memory of helpful moments in therapy, insight into the real process as it happens on a video recording of the session, can be accessed. Research exploring significant therapy events involving clients without IDs has shown there to be a link between significant events in therapy and positive therapy outcomes, and has found specific therapy events to be significant in bringing about change for the client, for example, the use of therapist words in facilitating change, the usefulness of therapist self-disclosure, the therapist bringing up issues difficult for the client, and the therapist remaining attuned to the client's frame of reference. Most notably, significant therapy events research has further evidenced the importance of the therapeutic relationship. However, although, one study was identified that explored the experiences of families who have a child with IDs following a methodology that shared similarities to significant therapy events research, this study did not go on to interview the therapist about significant events, and nor did it interview the client with IDs themselves. Hence, to date, no significant therapy events research could be found involving clients with IDs, and although a study by Burford and Jahoda (2012) evidences that the use of video recorded sessions as a methodology for enabling clients to more generally review their therapy sessions is a feasible approach

with this client group, significant therapy events research has not yet involved clients with IDs.

### **2.10 Significance of this research**

Following an extensive literature review, there could be found no studies exploring significant events during psychotherapy for people with IDs and hence, there appears to be a significant gap in the research literature. This piece of research will provide an original contribution to knowledge by exploring the process of psychotherapy and experience of significant therapy events for people with IDs.

Given the high prevalence of mental health difficulties of people with IDs, it is key to explore how to make psychotherapy more effective for this client group. Furthermore, research suggests there is a link between significant therapy events and positive treatment outcomes. Thus, it is hoped that this research will contribute to making psychotherapy more effective for clients with IDs through exploration of significant therapy events and the process leading up to those events.

### **2.11 Aims and research questions**

The aim of this research is to examine client-identified significant events in psychotherapy and explore the lived experience of psychotherapy with clients with IDs.

The following research questions will be explored: Do clients with IDs experience significant events in psychotherapy? What is the lived experience during the process leading up to a significant event? How do clients with IDs make sense of their experience of significant events in psychotherapy? How do therapists make sense of their experience of significant events in psychotherapy with clients with IDs?

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### 3. Methodology

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This study used a qualitative method adopting a modified version of interpretative phenomenological analysis. Semi-structured interviews focused on helpful events in psychotherapy, using videos of particular sessions as a stimulus to help prompt participant recall of that session.

#### 3.1 Research design

Taking a phenomenological theoretical stance to understanding significant events in psychotherapy, the research is concerned with meaning and the perspectives of the client and therapist participants; they are viewed as the experts on their unique experiences in the therapy room. It is the meanings and insights that the individual provides on how they make sense of their own experiences that are key (Smith, Flowers & Larkin, 2009). Furthermore, through a phenomenological theoretical lens, this understanding of how people make sense of their experiences is not readily available, and the researcher must engage in a process of interpretation (Smith & Osborn, 2003). From this theoretical perspective, it was necessary to adopt a qualitative strategy; data was collected by conducting qualitative research interviews with each participant on two separate occasions. Because of the focus on the participants' perspective and the need for interpretation to make sense of their perspective, interpretative phenomenological analysis (IPA) was selected to analyse the research data.

#### *Epistemology of IPA*

Phenomenological philosophy is based on the premise that reality is comprised of objects and events or 'phenomena' as the human consciousness perceives or understands them, rather than being anything separate and independent of human consciousness. Of key significance in the phenomenological movement was Husserl (1930-1939, 1965); "his way of linking consciousness to the external world was to try to describe the way in which consciousness worked on and transformed our sense perceptions into recognisable objects" (Benton & Craib, 2011: p. 83). In this way, 'sense perceptions' go beyond what

we can see and measure, and indeed, additionally incorporate our imagination and use of language (Benton & Craib, 2011).

In addition to phenomenology another key theoretical underpinning of the research comes from hermeneutics, which concerns the theory of interpretation. IPA is involved in exploring how a particular phenomenon appears, and the researcher is central in bringing about and making sense of this appearance. This analysis involves an active process in which the researcher is fully immersed in the data as they seek to uncover the individual's unique perspectives and meanings. This process is necessarily interpretative, focusing on the researcher's attempts to draw meanings from the world around them (Smith, Flowers & Larkin, 2009).

A further influence on the research is idiography, which is concerned with a focus on the individual rather than on the group or population level. Idiography emphasises the uniqueness of everyone, and hence suggests that everyone should be studied in an individual way. The connection to IPA is twofold. Firstly, there is a focus on detail and therefore on the depth of analysis, requiring a thorough and systematic approach to analysis. Secondly, IPA is concerned with understanding how specific phenomena are experienced by a particular group of people within a particular context (Smith, Flowers & Larkin, 2009).

Therefore, because of the need for this piece of research to explore significant therapy events from the participant's perspective, undertaking a process of interpretation in order to understand how people make sense of their experiences, and focus on particular people in a particular context, IPA was selected to analyse the data because it provides the most cohesive fit with the research design.

### ***Rationale for chosen methodology***

Selecting the most appropriate methodology for the research project involved making a number of important decisions and considerations, including deciding to adopt a qualitative rather than quantitative design, the decision to utilise IPA, and overcoming the



challenges of involving people with IDs in qualitative research; these will be discussed in the proceeding section.

#### A qualitative rather than quantitative design

According to Bryman (2001), there are a number of defining characteristics of qualitative research, including, seeing through the eyes of the people being studied; description and emphasis on context; emphasis on process; and flexibility. Taken together, these characteristics provide the rationale for the use of a qualitative design for the current research study. Significant therapy events are viewed as phenomena uniquely experienced by the individual themselves; the use of a quantitative design would miss the interpretations of this phenomena made by the people experiencing the significant therapy events. Because significant therapy events have not as yet been studied within the ID services context, there may be important intricacies in the psychotherapy sessions and therapeutic relationship that can only be understood in terms of the specific environment within which they operate. Significant therapy events have been explored in terms of the process leading up to the event, the event itself, and what happens after the event, thus, a qualitative design enables this sense of change and how events unfold over time to be explored. Finally, the flexibility of a qualitative design allows the researcher to change direction more easily than with a quantitative design, in order to follow the important issues raised by the participants.

A review of the literature by Lloyd, Gatherer and Kalsy (2006) revealed that there continues to be very few qualitative interview studies conducted with people with IDs compared to those studies conducted with the general population. It would seem unjust to only apply the above discussed advantages of a qualitative research design to individuals who are verbally articulate. There are a number of arguments, identified by Lloyd, Gatherer and Kalsy (2006), that account for why it was especially important to select a qualitative design when involving people with IDs in this research study. These specific reasons include: understanding the perspective of the individual and ensuring their voice is heard, by using the individual's preferred way of communicating; using this attempt to understand the individual's perspective in order to subsequently improve

service provision and care; and challenging disempowerment and marginalisation by validating the individual's experiences (Lloyd, Gatherer & Kalsy, 2006).

The aim of the research interviews was to enable the participant to express their lifeworld (Husserl, 1936, cited in Benton & Craib, 2011) in a guided way so as to focus on the phenomena they experienced during their therapy sessions. Interviews were selected to collect the data because there was a need to explore phenomenon from the participant's perspective. Interviews enabled a more in-depth and personal account to be given by participants and enabled the interviewer to be led by the issues raised by the participant, rather than by their own imposed agenda (Howitt, 2010). The type of interviews employed were semi-structured interviews; this type of research interview enabled both researcher and interviewee to take an active role in the research process. Whilst some of the initial focus of the interviews tended to be determined by the questions asked by the researcher, as the interviews progressed, the researcher was able to be led by the concerns of the participant; this enabled the researcher to follow up the specific matters brought up by the participant, making each interview unique to each individual participant.

A potential limitation of the use of semi-structured interviews is that some participants may have felt more comfortable talking in a group with other participants who have had similar experiences, as this may encourage contribution (Braun & Clarke, 2013). However, the use of focus groups for clients would provide them with no confidentiality, and the use of focus groups for busy professionals is problematic in terms of scheduling a date and location to suit everyone. Besides, it is the individual experiences with which IPA is concerned rather than a shared narrative. By the interviewer utilising active listening skills and allowing time for reflection, the participants were encouraged to explore their experiences in detail, enabling the interviews to prosper. To overcome the impact that client participants' cognitive impairment may have had on their ability to recall significant therapy events during the research interviews, the methodology utilised the Brief Structured Recall procedure (see section 3.1 'Development of the research instruments').

### The decision to utilise IPA

Whilst it was clear from the outset that a qualitative design was the most appropriate for exploring significant therapy events with people with IDs, it was less clear which specific method of data analysis would be the best match.

Two main alternatives to IPA were considered as viable options. First, thematic analysis was evaluated. Thematic analysis involves the analysis of what is said rather than how it is said through examining the data in order to identify broad themes that summarise the content of the data (Howitt, 2010). Both IPA and thematic analysis involve searching for themes and interconnections between themes within participant transcripts.

Furthermore, thematic analysis is not aligned to any one specific epistemological approach, making it a flexible method of data analysis that can be utilised across a range of qualitative designs. However, key to the current study was the exploration of the participant's experience from their perspective through the use of interpretation, and one of the disadvantages of thematic analysis highlighted by Braun and Clarke (2006) is that if not used within an existing theoretical framework, it offers insufficient interpretative value beyond mere description.

Grounded theory was the second alternative to IPA that was considered. Grounded theory has been described as: "theory that was derived from data, systematically gathered and analysed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another" (Strauss & Corbin, 1998, p.12). The key features of grounded theory are its concern with the development of theory from the data, and the iterative nature of data collection and data analysis, making theory generation a continuous process. There are many similarities between IPA and grounded theory. Both are systematic with clear stages to data analysis, and both involve the analysis of one case before moving on to the next case to integrate and produce a detailed understanding of the data. However, one of the key limitations of grounded theory is the question of whether researchers are able to put aside their awareness of relevant theories and ideas until later stages in the analysis. Given the researcher's status as an 'insider' (see section 3.2 'Reflexivity'), this key component of grounded theory was considered a nearly impossible task to achieve. Furthermore,

grounded theory was initially developed to address sociological research questions and later applied to psychological questions, whereas by comparison, IPA was primarily developed to address psychological research questions.

IPA was therefore considered to be the most appropriate choice for the current research study. This decision was based on its alignment with the epistemological approach of the research, its primary concern with how individuals experience phenomena, the interpretative element it is able to offer in order to understand how people make sense of their experiences, its ability to address psychological research questions, and the way in which it can address pre-existing researcher inside knowledge and ideas through reflexivity.

#### Overcoming challenges of involving people with IDs in qualitative research

Coons and Watson (2013) identify a number of ethical and practical challenges to involving people with IDs in qualitative research. The consent process poses a challenge; Coons and Watson (2013) assert that in order for consent to be informed, participants should be able to understand the information about the study, in addition to having the opportunity to ask questions and further discuss, and consider the risks and benefits of taking part. For the current research study, a detailed consent process was followed, taking account of positive and negative indicators for giving consent (see section 3.4 'Consent process' for further information). A further challenge is posed when determining capacity. Having capacity refers to an individual's cognitive ability to make a specific decision at a specific point in time (Coons & Watson, 2013); this takes account of the fact that an individual may have capacity to make a decision about certain things but not others, and at certain points in time, hence capacity is fluid and can change. Whilst the current research sought only to recruit clients with IDs who had capacity to consent, the challenge arose when determining who had capacity. By relying in part on experienced therapists to determine capacity, this challenge was minimised, however it was also important to follow the two-stage test of capacity outlined in the Mental Capacity Act (2005) to confirm the therapist's initial assessment of capacity (see section 3.4 'Consent process').

A further practical challenge of involving people with IDs in qualitative research is communication. Due to the difficulties that some individuals experience with expressive language and comprehension skills, some researchers have questioned the credibility of the responses given by participants during research interviews (Coons & Watson, 2013). Furthermore, Lloyd, Gatherer and Kalsy (2006) have found that open-ended interview questions often result in inadequate answers with little elaboration. To overcome this challenge, the current research study employed a creative research methodology involving the use of videoed therapy sessions to aid participants' recall during research interviews. In addition, challenging disempowerment and the difficulties with power relationships have been identified as a challenge. Authors writing on disability have argued that the majority of published research are not representative of people's experience because research tends to be researcher-led rather than being led by individuals with disability (Oliver, 1992). Whilst the current research study did not involve individuals with IDs as co-researchers in the data collection and data analysis stages of the research process due to issues of confidentiality, people with IDs were consulted during the research design phase of the research study, which is discussed in the following section.

### ***Development of the research instruments***

#### **Patient and public involvement and engagement**

Involving members of the public in research is considered highly valuable (Staley, 2009). Therefore, in designing specific aspects of the study, including the interview schedule, participant information sheet and participant consent form, the researcher consulted individuals with IDs to ensure that, for example, the language used during the interviews would be appropriate and accessible. During a visit to a local drop-in service for adults with IDs, potential client participants were asked for their feedback on the proposed methodology. During this consultation, individuals advised the researcher to use a larger font size; use pictures rather than text alone; utilise an Easy Read layout; employ 1-9 Likert scales that incorporate pictures; and use the term 'helpful moments' to refer to significant therapy events, as this is more easily understood. This type of engagement with potential client participants proved key in designing the study and study documents. Further research revealed that there exists an online library of full colour pictures, called

'Photosymbols', which was set up for use by people making Easy Read documents. This online library is used by the Department of Health when creating Easy Read versions of White Papers, as well as by many of the NHS learning disability services; it was therefore selected to design the participant information sheets, consent forms and questionnaires.

#### The Helpful Aspects of Therapy form

The Helpful Aspects of Therapy (HAT) form (see Appendix A) was completed by client participants at the end of each of their therapy sessions. The HAT form is a self-report measure, developed by Llewelyn (1988) as a means for identifying helpful and hindering events in psychotherapy. The original HAT form contained seven questions; these were: (1) 'of the events which occurred in this session, which one do you feel was the most important or helpful for you personally?'; (2) 'please describe this event'; (3) 'how helpful or hindering was this particular event?'; (4) 'about where in the session did this occur?'; (5) 'about how long did the event last?'; (6) 'did anything else particularly helpful happen during this session – please describe'; (7) 'did anything happen during the session which might have been hindering – please describe'. Following consultation with individuals with IDs, this form was adapted by simplifying the language used, including visual images, and making the Likert scales clearer. These adaptations were made to maximise the ease with which the client participants could complete the form; in addition, therapist participants offered and provided as much support as requested by client participants with regard to completing the HAT form.

#### Brief Structured Recall

The Brief Structured Recall procedure (BSR) (Elliott & Shapiro, 1988) was followed. This involved the researcher watching the video of the therapy session with the client and therapist separately whilst asking further questions about the session; the emphasis was placed on the client identifying events to be focussed on. BSR is a modified version of Interpersonal Process Recall (IPR) and differs from IPR in that it focuses on an event, which therefore means watching only one section of the session rather than the entire session. The BSR procedure was favoured over IPR for this particular study, in the hope of minimising the burden placed on clients with IDs as well as taking into account their capacity to concentrate for prolonged periods of time; furthermore, by placing less

burden on the therapist participants, it was hoped that engagement in the study would be maximised as well as ensuring the ease with which research interviews could be organised with these busy healthcare professionals. It is recommended that the BSR procedure takes place as soon as possible after the therapy session (McLeod, 2013), however, again in order to minimise the burden placed on client participants, interviews were scheduled at least two days after the session; the therapist participant interview then followed shortly afterwards. The researcher built good communication links with the therapist participants in order that they could promptly notify the researcher when they had selected a session to be included in the study.

### The interview schedules

Two different interview schedules were followed for the research study; one for the client participants (see Appendix B) and one for the therapist participants (see Appendix C).

For the client participant interview, an adapted version of the Client Event Recall Form was utilised. The Client Event Recall Form was developed by Elliott (1989) to provide a procedure for describing significant events that occur during a therapy session. The Client Event Recall Form was adapted by reducing the number of questions to ensure they were relevant to the focal therapy session. By omitting the sections containing rating scales, the relational element of the interview was maximised in the hope of encouraging client participants to elaborate on their experience; this also minimised the structured element of the recall form by enabling the researcher to follow up on the seemingly important aspects raised by the client participant. The interview schedule contained sections on the context of the event, the participant's experience during the event, the most helpful things about the event, and the impact of the event.

For the therapist participant interview, an adapted version of the Therapist Event Recall Form was followed. The Therapist Event Recall Form was developed by Elliott (1990), again, to provide a procedure for describing significant events that occur during a therapy session. The Therapist Event Recall Form was adapted by modifying its mode of completion from being a form independently completed by the therapist participant to forming the basis for a semi-structured interview between researcher and participant.

Furthermore, the number of questions were reduced by omitting questions requiring participants to rate their skilfulness, as well as questions relating to intricacies of sequencing during the session. These adaptations were made, both to foster a good relationship between researcher and participant in order to encourage participants to elaborate on their experiences, as well as minimising the time burden of a lengthy interview on busy healthcare professionals. The interview schedule contained sections on therapist event intentions and feelings, the context of the event, and the impact of the event.

#### Impact of the intervention on each dyad

Whilst it is difficult to provide any definitive conclusions about the impact that the intervention utilised in the current research had on the therapy dyads, it is hoped that the proceeding discussion addresses some of the likely impacts that the intervention had on the therapy dyads, as well as, detailing some of the strategies utilised to minimise the impact of the intervention.

The anticipated impact of being video recorded was discussed with individuals with IDs during the design phase of the research study. At that point, when asked their thoughts on being video recorded, individuals with IDs commented that they may feel nervous at first, however, reflected that they would soon feel at ease. However, this does not necessarily take account of the confidential nature of what may be expressed during a therapy session. In a study by Kingdon (1975), clients' self-reported inhibition, in relation to having their therapy sessions videoed, was found to reduce over time, and by their third session they began to self-explore at deeper levels. Using an audio/videotape comfort form, Briggie *et al* (2016) found that the majority of clients expressed no or only slight concerns about the use of a video camera during their psychotherapy sessions. They also found that comfort with being video recorded was not significantly related to treatment refusal, duration, or outcome (Briggie *et al*, 2016). Furthermore, during the research interviews in which video recordings of the focal therapy sessions were watched, the researcher observed no signs of distress or discomfort from any of the client participants, nor did any of the client participants verbally report feeling uncomfortable when watching the video recordings.



Although therapists were not asked their thoughts on being video recorded whilst engaging in psychotherapy with individuals with IDs, this methodology stems from a supervisory strategy developed by Kagan *et al* (1967) as a way of empowering counsellors to gain a better understanding of their client work in order for them to act upon these new understandings as appropriate. Studies have shown that therapists' self-reported inhibition, with regard to their therapy sessions being video recorded, decreases over time (Kingdon, 1975). Several studies have been conducted that evidence the positive impact this method has on therapy work, as well as its perceived usefulness by counsellors (Bernard, 1989; Lloyd-Hazlett & Foster, 2014). Furthermore, anecdotal reports from the therapist participants in the current research study reflect similar appraisals of usefulness of video recording therapy sessions.

Thus, it seems likely that the impact of the intervention on the therapy dyads was short-lived, and whilst participants may have been initially more aware of the presence of the video camera, it is likely that this awareness reduced as the therapy sessions progressed. Nonetheless, it was important for the researcher to explore and implement strategies to minimise the impact that the video camera may have had on clients and therapists during psychotherapy. The video camera used was relatively small and was set up in the corner of the room in such a way as to be as unobtrusive as possible. During consent meetings, client and therapist participants were reminded that they could choose to have the video camera switched off at any point during psychotherapy without needing to give an explanation. Furthermore, the video camera was set up for every session so that participants would come to see it as part of the furniture, rather than something that was introduced only for the sessions to be included in the research that would be the focus of the research interviews.

### **3.2 Reflexivity**

Qualitative research acknowledges the role of the researcher as an integral part of the construction of knowledge, with the intention to be that of a personal activity. This is what sets qualitative research aside from positivist research in which there is a clear separation of testable facts from subjective value-laden judgements (Benton & Craib,

2011). By contrast, in qualitative research, the researcher incorporates their own personal perspective, identity and experiences into the research report (Howitt, 2010). Reflexivity is therefore a key component of the qualitative research process. According to Nightingale and Cromby (1999), reflexivity involves:

...an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research (Nightingale & Cromby, 1999, p.228).

Therefore, the aim of this section is to make explicit the experiences, beliefs, values and interests of the researcher, and acknowledge the influence these may have had throughout the research process and how they may have shaped this process.

It is important to acknowledge the prior interest the researcher has in working therapeutically with individuals with IDs, which has been gained through previous roles working with this client group as well as through undertaking placements as a counselling psychologist in training. As part of the current professional doctorate, the researcher completed a second-year research project exploring therapists' experiences of the therapeutic relationship when undertaking psychotherapy with clients with IDs (Wills, 2015). Whilst this proved to be an enlightening piece of research with interesting insights on the therapeutic relationship, the experiences of the clients, as well as the intricacies of the process of psychotherapy, were overlooked. This then formed, in part, the rationale for the current topic of research, set within the context of an ID service.

The researcher acknowledges that through previous experience of the therapeutic relationship, both as therapist and as client, they view psychotherapy as helpful. More specifically they have experienced helpful moments in therapy when something important seemed to occur, leading to positive change. However, this change has not always been explicitly communicated by clients in the moment, only becoming apparent in later sessions; this experience activated the researcher's interest in the process of therapy and subsequently influenced the choice of research topic. Although the HAT

form did ask clients to identify unhelpful events in their therapy session as well as helpful events, the focus of the research interview was on the helpful events, and it is important to acknowledge the more specific focus that this research study took, that was undoubtedly influenced by the researcher's experience of psychotherapy.

As the researcher, I am a white, female in my thirties; it was important to be aware of the influence my previous experiences may have had on this study. It is therefore important to acknowledge my position as an 'insider'; I have worked with adults with IDs for seven years, as well as having undertaken my own personal therapy. I have held roles as a support worker within a supported living scheme based in the community as well as having held a role as an assistant psychologist working within an NHS ID team. Both of these contexts were heavily influenced by a person-centred approach with a strong emphasis on advocating for the rights of individuals with IDs and empowering them to live the life of their choosing. It was important for me to adapt as I changed my role from support worker and assistant psychologist to researcher. This reflects some of the discussions explored in a piece of research undertaken by Raheim *et al* (2016), in which dual roles of insider-outsider and researcher-researched were the topic of focus groups. The authors concluded that in order to manage such shifts in positions, continuous reflexive awareness is crucial. Whilst I had previously been on placement with the ID team during my first year as a counselling psychologist in training, I then began a process of changing my role to that of researcher as I carried out my second-year research project in the same service; this was initially difficult as I knew many of the therapists with whom I was interviewing, and it was imperative that I gave myself enough time to personally reflect on my experiences to help me recognise the influences they had on the research process. However, with my prior experience of adapting to the role of researcher, the passing of time, and some change of therapists within the team, making the change to the role of researcher was less complex.

Nonetheless in the nature of qualitative research, rather than separating my experience within my previous roles from the research, I became aware of the influence it may have on the research and recognise that this background heavily influenced the methodology of the current research study insomuch as empowering clients with IDs to have as much

control as possible during the research interviews through the use of BSR and the use of a modified remote control, in order to minimise power imbalances between researcher and participant. A similar approach to minimising power imbalances was taken when interviewing the therapist participants by giving them some control over which therapy sessions were selected for inclusion in the research. In addition, I believe my background and previous experience helped me to build rapport with the participants during the interviews.

Indeed, making the change from therapist to researcher brought some unexpected benefits to the relationship formed between researcher and client participant. Rather than the typical therapeutic relationship that the therapist aspires to build between themselves and their client, the relationship between researcher and client participant offered a more social aspect. Moreover, within the therapeutic relationship, it is important for the therapist to maintain boundaries in order to create a safe therapeutic space in which the client feels held. Contrastingly, the researcher appeared to hold something different to that of a therapist; whilst certainly there remained boundaries, there was a type of freedom which gave the relationship a more relaxed quality. Researcher and client participant could arrive at the research interview together and leave together, and the researcher was allowed or could allow themselves to be less formal without the pressures of analysing the impact, detrimental or other, this may have on the relationship.

The data collection stage of the research was a rather long process due to the complexity of the methodology. As a result, the researcher did at times experience frustration at both the expected and unexpected delays during the process of scheduling and undertaking the research interviews. These were the points during the research process when it was especially important for the researcher to spend time reflecting in their reflective journal, focusing on thoughts of being out-of-control. By reflecting on this, the researcher was able to reframe this feeling with the knowledge that it was a part of the process of building a relationship with the research itself and becoming more experienced with the methodology.

During the research interviews, the researcher gained a sense of how both client and therapist participants felt about being interviewed. It seemed that, based on levels of engagement throughout the interviews, clients felt more empowered in the sense that they had more control over the interview in terms of what parts of the therapy session they spoke about. Therapists showed signs of feeling exposed by reporting feelings of embarrassment as the video of the therapy session was played, however at the end of the interview, reported finding the process immensely helpful for them to help process what was going on in their therapeutic relationship with their client. These anecdotal reports from the therapists reflect findings from research exploring this methodology as a supervisory strategy (see section 3.1 'Impact of the intervention on each dyad'), in which the positive impact and perceived usefulness has been evidenced (Bernard, 1989; Lloyd-Hazlett & Foster, 2014).

### **3.3 Participants**

#### ***Sampling procedure***

A purposive sampling procedure was used to recruit participants who have experienced the same phenomena (Bloomberg & Volpe, 2008). Additionally, by utilising a pre-existing relationship that the researcher had established through undertaking a previous clinical placement within the NHS Community Learning Disability Team from which participants were recruited, the sample for the current research came about through convenience. Four therapy dyads, each consisting of one client and one therapist, giving a total sample size of eight participants, were recruited to the study. This is considered sufficient since the study is interested in the perceptions and experiences of a specific group.

Furthermore, a sample size of four therapy dyads, producing 16 short interviews using BSR, exceeds guidance given by Smith, Flowers and Larkin (2009) who suggest using a sample size of between four and ten interviews for professional doctoral research.

#### ***Inclusion and exclusion criteria***

On page 46, Table 1 shows the inclusion criteria, and Table 2 shows the exclusion criteria, for the participants and the therapeutic contract.

Table 1: Inclusion criteria for recruitment of participants.

<b>Criteria</b>	<b>Client</b>	<b>Therapist</b>	<b>Contract</b>
<b>Inclusion</b>	<ul style="list-style-type: none"> <li>Identified as having mild to moderate IDs with reasonable expression and comprehension skills</li> <li>Over the age of 18</li> </ul>	<ul style="list-style-type: none"> <li>Working in a Community Learning Disability Team (CLDT)</li> <li>Qualified counselling psychologist, clinical psychologist, counsellor or therapist with other similar qualification, accredited by reputable professional body (e.g. BPS, HCPC, BABCP, BACP), or</li> <li>Trainee Counselling or Clinical Psychologist undertaking an accredited programme of study</li> <li>Minimum of one year's experience of offering psychotherapy to this client group, or transferrable skills</li> </ul>	<ul style="list-style-type: none"> <li>Individual therapy</li> </ul>

Table 2: Exclusion criteria for recruitment of participants.

<b>Criteria</b>	<b>Client</b>	<b>Therapist</b>	<b>Contract</b>
<b>Exclusion</b>	<ul style="list-style-type: none"> <li>Client identified as having severe IDs</li> <li>Clients judged by therapist and/or research team not to be able to give informed consent</li> </ul>	<ul style="list-style-type: none"> <li>Unqualified therapist who is not currently undertaking an accredited programme of study to become qualified as a therapist accredited by a reputable professional body (e.g. assistant psychologist)</li> </ul>	<ul style="list-style-type: none"> <li>Therapy within a systemic model</li> </ul>

### **Participant Information**

In total, four therapy dyads, each consisting of one therapist participant and one client participant, were recruited to the study. Information relating to each participant is shown in Table 3 on page 47.

Table 3: Information relating to participants.

Therapy Dyad	THERAPIST PARTICIPANT			CLIENT PARTICIPANT		
	Therapist Pseudonym	Experience in ID	Theoretical Orientation	Client Pseudonym	Focus of Sessions	Sessions Attended
1	TP1	4 years, 2 months	CBT, CAT, Narrative, CFT, ACT, Systemic	CP1	Low mood	6 sessions
2	TP2	2 years	CBT, Person-centred, Narrative, Systemic	CP2	Anger	7 sessions
3	TP3	4 years, 2 months	CBT, CAT, Narrative, CFT, ACT, Systemic	CP3	Anger	5 sessions
4	TP4	22 years working with deaf children	CBT, Psycho-dynamic, Systemic	CP4	Low mood	11 sessions

Client Participant 1 completed his therapy sessions with Therapist Participant 1, however, withdrew from the research study, and therefore completed only one research interview. All other therapist participants and client participants took part in two research interviews each, giving a total of 15 research interviews for analysis.

### 3.4 Procedure

#### *Ethical considerations*

##### Ethical approval

The British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2009), as well as the BPS Code of Human Research Ethics (BPS, 2014), was adhered to throughout the study. Health Research Authority (HRA) approval was applied for using the Integrated Research Application System (IRAS). Following a favourable opinion from the Research Ethics Committee (REC) (see Appendix D), the research was assessed by the HRA and given full HRA approval (see Appendix E). Soon after HRA approval was granted, the participating NHS organisation confirmed their capacity and capability, constituting the NHS management permission to begin the research.

### Consent process

Valid consent involves fulfilling three criteria, namely, evidence of a signed consent form, the provision of relevant information required to make the decision in question given to a person with capacity to understand the information, who freely, without coercion, agrees to taking part in a study (Nisselle, 2008). Informed consent, however, is more complex; “it requires a balanced and interactive discussion of benefits and risks, a discussion of alternatives...and a discussion of what could happen if the patient elects to have no treatment...” (Nisselle, 2008, p.1). According to the National Institute for Health Research (2016), consent is a five-step process involving, (1) invitation to participate; (2) time to consider; (3) discussion; (4) formal agreement; and (5) willingness to continue.

Whilst the consent process for the therapist participants was straightforward, the process for the client participants was necessarily more complex. In order to go through consent procedures with the potential client participants, the two-stage test of capacity outlined in the Mental Capacity Act (2005) was followed to confirm the therapist’s initial assessment of capacity; this involved assessing whether the individual could understand the information, retain the information for long enough to make a decision, weigh up information in order to make a decision, and enable the individual to communicate their decision through any communication method. Guidance provided by Cameron and Murphy (2006) on recognising positive and negative indicators for giving consent was followed, as well as important recommendations, such as offering repeated consent meetings to give potential participants the necessary time to process information. Importantly, the clients were informed that whether or not they chose to take part in the study, their therapy would not change in any way and they were free to withdraw their consent to taking part in the study at any point.

### ***Recruitment***

Therapists that matched the inclusion criteria for the study were approached in the first instance; they were given the Therapist Participant Information Sheet (see Appendix F), providing them with information about the research. Those therapists that were willing to participate, were invited to attend a consent meeting with the researcher; those who consented to taking part in the study, signed the Therapist Participant Consent Form (see



Appendix G). Participants were then asked if they were due to start therapy with a client matching the inclusion criteria and engaging in a therapeutic contract that matched the inclusion criteria. Where this was not the case, they were asked to notify the researcher when they next found themselves in this situation.

For each therapy dyad, once the therapist had been identified and a possible client had been found, the therapist was requested to ask the client during their assessment session if they were happy to be contacted by the researcher about a study; those clients who were willing, completed the Consent To Contact Form (see Appendix H). A meeting was then arranged between the researcher and the client before therapy was due to start; during this meeting the researcher used the Client Participant Information Sheet (see Appendix I) to provide the client with information about the study. Those clients who consented to taking part in the study completed the Client Participant Consent Form (Appendix J). This recruitment process continued until four therapy dyads had consented to taking part in the research.

### ***Interview process***

All therapy sessions with each therapy dyad were video recorded by setting up a small unobtrusive camera in the corner of the therapy room to ensure view of both client and therapist. At the end of each session, the HAT form was completed by the client in order to identify the most helpful events in the session. Data was collected by conducting qualitative research interviews with each participant on two separate occasions. In order to minimise the burden placed on client participants, interviews were scheduled at least two days after the session; the therapist participant interview then followed shortly afterwards. Therefore, two therapy sessions for each therapy dyad were included in the study, with a separate interview occurring on a separate day for each participant; the therapist participants were asked to select one session out of the first few sessions and one session out of the final few sessions. This method of session selection was chosen because it was hoped that, by asking the therapists to select sessions based on how productive they thought the session was, it would be less threatening for them. That is, by giving them some control over which sessions were focussed on for the purpose of the study, the therapists may feel less exposed; this method of session selection was also

hoped to maximise the richness of the data by relying upon therapist judgement, as well as consulting the client experience of the session by referring to the HAT form.

In accordance with the BSR procedure described by Elliott and Shapiro (1992), the researcher played the recording of the session to the client until the event was located; the client was asked to describe the context of the event, the event itself and its impact. The HAT form was used as a flexible tool to support this process in identifying the event, rather than being solely relied upon; therefore, where the client was unable to identify a discreet event, the researcher encouraged the client to stop/start the video at any point and encouraged them to talk about the most helpful part(s) of the session. To this extent, an adapted remote control with fewer and larger buttons was utilised to support the client participants to independently control the video recording. In a separate interview, the researcher played the identified event/parts of the session for the therapist, asking them to describe the context of the event, their intentions during the event and its impact on the client. This data collection procedure was then followed for each therapy dyad for each of the selected sessions. The interviews lasted for between 14 minutes, 41 seconds and 59 minutes, 54 seconds.

### ***Transcription***

Client and therapist participant interviews were transcribed by the researcher using the orthographic transcription method; this was considered adequate since IPA is interested in what participants say about their experiences rather than any in-depth analysis of how words are said. Whilst, by having an external person to undertake the transcription may add veracity to the interview transcripts, it was important for the researcher to transcribe all of the interviews themselves as this allowed immersion in the data and formed the beginning stage of IPA. Furthermore, once the interviews had been transcribed, the researcher then checked each one for accuracy against the audio recordings.

### ***Data protection***

All data generated during the study was kept confidentially and in line with the former Data Protection Act 1998 up until the completion of data collection in April 2018. At this point new legislation came into effect, and from this point forward all data was stored

confidentially in line with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. All study data, including video recordings of the therapy sessions, audio recordings of the research interviews, and transcribed interview data, was stored on a 7-Zip encryption folder on the University of the West of England secure server which gets automatically backed up. The video camera was stored in a locked filing cabinet at the NHS site and was never moved from the NHS site without its contents first being erased; once video recordings had been transferred from the video camera to the 7-Zip encryption folder, they were deleted. Video recordings of the selected therapy sessions were viewed on a laptop during the research interviews, but were never saved to the laptop. The Dictaphone used to record research interviews was never moved from the NHS site at which the interview took place without its contents first being transferred to the 7-Zip encryption folder, and its contents being subsequently erased. Questionnaires, consent forms and paper copies of the analysis were stored in a locked filing cabinet. Participants were given a pseudonym to ensure the data they contributed was as far as possible anonymised for the purpose of the study write-up. Any identifying data linking participants to their pseudonym were locked in a separate filing cabinet.

### **Data analysis**

Interpretative phenomenological analysis (IPA) was used to analyse the interview data; the following procedure was followed, as detailed by Smith, Flowers and Larkin (2009). The researcher began by listening to the first interview recording and then re-read the interview transcript in order to feel fully immersed in the interview data. Initial notes were then made on the right-hand side of the transcript; these notes included descriptive comments that focused on the content of what the participant said, linguistic comments that examined the language used by the participant, and conceptual comments that focused on engaging with the data at a more interpretative level. On the left-hand side of the transcript, the researcher next identified emergent themes; these were based mostly on the initial notes but were also closely tied with the interview transcript. Once a list of emergent themes had been developed, they were then refined into an initial list of super-ordinate themes and sub-themes. The researcher then moved onto the next interview transcript to repeat the process, making sure that each new transcript was approached on its own terms. Once this process had been repeated for each interview transcript, the

researcher then moved onto looking for patterns and connections across cases which involved further refinement of the themes into a master table of super-ordinate themes and sub-themes.

More specifically, patterns and connections across clients and also across therapists were explored, as well as exploration of the extent to which there was any consistency between clients and therapists. The analysis also looked for patterns and connections within each therapy dyad between client and therapist.

In order to illustrate the data analysis process, a number of sections of analysed interview transcripts can be found in Appendix K.

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## 4. Results

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Interpretative phenomenological analysis (IPA) was used to analyse the 15 interview transcripts. To illustrate how themes were identified from the interview transcripts, see Appendix L for the map of initial themes for Client Participant 4 and Appendix M for the table of initial themes; Appendix N then shows the master table of themes for all client participants. Furthermore, see Appendix O for the map of initial themes for Therapist Participant 2 and Appendix P for the table of initial themes; Appendix Q then shows the master table of themes for all therapist participants.

The analyses were focused on exploring themes from the interviews of client participants and therapist participants, as well as exploring themes within the individual therapy dyads. Upon examining the themes identified from time one and time two, no dissimilarities were found, and indeed this analysis did not differ from that of the analyses of client themes and therapist themes; therefore, this analysis has not been included in the writeup of the results.

The proceeding sections will first present the significant therapy events that were the focus of the research interviews, identified by the client participants using the Helpful Aspects of Therapy form. The following section will then focus on describing and illustrating the super-ordinate themes and sub-themes identified from the client participant and therapist participant interviews. Finally, this chapter on 'Results' will then conclude by presenting a schematic diagram depicting a speculative relationship between the sub-themes.

Direct quotations from the interview transcripts are presented to illustrate each of the themes. Table 4 on page 54 shows a key to indicate from whom the quotation has been taken, as well as to indicate pauses, inaudible sections, and points at which names have been omitted to ensure confidentiality.

Table 4: Key to supplement direct quotations.

<b>Key to Abbreviations</b>	
<b>CP</b>	Client Participant
<b>TP</b>	Therapist Participant
<b>I</b>	Interviewer
<b>...</b>	Indicates a pause in conversation
<b>[Inaudible]</b>	Indicates that the participant's speech could not be understood
<b>[Therapist]</b>	Indicates where the therapist's name has been omitted
<b>[Client]</b>	Indicates where the client's name has been omitted
<b>(interview 1)</b>	Indicates a quotation taken from the participant's first interview
<b>(interview 2)</b>	Indicates a quotation taken from the participant's second interview

## 4.1 Identifying significant therapy events

The Helpful Aspects of Therapy form was completed by all client participants at the end of every therapy session. Table 5 shows the significant therapy events identified by each client participant, which were then focused on during the research interviews.

*Table 5: Client-identified significant therapy events.*

<b>Therapy Dyad</b>	<b>Interview 1</b>	<b>Interview 2</b>
<b>Dyad 1:</b> <i>CP1 &amp; TP1</i>	The hot cross bun – the idea that I can change thoughts and behaviours	Expressing my feelings
<b>Dyad 2:</b> <i>CP2 &amp; TP2</i>	Gave positive answers to questions that were asked	Getting things off my chest
<b>Dyad 3:</b> <i>CP3 &amp; TP3</i>	Understanding my anger better – coming up with the phrase “HSD anger”	Learning how the way I feel affects other people and how other people think differently to me
<b>Dyad 4:</b> <i>CP4 &amp; TP4</i>	Mindfulness with chocolate	Drawing about my friends

## 4.2 Super-ordinate themes and sub-themes

Five super-ordinate themes were identified from the analysis; see Table 6.

Table 6: Master table of super-ordinate themes and sub-themes.

Super-ordinate Theme	Sub-Theme
<b>1. The Uniqueness of the Therapeutic Relationship – “...I’m saying things now that I would never say to anyone...”</b>	a) To talk and be heard
	b) Importance of building trust
	c) Working collaboratively
	d) Walking in the client’s shoes
<b>2. Using Adaptations to Express Emotions – “...I wanted [therapist] to see it”</b>	a) The process of expressing emotions
	b) The shift in emotions
	c) Making adaptations
	d) The others in the room
<b>3. Client Behaviour/Therapist Behaviour – “...and she just started spontaneously drawing and I went with it”</b>	a) Focus on coping strategies
	b) Therapist approach
<b>4. Hope and Paternalism – “I always think like maybe she’s telling me, I might be wrong here, that you are not alone...”</b>	a) The message of hope
	b) Empowering the client
	c) Worry and protection
<b>5. Meaning Making – “...I want to be here. I want to be with [partner] for the rest of my life”</b>	a) Client realisation – the shift
	b) Focus on significant therapy event
	c) Choice of significant therapy event



### **4.3 Relationship between themes**

Through undertaking the analysis of the research interviews, a more detailed understanding of the process surrounding significant therapy events has been gained. This has therefore enabled a speculative understanding of how the sub-themes identified for the client participant and for the therapist participant interviews, may be connected. That being the case, a schematic diagram illustrating how these themes may fit together is shown in Figure 1 on page 57.

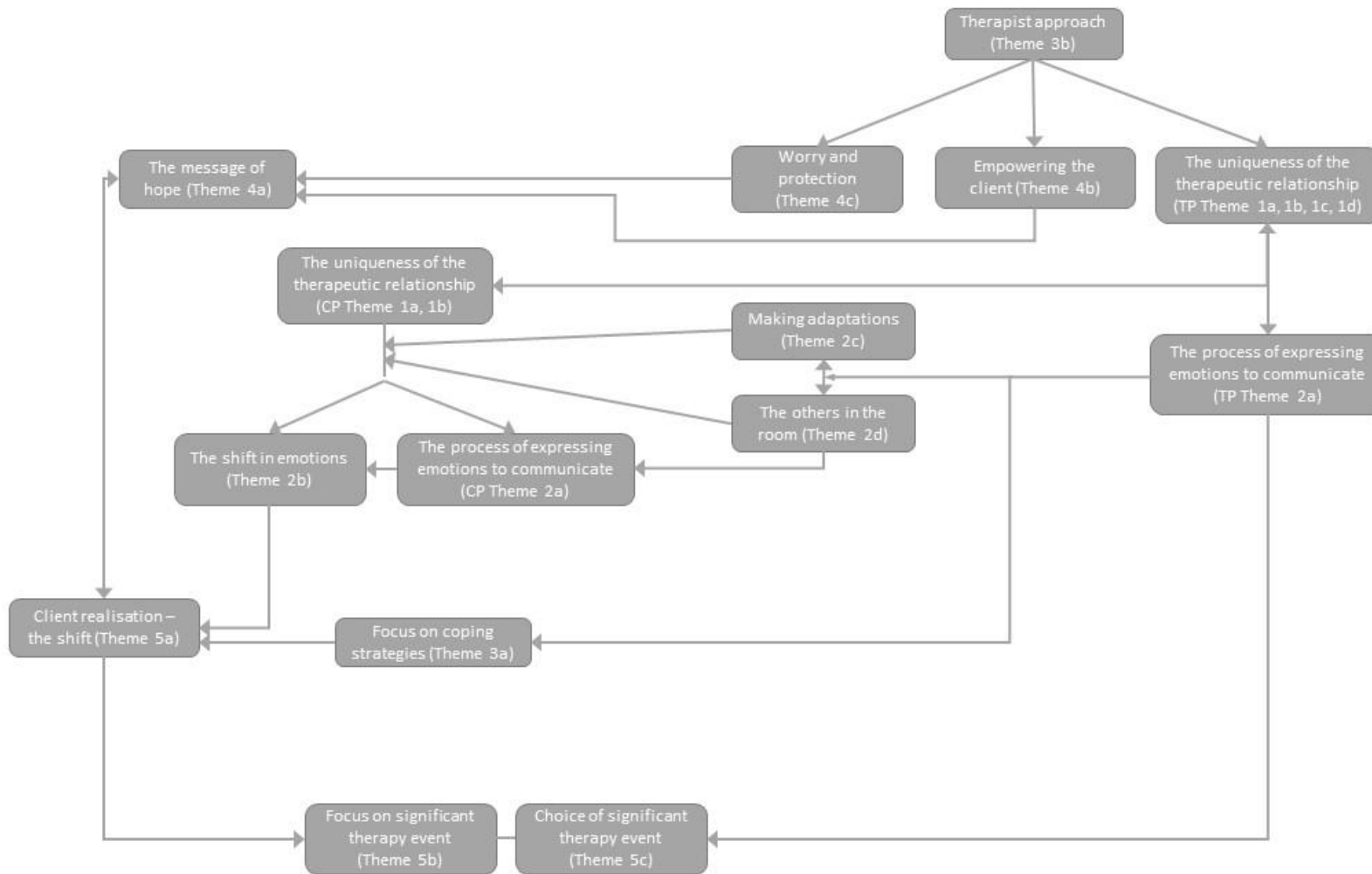


Figure 1: Schematic diagram illustrating the sub-themes.

#### **4.4 Presentation of the super-ordinate themes and sub-themes**

A more detailed presentation of the super-ordinate themes and sub-themes now follows, with direct quotations from the interview transcripts presented to illustrate each of the themes.

##### ***Super-ordinate Theme 1: The Uniqueness of the Therapeutic Relationship – “...I’m saying things now that I would never say to anyone...” (CP3).***

The first theme encapsulates participants’ experience of the relationship they had with one another at the point of experiencing a significant therapy event. Client participants spoke about what it was like to talk and be heard as well as having trust. Therapist participants spoke about the key aspects of the therapeutic relationship, namely, listening, building trust, working collaboratively, and showing empathy.

##### **Sub-theme 1a: To talk and be heard**

Client Participants seemed to be alluding to the therapeutic relationship in their narrative by exploring what it was like to talk to their therapist.

“Coz although I love to talk to [partner] but I felt coz...[partner] got other [partner] not been very she’s not been feeling very well herself and I just haven’t I haven’t wanted to put pressure on [partner] and I just it was just nice to talk to someone it was just nice to talk to someone outside the family, to talk to a stranger how I was feeling” (CP1, interview 1: 12).

“Yeah, well er...just to talk to someone normal” (CP2, interview 2: 6).

Client Participant 3 referred more specifically to the skill his therapist had in listening to him and understanding exactly what he was saying.

CP3: “...um and listening”

I: “Ah listening...”

CP3: "So I'm basically talking every single second and [therapist] all she's saying is 'oh that's what you're saying' um...and like writing down it's like 'oh my god you are good'"

I: "Ah, so you found that helpful that she was listening?"

CP3: "That's right, yeah she listened to every single word um...if she didn't understand what I was saying she normally asked me anyway 'so you're on about this or are you on about this', so I'd be like 'no it's this' or 'it's that'" (CP3, interview 1: 6-7).

Therapist Participant 2 spoke about providing their client with a therapeutic space within which the client could talk.

"Um...I think I tried to offer him a space where he could speak and I could show him that I was listening. So, I would summarise what he was saying and um...trying to get more clarification from from him" (TP2, interview 1: 3).

#### Sub-theme 1b: Importance of building trust

Building trust with the therapist seemed to be key for enabling clients to talk more easily and freely.

CP1: "I felt anx I felt anxious"

I: "You felt anxious when you were sat there with [therapist]?"

CP1: "Yeah"

I: "Yeah. Why do you think you felt anxious?"

CP1: "Um coz like it was my first session...and I and I didn't really know [therapist] that well. But that now I know [therapist] I don't get so anxious" (CP1, interview 1: 6-7).

"...I'm saying things now that I would never say to anyone..." (CP3, interview 2: 17).

Within therapy dyad 4, participants spoke about the importance of trust, which can be thought of as an important aspect of the therapeutic relationship. Client Participant 4

spoke about needing time to build trust with people, and Therapist Participant 4 acknowledged the need for time in building trust with her client.

“Coz like when it’s different people say like if I don’t know them sometimes I won’t let anything out. But I try and get some of it out but most of the time I can’t get it out. And it’s like as I get to know you I trust you and then that’s when I start letting stuff out” (CP4, interview 1: 9).

“I think the way I related with her was more like relational I think you know for me it’s about that um...the relationship the you know building that trust. [client] has had lots of um...disruptive disrupted relationships in her history um...so she finds it difficult to trust people, people keep coming in and out of her life um...so for her it’s quite difficult so the trust, the relationship and what happened in the room...” (TP4, interview 1: 5-6).

Within therapy dyad 3, participants spoke about particular aspects of their relationship that seemed helpful. Client Participant 3 reflected on trusting his therapist and how trust is usually hard for him.

CP3: “More calm, happier, trust, and that’s very very hard with me, I can’t trust no-one”

I: “Hm mm...but it felt like you were starting to trust [therapist]?”

CP3: “Hm mm...yeah that’s it...” (CP3, interview 1: 11-12).

Therapist Participant 3 spoke about the importance of time for building up the trust.

“...I think he felt listened to and I think because he lacks self-confidence and it’s taken a few sessions of assessments for him to even have the confidence to speak...” (TP3, interview 1: 2).

### Sub-theme 1c: Working collaboratively

All therapist participants spoke about building the therapeutic relationship, focusing more specifically on some of the things they do to build this relationship. Some participants spoke about working collaboratively with their client.

“Um well I we set the agenda agenda together” (TP1, interview 1: 7).

“...all of the questions that I ask him, including in that session, he says ‘oh I never thought about that before’ and then he panics for a second and thinks he doesn’t know the answer so we just say oh I say, ‘let’s just think about it together’ then he’s able to come up with an answer...” (TP3, interview 1: 15).

### Sub-theme 1d: Walking in the client’s shoes

The use of empathy was also spoken about in terms of helping to build the therapeutic relationship.

“...trying to understand that actually yes he has been through quite a lot and there are people that will can make you feel angry...” (TP2, interview 1: 3-4).

“Um...I was feeling um...empathic towards him...” (TP3, interview 1: 2).

Humour, used as a way of empathically connecting to a client, was also mentioned by Therapist Participant 1.

“...and then talking more about his personal life and helping to relax him and building that therapeutic relationship. And use humour like we were talking about the cats and humans and fish” (TP1, interview 2: 1).

***Super-ordinate Theme 2: Using Adaptations to Express Emotions – “I wanted [therapist] to see it” (CP4).***

When client participants focused on the significant therapy event, they spoke about how they were able to express their emotions to their therapist, noticing how their mood changed from beginning to end of the event. Therapist participants focused on describing the adaptations they made in order for their client to communicate, as well as the unintentional adaptations to therapy, namely the others in the room with the client.

Sub-theme 2a: The process of expressing emotions

This sub-theme reflects the importance client participants placed on expressing their emotions as a way of reflecting their inner world and letting their therapist know what was going on for them.

I: “...what were you doing or what were you trying to do?”

CP1: “Um...talk talk about how I was feeling”

I: “Hm...mm...”

CP1: “Of being really stressed out...and stuff like that” (CP1, interview 1: 8-9).

“Um...express my feelings and that...it feels like it’s been a great great big weight on my shoulders has been lifted off” (CP2, interview 1: 9).

“Yeah, it’s like um...when I was talking about the problem it’s a lot easier than keeping it in, the more you talk about it the more better it is” (CP3, interview 1: 1).

“Um...get getting out how I was feeling off my chest” (CP1, interview 1: 12).

Client Participant 4 spoke about drawing in her therapy session as a way of being able to express her feelings to her therapist.

“Yeah sometimes it depends sometimes I like just drawing on my own and have no-one see you, but obviously I want at that time I wanted [therapist] to see it” (CP4, interview 2: 29).

Within therapy dyad 2, participants seemed to refer to talking during the therapy sessions as being helpful. Client Participant 2 spoke about the helpfulness of talking by contrasting this experience with not having anyone to talk to outside of therapy sessions.

“...sometimes I hate it and then just look at the four walls and the only interaction you get is when you phone someone or you know on the tv really but...” (CP2, interview 2: 3).

“...I think being able to talk it out aloud was really good for him to kind of think about actually the way if I think angrily then I’m gonna feel anger and I’m gonna behave aggressively...” (TP2, interview 1: 6).

Client Participant 3 spoke about his emotions in therapy in terms of the stark contrast between his previous experience of not being understood, and now being able to successfully express his emotions in therapy.

CP3: “Yeah with me it’s like with my speech and that it’s like not good so every time I try and talk it’s like [I] don’t make English so I try and teach myself to talk properly, got help for it”

I: “Hm mm...but [therapist] seemed to understand you?”

CP3: “Yeah that’s one thing that I don’t understand how did she understand...” (CP3, interview 2: 7).

Therapist participants spoke about being able to recognise the emotions of their client. They particularly spoke about this with regard to recognising and appreciating their client’s efforts in being able to express their emotions.



“...I suppose it doesn’t matter what language you’re using to express yourself, at least if he feels he’s got his point across and it’s and it’s a positive evaluation then perhaps that’s enough...” (TP1, interview 2: 2).

“...he took more ownership of the whole process I think so...he was really keen to get going coz I think he lacks a feeling of any mastery or ability in his the rest of his life, he hasn’t got a job or anything so be able to do this and do it, feel like he’s doing it well and better at understanding himself at the same time I think that was really powerful” (TP3, interview 1).

“...she just gets into a place where she feels comfortable and she can talk about things” (TP4, interview 2: 11).

Within therapy dyad 1, talking during the therapy sessions was referred to quite differently by the client and therapist participants. Client Participant 1 found talking to be helpful.

“Um...it helps me talk my thoughts what how I’m feeling” (CP1, interview 1: 2).

By contrast, Therapist Participant 1 seemed to allude to talking as not always being easy.

“Um...I think I was trying to um...elicit from [client] what he found helpful about the therapy up to that point” (TP1, interview 2: 1).

“...he was quite quiet, he’s not hugely articulate, wondering if I could, if I needed to elicit more...” (TP1, interview 2: 2).

### Sub-theme 2b: The shift in emotions

Client participants reflected on noticing a change in their emotions from beginning of the significant therapy event to the end of the significant therapy event.

I: “...how were you feeling when you arrived at the session, do you remember that?”

CP3: "Yeah I was p\*\*\*ed off"

I: "Ah...so you were p\*\*\*ed off when you arrived?"

CP3: Yeah I was really angry, really annoyed, really fed up and as I talking about it and talking how I felt and yeah I reckon it is leads up to what I'm talking about...I felt more happier um...coz I let it out my feeling was in that week, um...yeah I love it, I really love it" (CP3, interview 1: 8-9).

"Coz sometimes when I'm unhappy obviously obviously coz to be honest that day you know I was a bit unhappy but after that it did cheer me up" (CP4, interview 1: 3).

Client Participant 1 reflected on how he noticed that some of his emotions improved or became less intense after the significant therapy event, however this was not the case for all of the difficult emotions he was aware of.

I: "...and did they change once you'd kind of looked through at that hot cross bun?"

CP1: "Some some of them but not all of them"

I: "Some of them but not all of them ok"

CP1: "I still felt uptight...I didn't feel didn't feel I still felt still anxious, uptight and but I didn't feel so frightened" (CP1, interview 1: 13-14).

Therapist participants seemed to become more attuned to their client's emotions, and spoke about recognising changes in their client's mood from the beginning to the end of the significant therapy event.

"Um...yeah he he seemed to brighten up. He seemed to be more engaged um...he's his kind of body posture, his facial expressions changed..." (TP2, interview 1: 6).

"...he did seem pleased to be able to to realise that there was something he could do" (TP1, interview 1: 9).

“...he was much happier and self-confidence seemed to have improved by the end...” (TP3, interview 1: 13).

### Sub-theme 2c: Making adaptations

Therapist participants spoke about adapting the therapy to suit the needs of their client. This was often achieved more broadly through making adaptations to communication.

“...kind of balancing the encouraging him to express himself with like I said use some different words but also not wanting to put too much pressure on him either...” (TP1, interview 2: 2).

“...so, I’m just looking at her drawing and I’m just saying I I need to go with this because she’s trying to communicate something to me with drawing with the with this people and what’s happening to them that um...that she can’t put into words...” (TP4, interview 2: 3-4).

“Um...trying to give him time to speak” (TP3, interview 2: 7).

Therapist participants spoke about making adaptations to the therapy model and the work undertaken in the therapy sessions themselves. Therapist Participant 1 spoke about making adaptations to the therapy model.

“...I guess the agenda on the review is really I kept it quite simple due to [client] level of understanding um...and concentration span I guess...” (TP1, interview 2: 4).

“...I wasn’t quite as rigid as you would be in a kind of really traditional CBT model because I thought the with [client] he’s not got the level of understanding you wouldn’t be able to fit all of that in anyway so I kind of tailored it to him...” (TP1, interview 2: 5).

When referring to the use of coping strategies, therapist participants tended to reflect on how the strategies were adapted in some way to meet the needs of their client.

Therapist Participants 2 and 4 spoke about the need to repeatedly practise coping strategies with their clients in the session, so that through repetition they would be more able to practise the coping strategies independently outside of therapy.

“...and he was gonna um...practise these um...thought patterns and implement relaxation strategies” (TP2, interview 1: 7).

“...I think my intention was um...to allow [client] to practise one of the strategies that we had worked on in session, so that through practise with me she could learn to practise mindfulness independently so it was really learning, it was practising and learning” (TP4, interview 1: 1).

#### Sub-theme 2d: The others in the room

Whilst all client participants were attending individual therapy sessions, most therapist participants spoke about there being someone else in the room with their client during the therapy sessions. The impact of this was reflected on by participants in differing ways. Therapist Participant 1 spoke about questioning the appropriateness of having her client’s partner in the room.

“...the whole time I’m wondering if it’s appropriate for her to be in the session, but he wants her to be so that’s appropriate in that sense” (TP1, interview 1: 4-5).

Therapist Participant 2 spoke positively about having her client’s mum in the therapy sessions.

“...and also having [client’s mum] there was really good because she could also help me understand what was happening and what was going on and how that was affecting their relationship...” (TP2, interview 1: 4-5).

By contrast, Therapist Participant 3 spoke about having a negative experience of having a support worker in the therapy sessions with her client.

“I think one of them was talking a lot at the beginning, taking lots of phone calls and that was quite disruptive kind of ‘oh I didn’t realise this session was an hour’, then ‘I have to go and make a phone call now’” (TP3, interview 1: 7).

However, Therapist Participant 3 did then reflect on how this situation provided an opportunity for her client to feel empowered to take control in a safe space.

“...I thought it was quite key because he was able to say, ‘actually don’t interrupt my session, can you go out the room please’, so that was really good” (TP3, interview 1: 7).

***Super-ordinate Theme 3: Client Behaviour/Therapist Behaviour – “...and she just started spontaneously drawing and I went with it” (TP4).***

This theme illustrates the behaviours of the client and therapist during the time surrounding the significant therapy event. These aspects of the event appeared to relate to that which the therapist could see and was aware of. These tangible elements were spoken about by client participants as coping strategies. Therapist behaviours tended to relate to the type of approach they followed with their client, with the emphasis placed on being client-led, but with some aspects of taking a more directive approach at times.

Sub-theme 3a: Focus on coping strategies

Learning about coping strategies to manage difficult emotions was spoken about by all client participants. Some participants also referred to issues of dependence upon others, since coping strategies involve the client independently implementing such strategies outside of therapy.

CP1: “Um yes it was about planning on going to [town]”

I: “Mm hm...yeah”

CP1: “Coz like, well until we went to [town] I wasn’t going I wasn’t going out I was just I was just staying in all the time”

I: “Ah ok”

CP1: “And that I felt that I felt that once I got out although I felt anxious about it and I felt really anxious about it but I felt better because I got out of the house, I got out in the fresh air and I I got out instead of looking at the same four walls all the time” (CP1, interview 1: 4).

“Um...talk about strategies and how to calm down by listening to music and things” (CP2, interview 1: 7).

“Well the anger I just want to get rid of or control it or think about something else like say I’m angry right now, I just want to think of the technique to like tell me

that 'no I can't, I'm happy, I'm not going to let that bother me, jog on'" (CP3, interview 1: 4).

Client Participant 4 reflected on how mindfulness was a new strategy that she had not used before, but was open to trying it in the session with her therapist.

"...I didn't know that what we done on there I didn't know that it it helps doing that coz I didn't know nothing about it" (CP4, interview 1: 1).

Despite there being a focus on coping strategies as being useful, some participants did speak about some of the difficulties of using coping strategies outside of therapy and how their dependence on others sometimes made it difficult to independently implement such coping strategies.

"Yeah I do get upset a lot. But obviously yeah it does well I haven't done it yet so..." (CP4, interview 1: 2).

CP2: "Yeah and um...this was like before I even met my mum and I I did fly off the handle and I said, 'just watch yourself because next time I won't be so nice' and they were like 'oh well this is [inaudible]' and I was like I couldn't walk away from it because I had to wait for mum to give me a lift"

I: "Ah so you had to be there you couldn't go anywhere, that's very hard"

CP2: Normally I would walk away but course can't walk away from the situation when because then mum would've gone 'well you're late'" (CP2, interview 2: 7).

### Sub-theme 3b: Therapist approach

Therapist participants spoke about the type of approach they followed when working with their client. Participants seemed to allude to taking more of a client-led approach.

"Probably playful and allowing her to just have some fun and um...and tolerating that without judgement in terms of you know telling her 'oh [client] you shouldn't have done that and stay focused' or whatever this was like 'oh that's fine just

thank you for having tried', it was the end of the session as well, so she's been working um...for a long time...". (TP4, interview 1: 4)

"...just me trying to capture that, any positives because of my, the level of anxiety I was feeling by help trying to help him so he mentioned that he'd been to the YMCA...so he was quite pleased with that, so that...and I was just making sure I'd spent enough time on that" (TP1, interview 1: 7).

"...I'm happy to throw my papers in the air and go 'yeah yeah, what do you want to do?' 'star jumps, let's start there', you know so..." (TP4, interview 2: 16).

For Therapist Participants 2 and 3, there seemed to be some initial uncertainty about the usefulness of providing their clients with the space to express themselves.

"...I could've intervened more I guess and done short summaries to try and keep on track and refocus it back on what I was trying to do but I was trying to also allow him space to just go with it" (TP3, interview 1: 5).

TP2: "...I think as a therapist I'm I don't know if maybe I've let I let him speak too long or didn't kind of stop him to kind of clarify certain bits or um...coz there was one bit where he went off in a bit of a tangent um...to pull him back, I may may not have had the confidence to do that. Um..."

I: "And yet this is a helpful point for him as well..."

TP2: "Yeah yeah which is interesting um...yeah I suppose I just gave him that time to kind of talk and listen to him..." (TP2, interview 2: 3-4).

It does also seem to be very important to have the resources available for clients to use should they so choose, if indeed a client-led approach is being followed.

"...we had been using the big paper for the maintenance cycles and she just started spontaneously drawing and I went with it. So, it was not my intention for her to start drawing in the middle of my ending session but that's what she



wanted to do and I just went with it and thought let's see where this takes us"  
(TP4, interview 2: 2).

At other points, there seemed to be a contrast with taking a client-led approach, by participants talking about taking a more directive approach in the therapy sessions.

"Um, using the CBT model to give him something to do to structure his time um...to get him on board with the model..." (TP1, interview 1: 2).

"...so, aiming...redirecting his focus and asking him to clarify what he, how he experienced his anger, what it felt like, what it looked like um...and to give him some, and I was also trying to explore the, so doing that also exploring the function of the anger..." (TP3, interview 1: 2).

***Super-ordinate Theme 4: Hope and Paternalism – “I always think like maybe she’s telling me, I might be wrong here, that you are not alone...” (CP3).***

This theme encapsulates the tension between hope and paternalism. Client participants tended to speak about their experience of having hope, whilst therapist participants alluded to the need to manage more of a beneficence/paternalism balance, by having hope for their client to succeed and feel empowered, while simultaneously protecting their client and managing risk.

Sub-theme 4a: The message of hope

All client participants spoke about experiencing hope in their therapy. For some, this seemed to begin initially as an indirect message that they received from their therapist.

“I don’t know just like listening and talking to me so that’s how and like I thought I always think like maybe she’s telling me, I might be wrong here, that you are not alone, maybe there is loads of other people out there who feel exactly the same that’s what I think to myself” (CP3, interview 1: 12).

“Um...I think she um...I what did I...that’s a tricky questions um...it was helpful what she said and how she um...said to how to get round it and that’s when I thought ‘yeah’...” (CP2, interview 1: 6).

Within therapy dyad 1, participants spoke about receiving the message of hope as being very powerful.

I: “So even though you felt really anxious you found that session one of the really helpful ones?”

CP1: “Yeah”

I: “Mm hm. Why do you think that was?”

CP1: “Um, because coz actually how how she said about getting out every day” (CP1, interview 1: 7).

“...I suppose that just speaks to the powerful message that he’d received from the first session in that in that something can be done, there’s hope and it’s empowering...” (TP1, interview 1: 12).

After experiencing a significant therapy event, all client participants expressed having hope for their future and hope that they will achieve their goals or make positive changes to their lives.

“...going out...um going to YMCA and playing snooker” (CP1, interview 1: 15).

“Yeah, it’s just like I’d like to I just want a full-time job...I just want something what sort of keeps me active and doing something” (CP2, interview 2: 11).

“Have more friends. And sometimes I wish they were real was real coz if they were real I could just do anything” (CP4, interview 2: 37).

Some therapist participants seemed to talk about a desire for clients to experience hope.

“I think yeah, definitely progress towards what to do about the problems um...kind of again gave him some hope that actually he’ll he is able to manage his anger” (TP2, interview 1: 7).

“...it’s not this mysterious therapy – what’s going to happen, what’s it going to entail, this is what we’re going to be doing, it’s quite a simple idea, we won’t spend a lot of time on it” (TP1, interview 1: 9-10).

Other therapist participants seemed to talk about holding on to some doubt about the usefulness of coping strategies or whether the environment within which the client lived would prevent any positive change from generalising into the client’s life outside of therapy.

“...she came to therapy and she said ‘I had a whole bag of chocolate’, but then I said to her ‘oh yeah did you do it mindfully?’, she said ‘no I didn’t’, so and she rarely ever said that she’d used the techniques anyway” (TP4, interview 1: 12).

“Um...I think if he was living in a different setting then he might have more um...or his hours of support might be used in a different way but the place he lives is consistent with kind of view of from the clients and from the professionals that go in there is that it’s more like a hotel – the staff are there in the background...” (TP3, interview 2: 14).

Within therapy dyad 4, participants spoke about hope as if it were on a continuum running from hope to hopelessness. Client Participant 4 reflected on feeling hopeful that she will learn, but recognising that this may take a long time.

“...and one day I will eventually learn, but it might take years and years and years, but I will learn” (CP4, interview 2: 25).

In contrast, Therapist Participant 4 expressed hopelessness when talking about introducing mindfulness into the therapy sessions.

“Um...and so we did this one and I realised when I was doing this one how hard it was to actually keep the focus of what mindfulness is trying to do” (TP4, interview 1: 1).

However, by the time the therapy sessions came towards the end, Therapist Participant 4 spoke about having hope for her client.

“...the [therapeutic] letter has something where there’s a part of it, bit of it that says ‘you have a lot of creativity and perhaps you and your friends, you could write a story um...that could help children with learning disabilities and children that are looked after and how to, you know perhaps you can do some comic strips or um’...just encouraging

her to keep writing or keep drawing about that coz that has to mean something and it needs to come out..." (TP4, interview 2: 15).

#### Sub-theme 4b: Empowering the client

Therapist participants spoke about trying to empower their client by enabling them to take control over the sessions and make decisions themselves.

"...I was trying to encourage him to feel more confident and heard and develop his confidence in that I could understand what he was saying and then giving him some ownership towards of of the idea of what a of the structure of the session of the aim of the session so he was able to name I was hoping he'd be able to name his anger and and feel proud of being able to do that" (TP3, interview 1: 3).

"...so, it was kind of about kind of breaking that spiral slightly and try to...it was all I almost kind of used elements of CAT theory thinking about what was his exits, how could he get out of this spiral..." (TP2, interview 1: 3).

#### Sub-theme 4c: Worry and protection

However, in contrast, some therapist participants spoke about a need to protect their client as well as experiencing worry about them. Such responses could be likened to that of a paternal response.

"...I was feeling more pressure to make sure that the risk stuff had been considered..." (TP1, interview 1: 3).

"I think I was worried that he was disengaging a bit coz he was worrying. I was worrying about the risk at the same time because when he feels very low he does self-harm..." (TP3, interview 2: 4).

"...it had been helpful so I wanted to kind of draw that out um...draw out all the positives to help keep him safe and keep him feeling better..." (TP1, interview 1: 7).

For Therapist Participant 4, there seemed to be some sort of tolerable balance between protecting her client and empowering them.

“Um...I think she realises she can speak to me about these things which are very intimate um...she can talk about thoughts you know I ask her questions that are very provocative, ‘what’s the crime that you would like that you would want to do the most’ and she’s like ‘gosh ok you can talk about someone without...she’s not freaking out’ because that’s what she’s seeing, I can tolerate it, I can hold it, she’s not you know and and and gets that you know unconditional acceptance. Yeah let’s talk about it, let’s manage risk if there’s any...” (TP4, interview 2: 13).

***Super-ordinate Theme 5: Meaning Making – “...I want to be here. I want to be with [partner] for the rest of my life” (CP1).***

This theme refers to making sense of the significant therapy event as well as the impact of the event. The way in which the therapist participants focused on the significant therapy event reflected a sense that meaning making for clients was often internal. Indeed, there is some suggestion of disparity between client participants and therapist participants as to which session contained a significant therapy event.

Sub-theme 5a: Client realisation – the shift

Client participants spoke about experiencing moments of change during therapy in which they noticed a shift in the way they appraised a situation or the way in which they viewed themselves.

CP1: “Um...I felt that when I felt I didn’t want to go in the first place to the YMCA but once I done it I felt relieved and happy”

I: “Ah, you felt relieved and happy?”

CP1: “That I done it” (CP1, interview 1: 2).

“...but it was a test for myself, very positive own test...” (CP2, interview 1, 8).

The way in which some participants spoke about this indicated that this was more of an internal process of which their therapist was perhaps not aware.

I: “...what sort of thoughts do you think were going through your mind at that point when you were feeling anxious and uptight?”

CP1: “Um it was I don’t want to be here”

I: “Ah I see, so in the session you kind of you felt...”

CP1: “No”

I: “Oh not in the session but...could you say more about that?”

CP1: “Not be here at all”

I: “Ah I see. And that’s what you were thinking about in the session?”

CP1: "Yeah"

I: "Right ok. And then something did that thought change after you'd kind of talked through?"

CP1: "Yeah it changed"

I: "Ah, what did it change to?"

CP1: "That I want to be here. I want to be here. I want to be with [partner] for the rest of my life. I want to be there for my mum, because my mum's not well..." (CP1, interview 1: 9-10).

Perhaps because this meaning making process for Client Participant 1 appeared to be internal, Therapist Participant 1 perceived her client to be passive.

"Um...I think he's being a bit more passive in this session than he has been in in the last few sessions and I think maybe he was feeling so hopeless and desperate to start therapy to feel better maybe that's one of the reasons he's chose this first session as the most helpful, even though I'd I've identified the second session as probably as what one that I thought he'd find more helpful" (TP1, interview 1: 5).

Client Participant 4 spoke about how she was able to tell her therapist for the first time about her imaginary friends.

I: "So you were feeling quite miserable but you were still able to get to the session, and then once you got to when you were drawing your friends in the session, you then noticed that you felt quite happy and you were smiling?"

CP4: "Yeah, it's coz they were smiling as well so..."

I: "Ah, they were smiling?"

CP4: "Yeah. A few times they've asked me not to not to tell anyone but I didn't tell anyone but then that time they did actually say that they want me to tell her now so, tell someone now" (CP4, interview 2: 31).

Within therapy dyad 2, participants spoke about the importance of hope in the therapy sessions. Client Participant 2 spoke about how change for the better can happen, and



Therapist Participant 2 noticed the importance the client placed on making these changes.

“Um...life really um...life will change me er...for the better. And it’s no more downward spirals...” (CP2, interview 2: 18).

“...I think he was kind of, he just showed his parents actually he can do something he can change his behaviour...” (TP2, interview 2: 4).

Within therapy dyad 3, participants spoke about making sense of the client’s emotions. For Client participant 3, this involved making sense of the anger itself, and for Therapist Participant 3, this involved making sense of her client’s responses during the therapy sessions.

“...there’s someone like making me do it to survive so it’s like the anger is telling me to do it and then I survive...” (CP3, interview 2: 2).

“...maybe it’s alluding to the realisation that other people might see his anger in a way that he hadn’t thought before. He did say a lot through the session, ‘I hadn’t thought about this before’, so maybe and that’s why it’s difficult to think about” (TP3, interview 2: 12).

Some client participants spoke about there being a tension between independence and dependence, and they seemed to gain new clarity and acceptance about themselves as a result of the significant therapy event.

“And obviously it’s like that’s because I’ve got a disability and I’ve got to understand I’ve learning disabilities. It doesn’t mean I can do everything because I know I can’t, but I can do most stuff. And obviously it’s like I want to learn to drive but I don’t think I’ll be able to or if I want to go to college I can’t even do that, I can’t even go to university coz it’s gonna be too hard for me so I can’t get a job” (CP4, interview 1: 4-5).

“Yeah so, it’s like if I don’t want the anger to get in my way I just want like keep the anger far away from me I just want to be happy, be normal, be healthy, but I can’t do that, can’t do that on my own” (CP3, interview 2: 4).

Within therapy dyad 4, Client Participant 4 alluded to experiencing some acceptance of herself, and Therapist Participant 4 spoke about offering her client a space within which to feel accepted, imaginary friends and all.

“...yeah coz obviously my disabilities, I can’t get rid of it, all I can do is try and beat it, which is what I have been doing, so my disability’s not as bad now as it was when I was younger...” (CP4, interview 2: 18).

“...so, I kind of went ok let’s see if we can get some help from the friends and then that was it, brought the friends in and she went like ‘oh yeah fine you’re happy to work with them so’. And I think in a way she found it quite liberating...” (TP4, interview 2: 10).

#### Sub-theme 5b: Focus on significant therapy event

This sub-theme concerns the way in which therapist participants focused on the significant therapy event by making sense of it.

“...we went through this CBT model...to see how much he remembered um...which he did the second with the second hot cross bun he certainly did get the that he was able to compare the two diagrams as he then looked between thoughts, feelings and behaviours” (TP1, interview 1: 2).

“You know we were finishing the and she was playing up, put the headphones she was like ‘yeah I’m not going to do whatever you want me to do’ which is fine coz I do whatever they want to do. Um...and suddenly she grabs pen and paper and she’s there she’s like telling me about these people and I can ask her questions and she’s answering...” (TP4, interview 2: 11).

“...he did seem pleased to be able to realise that there was something he could do. I suppose therapy might in his mind or in lots of people’s minds be something that happens to you um...and his idea, him receiving the idea and acknowledging that it’s something he has to do and can do himself, so he can change this pattern you know to feel better” (TP1, interview 1: 9).

#### Sub-theme 5c: Choice of significant therapy event

When reflecting on their client’s choice of significant therapy event, some therapist participants seemed surprised.

“I would have said that the previous one, it was more significant therapeutically, for me it was more like ‘yes, we’ve achieved something’” (TP4, interview 2: 14).

“...I suppose it is quite um...surprising that it’s not it’s not a kind of um...I thought he might pick one like a little strategy that he’d, not a strategy but something maybe more concrete like this list of my happy happy thoughts he might have coz that kind of like a maybe due his level of understanding a a concrete thing to hang on to may may have been a choice but he’s chosen a skill which is a bit more abstract expressing himself so it’s surprising in that sense...” (TP1, interview 2: 9-10).

However, by contrast, some participants found their client’s choice of significant therapy event as not surprising.

“I thought it was expected, I thought he would choose that because he seemed so high up in mood, higher in mood after he had felt so proud of himself for coming up with this expression HSD anger, and so I was expecting that” (TP3, interview 1: 16-17).

“...it feels expected coz it felt like that was a moment of change for him” (TP2, interview 1: 8).

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## 5. Discussion

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The research questions of the current study were: i) Do clients with IDs experience significant events in psychotherapy? ii) What is the lived experience during the process leading up to a significant event? iii) How do clients with IDs make sense of their experience of psychotherapy? iv) How do therapists make sense of their experience of psychotherapy with clients with IDs? The findings relating to these research questions are discussed in the context of the existing literature. A discussion then follows focussing on the lessons learned and the considerations to be taken into account for involving people with IDs in research. Quality in qualitative research is then assessed with regard to credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Guba & Lincoln, 1994). Next, a discussion of the implications of the study findings for counselling psychology are considered. There then follows a discussion of the limitations of the study. This chapter concludes by making recommendations for future research.

### **5.1 Do clients with IDs experience significant events in psychotherapy?**

The Helpful Aspects of Therapy Form was completed by client participants at the end of every therapy session. All client participants could identify a helpful aspect of therapy, and a helpful aspect from two therapy sessions was then the focus of the research interviews with client and therapist participants.

The exploration of significant therapy events experienced by clients with IDs are not documented in the current research literature. That being the case, it is only possible to situate direct reference to the content of significant therapy events in the research undertaken within the non-ID population. With regard to the content of significant therapy events, the current study mirrors the existing literature; events have been found to contain awareness and meaning making (Llewelyn *et al*, 1988; Grafanaki & McLeod, 2002), expressing emotions (Holowaty & Paivio, 2012; McVea, Gow & Lowe, 2011) and sharing meaningful material (Grafanaki & McLeod, 2002).

By contrast, the existing literature additionally identified significant therapy events as containing problem solution (Llewelyn *et al*, 1988; Gold *et al*, 1993) and therapist contributions (Timulak, Belicova & Miler, 2010; Grafanaki & McLeod, 2002; O'Halloran *et al*, 2016). This could perhaps suggest that clients with IDs find events that they perceive to be directly linked to what they are doing as helpful rather than the contribution of their therapist. It may also suggest that clients with IDs find events that are immediately experienced within the therapy session as helpful rather than events that may help them to resolve situations at some point after their therapy session. Indeed, people with IDs have impaired executive functioning, making them less able to plan strategies in the future (American Psychiatric Association, 2013).

Therefore, it seems that clients with IDs do indeed experience significant events in psychotherapy, however these identified events do not necessarily match the perspective of research within other populations.

## **5.2 What is the lived experience during the process leading up to a significant event?**

The lived experience during the process leading up to a significant therapy event is covered in the first four themes. For clients, these themes encapsulate the value of the therapeutic relationship, being able to express their emotions and experiencing hope that they can make changes. For therapists the emphasis was on building a strong therapeutic relationship, making appropriate adaptations to ensure their clients are able to express themselves, and empowering their client during therapy by for example, taking a client-led approach. Significant therapy events have not previously been explored in psychotherapy with clients with IDs, however, it has been possible to make comparisons with research focusing more broadly on the experience of psychotherapy, and the results of the current study provide much support. By contrast, when examining the existing literature on significant therapy events within the non-ID population, there are several instances in which the findings of the current study differ.

The importance of the therapeutic relationship in facilitating and bringing about significant therapy events supports existing literature (Timulak, Balicova & Miler, 2010; McCarthy, Caputi & Grenyer, 2017). Feeling heard and having trust are thought to represent key aspects of the therapeutic relationship, indeed reflecting Bordin's (1979) theory of therapeutic alliance, as well as those essential aspects of the therapeutic relationship proposed by Rogers (1951).

It was predominantly the client participants who referred to their experience of talking in therapy; they described this experience positively, but more specifically and importantly they spoke of being heard and understood by their therapist. This supports existing literature on the client experience of psychotherapy and the therapeutic relationship (McDonald *et al*, 2003; Merriman & Beail, 2009; Pert *et al*, 2013), as well as providing support for a feasibility study in which clients reported a number of helpful aspects of their therapy sessions (Burford & Jahoda, 2012). Listening is important because, when clients feel heard, they are more likely to explore their own experiences (Myers, 2000), however, participants seemed to allude to having had little prior experience of truly being listened to, and for them this appeared to be a new and astonishing encounter. In the researcher's experience of working therapeutically with people with IDs, a general theme of clients expressing their experience of being listened to and how this contrasted to their experience outside of therapy, was always quite prominent, and many instances of such similarities were noted in the researcher's reflective journal throughout the analysis stage. Indeed, previous research has found that clients with IDs engaging in psychotherapy, reflected on how talking to their therapist felt different to talking to other people in their lives (Lewis, Lewis & Davies, 2016). This is in contrast to the experiences of people with IDs in their everyday lives in which their interactions with, for example staff, are frequently marked by a lack of reciprocity and the presence of power imbalances (Jingree, Finlay & Antaki, 2005).

Both client and therapist participants spoke about the importance of trusting one another; this seemed to be key for clients to be able to feel more at ease and be able to talk to their therapist. With regard to building the therapeutic relationship, this sub-theme of building trust supports Bordin's (1979) theory in which a key aspect of the

therapeutic relationship is the development of bonds between client and therapist which is based on trust. The importance of building trust supports the existing literature on the therapist experience of psychotherapy and the therapeutic relationship (Ryan, Guerin & McEvoy, 2016; Jones, 2013) as well as the client experience of psychotherapy and the therapeutic relationship (Roscoe *et al*, 2016).

Although trust does not receive mention specifically in the research literature on significant therapy events, it certainly has been found to be strongly implicated in the therapeutic relationship, and there has been a wealth of research on how this unique relationship facilitates significant therapy events (Timulak, Balicova & Miler, 2010; McCarthy, Caputi & Grenyer, 2017). Indeed, previous research has shown rapport and trust building between a mental health professional and a client with IDs is key for enabling the client to feel comfortable to talk about themselves and more personal issues (Weise *et al*, 2018). In addition, outside of therapy sessions, clients with IDs may be dependent upon care staff who, as part of their professional role have a need to know some quite personal information about the client, without the client themselves knowing the member of staff well enough to trust them with this information. Hence, it may well be that clients with IDs perceive trust to be a luxury they do not have much experience of, and hence this really does make the therapeutic relationship quite unique for them.

Having a collaborative relationship supports research undertaken by Lloyd and Dallos (2008), in which mothers of children with IDs spoke about the importance of the collaborative relationship, as a sub-theme of the super-ordinate theme of 'therapeutic relationship'. Of note, working collaboratively is not present in the existing literature on significant therapy events within the non-ID population. A possible reason for this could be that clients without IDs have plenty of opportunities to experience collaborative relationships outside of therapy, for example at work or within friendship groups, and therefore working collaboratively is not something such clients would find a new or privileged experience. On the other hand, for clients with IDs, it is more usual to experience power imbalances outside of therapy within their relationships with others, such as care staff (Jingree, Finlay & Antaki, 2005), and therefore to experience such an

empowering type of relationship within therapy could feel quite unusual and liberating, and hence something that is spoken about by the client or witnessed by the client's carer.

Client participants spoke at length about being able to successfully express their emotions to their therapist and how this felt like a positive experience to get the emotions out. This finding mirrors the researcher's experience of working with clients with IDs during therapy, with clients either verbally reflecting on their positive experience of being able to express their emotions or showing visible signs of this being a positive experience, such as appearing less tense or smiling. Similarly, Burford and Jahoda (2012) found that clients with IDs reported being able to express themselves in sessions as well as say how they are feeling, as helpful aspects of their therapy sessions. On talking more generally about their experience of group psychotherapy, clients have also reported enjoying talking (McDonald *et al*, 2003).

By contrast, the existing literature on significant therapy events within the non-ID population does not depict the expression of emotions as part of the client-identified significant therapy event, but rather the release of emotions only where it was associated with a moment of insight. For example, social atom repair with emotional release (McVea, Gow & Lowe, 2011), an observable emotional expression within the model of insight (Elliott *et al*, 1994), and insight that is accompanied by emotional expression of newness (Timulak, 2010). This could be understood in terms of the clients' prior experiences outside of therapy. For clients without IDs, they may experience little difficulty in being able to express their emotions and hence this in itself is not hugely helpful during a therapy session unless it results in a moment of insight. However, clients with IDs may often find themselves in the situation in which there are few people they have around them to whom they can express their emotions, or may be unable to express their emotions due to challenges associated with communication; therefore, the moment of being able to express previously unexpressed emotions may be experienced as helpful in itself.

For one therapy dyad there was a mismatch between client and therapist when discussing the experience of talking during the session; the client found talking to be



helpful, yet the therapist found talking to be challenging for the client. Taken separately, these accounts support the existing literature with regard to clients with IDs finding talking helpful (McDonald *et al*, 2003; Merriman & Beail, 2009), and therapists finding it challenging to enable their clients to express themselves (Jones, 2013; Wills, 2015). However, because no research literature following the significant therapy events methodology involving clients with IDs could be found, it is not possible to compare this finding with previous research. One possible explanation for the mismatch between client and therapist regarding the experience of talking during therapy sessions could be, that for clients this is the first experience they have had of being able to express their emotions, and so for them this experience is appraised as helpful despite it also being initially challenging. However, for therapists, they may be so focused on empathising with the client's initial challenge of expressing themselves, that they remain focused on that part rather than on the positive outcome of the client expressing themselves.

Client participants reflected on noticing a change in their emotions from beginning to end of the significant therapy event. Similarly, McCarthy, Caputi and Grenyer (2017) found that significant events in psychotherapy contained emotional awareness, and Gold *et al* (1993) found that clients reported feeling relieved and more comfortable after the helpful event. For client participants in the current study, this change in emotions tended to be from negative emotions such as annoyed, angry, and unhappy to positive emotions such as happy and less frightened. For one client participant, they experienced a reduction in the intensity of fear, but did not experience a reduction in the intensity of all of their difficult emotions. This could suggest that their fear was specifically linked to their outlook of the future, and when they then felt hopeful, this fear reduced because they realised that their future could become better. It does certainly appear that, for client participants in the current study, experiencing a significant therapy event coincided with a predominantly positive change in their emotions. Furthermore, research in the area of emotion-focused therapy (Greenberg, 2002) has shown that enabling clients to express maladaptive emotions, such as fear, and transform them by evoking more helpful responses, such as compassion, is effective (Goldman, Greenberg & Angus, 2006; Ellison *et al*, 2009).

All client participants spoke about focusing on coping strategies at some point during their therapy sessions. Whilst there has been mention of therapists introducing coping strategies in therapy within the significant therapy events research literature (Elliott *et al*, 1994; Rees *et al*, 2001), coping strategies were not found to be referred to by clients in the existing literature. During the analysis, the researcher was acutely aware of their experience as a therapist working with clients with IDs and, as a therapist, their focus on empowering clients throughout therapy; supporting clients to use coping strategies could be one such way of empowering clients. Therefore, one possible explanation for the participants in the current study focusing on coping strategies could be that they felt empowered to help themselves rather than being dependent on others to help them, as is so often case for people with IDs; Beail and Jahoda (2012) noted a number of barriers for clients with IDs accessing therapy related to their dependency upon others, compared to clients without IDs. Because there was a focus on practical coping strategies that the client participants could do outside of therapy sessions to help themselves, and because the idea of helping themselves may have been less familiar for them, they may have found this an important aspect of their sessions upon which they wanted to reflect. However, some participants in the current study did allude to the issue of dependency upon others preventing them from being able to independently utilise coping strategies outside of therapy sessions.

Having hope in therapy is one of the common factors identified by Wampold (2001), that together with other common factors such as empathy, account for 70% of the effects in therapy. Client participants in the current study spoke about receiving the message of hope from their therapist; this was described as being very powerful. However, only one previous study involving clients with IDs could be found that referred to clients experiencing hope; Pert *et al* (2013) found clients to be cautiously optimistic about the outcomes of their therapy, hoping that their therapist would be able to help them, but recognising that this may take some time. Perhaps the absence of hope in previous research within the ID population, is a reflection of past literature not focusing on significant therapy events in this client group; furthermore, perhaps receiving the message of hope is a pre-requisite of experiencing a significant therapy event. Indeed, significant therapy events research within the non-ID population has found hope to be

implicated (Cahill, Paley & Hardy, 2013; Grafanaki & McLeod, 2002; McVea, Gow & Lowe, 2011).

Therapist participants spoke at length about the importance of building the therapeutic relationship. Indeed, they spoke about working collaboratively with their client, which supports Bordin's (1979) theory in which the therapist and client collaboratively agreeing on the goals for therapy is the initial stage in building the therapeutic relationship. Furthermore, working collaboratively reflects the definition coined by Hatcher and Barends (2006), in which they refer to the therapy dyad as engaging in collaborative work.

Empathy, which can be thought of as an important therapeutic factor, along with the therapeutic relationship (Wampold, 2015), was referred to by the therapist participants. Participants spoke about empathising with their client as a way of strengthening their relationship. This experience of empathy supports previous research in which empathy is thought to be one of the essential aspects of the therapeutic relationship (Rogers, 1951). Therapists showing their client empathy supports the existing literature on significant therapy events (Wiggins, Elliott & Cooper, 2012; Shapiro *et al*, 1999). Therapist participants expressed feeling empathic towards their client as well as showing their client that they were doing their best to understand them. Similarly, Balmforth and Elliott (2012) found that the therapist was able to facilitate the significant therapy event by remaining attuned to the client's frame of reference.

Notably, the client participants did not make explicit reference to feeling that their therapist was empathic towards them, despite therapist participants reportedly showing their clients empathy. This finding is in contrast to the existing literature within the non-ID population in which clients spoke about their therapist being empathic towards them (Timulak, Belicova & Miler, 2010). Although Wiggins, Elliott and Cooper (2012) found that therapists more than clients were likely to experience empathy, their study nonetheless evidenced the client experience of an empathic response from their therapist. Furthermore, on examination of the limited existing literature involving clients with IDs, Burford and Jahoda (2012) found that clients reported feeling understood as a helpful aspect of therapy. It could however be argued, that the difference between the existing

literature and the current study is due to semantics. Indeed, rather than explicitly using the word 'empathy', clients with IDs in the current study spoke about their therapist as truly hearing what they were saying, which is a sub-theme identified in the current study. Moreover, it could be argued that empathy is too abstract a concept for clients with IDs.

Therapist participants reflected on becoming more attuned to their client's emotions and spoke about recognising the changes in their client's mood. Indeed, they spoke about using a range of information to become aware of a change in mood, including facial expressions and body posture, in addition to focusing on what their client was explicitly telling them. Indeed, utilising a total communication approach in which consideration should be given to selecting the most appropriate mode of communication for the client has been advocated in previous research (Jones, 2000; Bradshaw, 2000). Consistent with the current study, therapists in Grafanaki and McLeod's (2002) study described being emotionally involved with the client's narrative enabling them to maintain contact with the client's frame of reference and recognise changes in their client's emotions. Similarly, Balmforth and Elliott (2012) found that the therapist participant remained close to the client's frame of reference enabling them to facilitate the significant therapy event. It could therefore be suggested that by the therapist participants in the current study remaining attuned to their client's emotions, they were able to contribute to facilitating a significant therapy event.

The therapist participants in the current study spoke about the adaptations that they made to enable their client to communicate and express their emotions. The adaptations that the therapists made varied widely and included: giving their client more time, using different words, and following their client's lead to communicate through drawing. The therapy model was also sometimes adapted, for example, by simplifying the agenda when following a CBT approach. Similarly, Willner and Goodey (2006) describe the adaptations that were used in CBT with a woman with IDs; these adaptations included using simple words and short sentences, as well as adapting the CBT model by using in vivo exposure rather than imaginal exposure. Furthermore, previous research has also made suggestions as to the type of adaptations that may need to be made to therapy, such as

using more practical tools within the sessions (Wills, 2015); this can be likened to the use of drawing to communicate within the current study.

Coping strategies were also spoken about by the therapist participants in the current study as being adapted for their client. Essentially, coping strategies were adapted through therapists enabling their client to spend more time in the session practising the strategies with their therapist, in order for them to be more able to independently implement them outside of therapy. In a similar way, existing literature has found that more sessions are offered to clients with IDs, to provide them with the time needed to acquire new coping strategies, as well as time for processing (Willner & Goodey, 2006; Wills, 2015). Indeed, it has been the experience of the researcher that in working in services affording the luxury of being able to offer clients with IDs a greater number of sessions, stronger therapeutic relationships have been built with clients, enabling them to acquire a larger repertoire of coping strategies.

Although all of the client participants in the current study were attending individual therapy, nearly all of the therapist participants spoke about there being someone else in the therapy room with their client during the sessions. This experience can be likened to the use of interpreters in psychotherapy; research in this area has shown there to be an impact on the therapeutic relationship. Miller *et al* (2005) found that therapists and interpreters perceived the role of the interpreter to be more relational rather than a type of translation machine, whereby the interpreter became an integral part of the relationship within the therapy triad, who was often able to provide cultural guidance to therapists. However, the authors also described other impacts on the therapeutic relationship, such as some therapists preferring the interpreter to aim for becoming invisible during the session, or conflict developing between interpreter and client (Miller *et al*, 2005). Similarly, such disparity in experiences of having another person in the therapy room with the client, was reflected on by therapists in the current study; therapists reflected on their experiences of feeling unsure about the appropriateness, finding it helpful as it better enabled the therapist to understand their client, and having a support worker causing disruption to the session. The differing ways that therapists reflected on their experience of having the client's carer in the therapy room, supports

existing literature. For example, carers can be thought of as promoting engagement in therapy, but also as displaying limitations of ability and motivation, which if not addressed, can become a barrier to therapy (Willner, 2006). Throughout the course of the analysis, it was especially important for the researcher to make good use of their reflective journal due to their previous experience of having carers in the room with clients. For the researcher, such experiences have triggered a sense of anxiety and have created challenges in building the therapeutic relationship. However, rather than the analysis portraying this particular theme negatively, it brings a balanced understanding of this somewhat unique factor that is perhaps less frequently experienced in psychotherapy within the non-ID population.

In a study by Ramsden *et al* (2016), 'the influence of others' was identified as a sub-theme which reflected carer negativity in so much as clients' carers dissuading them about the usefulness of therapy, acting as a barrier to positive therapeutic change. One therapist participant in the current study spoke about having a negative experience of having a support worker in the room. However, they were able to reflect on how this enabled their client to assert themselves and take ownership of their therapy by asking the support worker to leave the session, so as not to disrupt their session any further.

In addition, all but one therapist in the current study spoke about having another person in the therapy room with their client. However, of note, within the therapy dyad without another person to support the client during the therapy sessions, the client brought their imaginary friends. Perhaps there is an important issue to be considered with regard to clients feeling supported enough within their therapy sessions, and this is likely to be different for each client.

Therapist participants alluded to taking a client-led approach; they spoke about making sure they focused the session on what their client wanted to explore, and putting their own agenda to the side to follow their client. Similar to person-centred approaches, therapists alluded to focusing on their client and the way in which they perceived their world, in order to understand their client's individual experience. According to Rogers (1986), clients have an actualising tendency in which they take on an active role, devoting

energy to their own development and growth. In the area of IDs, this person-centred approach has been at the forefront since the shift from a medical to a social model of disability. However, it is not clear as to whether this actualising potential is the same for clients with IDs. Whilst Fitzgerald (2010) found that people with IDs had lower expectations with regard to meeting their needs, the author found that adopting a holistic assessment based on Maslow's (1943) hierarchy of needs could enable people with IDs to reach their full potential. This suggests the actualising potential is perhaps based, in part, on a type of collaboration between the person with IDs and their support worker or therapist.

Although participants in the current study alluded to taking a client-led approach, they also reflected on feeling uncertain about the usefulness of simply providing their client with space to express themselves. Indeed, some therapists expressed self-criticism for not intervening sooner, when their clients were actively using the therapeutic space to express themselves. The researcher was particularly attuned to identifying this experience of self-criticism due to being a current trainee and being relatively new to working within particular models. It was therefore important for the researcher to be aware of identifying with participants in this way and explore other related research. This can be likened to research by Kannan and Levitt (2017), who explored self-criticism in therapist training; they found that trainees' self-criticism was triggered when they found themselves in a situation in which they were unsure about how to direct their clients during therapy.

Contrastingly, at other points, participants discussed taking a more directive approach in the therapy sessions; this is consistent with a cognitive behavioural approach to therapy in which the therapist may utilise various techniques, such as psychoeducation, thought challenging, behavioural activation, or Socratic questioning, in order to keep to a collaboratively agreed agenda (Beck, 2011). However, the variation in therapist approach is likely to be much more a reflection of therapists following and utilising an integration of approaches to best meet their client's needs (Tiller, 2011).

Therapist participants in the current study, expressed a desire for their client to experience hope. In a study by Coppock *et al* (2010), the relationship between therapist and client hope with therapy outcomes was examined; they found there to be a significant relationship between therapist hope in their clients and therapy outcome from second session to final session. However, some therapist participants in the current study were found to hold on to some doubt as to whether or not any positive change would occur for their client. A possible reason for this difference among therapists could be due to a focus on more systemic factors; indeed, therapists reflected on their client's environment as being a hindering factor in their client's ability to make positive changes in their life. This is consistent with a study by Haddock and Jones (2006) in which the perspectives of therapists were explored; they identified 'obstacles' as a theme which illustrated the difficulties therapists experienced in helping their clients to generalise to different settings as well as expressing the reality of how challenging their clients' environments can be.

However, a change from hopelessness to being hopeful occurred for one therapist participant from beginning to end of their therapeutic relationship with their client. This supports existing literature by Kothari, Hardy and Rowse (2010), in which the theme of 'finding hope' was identified, with hope and hopelessness being at opposite ends of the spectrum to which therapists gravitated at different points in the therapeutic relationship. One possible explanation for the therapist in the current study moving from hopelessness to having hope could be as a result of witnessing their client experiencing a significant therapy event, whereas prior to this, the therapist held onto the hopelessness in order for their client to experience the hope. Certainly, the participants in Karhari, Hardy and Rowse's (2010) study described a need to find some hope deep inside, that their client would get through a difficult situation when it arose, despite feeling the hopelessness of the situation.

Therapist Participants described trying to empower their clients during the therapy sessions by enabling them to take ownership of their sessions and make decisions. Similarly, findings from Grafanaki and McLeod's (2002) study emphasised the importance for the therapist of empowering their client to comment on the process in therapy and to



make decisions relating to the therapeutic plan. The existing literature also illustrates how clients without IDs feel empowered during their sessions (Timulak, 2010; Timulak, Belicova & Miler, 2010; Holowaty & Paivio, 2012), however, clients with IDs in the current study did not explicitly express feeling empowered. For clients with IDs, the amount of control they have over their lives outside of therapy can be quite limited; that is, many can experience feeling disempowered in various situations (Jones 2013). Because of this, therapists may feel more motivated and determined to ensure they enable their clients to feel empowered, at least within the context of their therapy sessions. Indeed, therapists working with clients with IDs have been found to be passionate and determined when it comes to advocating for the rights of people with IDs (Wills, 2015).

Although therapist participants spoke about wanting their clients to experience hope during therapy, they also alluded to experiencing a paternal response in which they worried about their client and felt a need to protect them. Of course, a certain amount of this type of protective response is part of the role of working with vulnerable individuals within situations where risk requires careful management. Indeed, assessing and managing risk is part and parcel of work in therapy with clients with IDs (BPS, 2016). Certainly, this sub-theme of 'worry and protection' seems to provide support for Bordin's (1979) theory of therapeutic relationship, with its reference to the development of bonds, providing an apparent connection to this type of attachment perspective.

By contrast, however, the research undertaken within the non-ID population does not reflect such findings; instead research has found therapists to focus on their awareness of boundaries (Grafanaki & McLeod, 2002), their client's responses (O'Halloran *et al* (2016), or relational depth (Wiggins, Elliott & Cooper, 2012). One possible explanation for this discrepancy, could relate to therapists working with clients with IDs experiencing a need to hold on to the worry, in order for their client to experience hope. Indeed, Newman and Beail (2010) found that clients with IDs use a range of defence mechanisms; of note, they found that clients particularly used the defence of affiliation containing qualities of dependency. Of course, this could well be more relevant for clients with more severe IDs who require higher levels of support to undertake tasks of daily living; certainly, therapists in the current study spoke at length about empowering their clients during

therapy. However, if clients in the current study were adopting this defensive style at points, it could be that it was eliciting a paternal type of response from their therapist.

### **5.3 How do clients with IDs make sense of their experience of significant events in psychotherapy?**

All client participants in the current study reflected on the significant therapy event and the impact that it had on them; most participants noticed a shift in the way they appraised a situation or the way in which they viewed themselves. The researcher does however, acknowledge approaching the research with the hope and anticipation of client participants reporting on the occurrence of significant therapy events, owing to their past experience of psychotherapy as being helpful. That being said, this is consistent with findings in Cahill, Paley and Hardy (2013), whereby helpful impacts, identified using the Helpful Aspects of Therapy form, included ‘problem clarification’ in which clients gained an understanding of what needed to change through working on it in therapy. Similarly, Grafanaki and McLeod (2002) identified a category entitled ‘momentary heightened awareness/realisation’ whereby the client gains a better understanding of themselves and is able to identify the main issue to be worked on. However, although these findings are in contrast to Macdonald, Sinason and Hollins (2003), who found that clients with IDs attending group analytic therapy denied that they had experienced any change as a result of attending sessions, this could be as a result of this being group therapy rather than individual therapy, making it perhaps less likely that they would have experienced a significant therapy event.

### **5.4 How do therapists make sense of their experience of significant events in psychotherapy with clients with IDs?**

For some therapist participants in the current study, there were clear points in which they were able to recognise and reflect upon their client’s identified significant therapy event. At these points, participants understandably spoke about what they could observe in their client, and some therapists went on to make interpretations as to what their client may have been experiencing or how they may have been making sense of the situation. This could be likened to therapists formulating, a process whereby they draw “...upon

psychological theory in order to create a working hypothesis or ‘best guess’ about the reasons for a client’s difficulties, in the light of their relationships and social contexts and the sense they have made of the events in their lives” (Johnstone & Dallos, 2014). In order to inform interventions, therapists continue to formulate with their clients throughout the course of therapy. Indeed, it could be the case that the therapist participants in the current study were keeping the formulation in mind during their research interviews, and hence were focusing on how their clients may have been making sense of the significant therapy event for the purpose of re-visiting the formulation.

This finding is not something that could be found in the existing literature, although there are various case studies highlighting the importance of being formulation-led when adapting therapy for clients with IDs (Cowdrey & Walz, 2014). The reason for this is likely to be due to methodological differences. That is, most of the significant therapy events research either adopted a different method of data analysis that did not involve interviewing therapists, had a specific focus during the interviews, for example on congruence (Grafanaki & McLeod, 2002) or interviewed clients only (Lloyd & Dallos, 2008; Burford & Johoda, 2012).

Interestingly for one therapist, they were not aware of any meaning making taking place for their client, instead observing them as being rather passive. The client in this therapy dyad, however, described experiencing a change in the way they thought about themselves and their situation. Perhaps because this meaning making process was internal, the therapist was unaware of the change that their client experienced in that moment, instead perceiving their client as being quiet rather than actively processing and making sense of their situation. Drawing upon the researcher’s previous experience of working therapeutically with client’s with IDs, it could be that the therapist would go on to become aware of this internal change process that the client experienced, in later sessions once they could perceive a positive change in their client. Indeed, this helpful moment occurred in the client’s first session, and it could be that once the therapeutic relationship had been built, the client and therapist were better able to explore how the sessions were progressing and what the client had experienced as helpful. However, little

is known in the research literature about this internal meaning making process, and therefore this area would benefit from further research.

It became apparent that there was sometimes a disparity between what the clients selected as a significant therapy event, and what the therapists would have identified as the significant therapy event. This supports the existing literature; in particular, a review by Timulak (2010) found that the perspectives on what was described as a significant therapy event differed significantly, with client and therapist perspectives matching in only 30-40% of therapy events. On the other hand, the current study also found that some client and therapist perspectives on what is described as a significant therapy event matched, with therapists expecting their client to select the particular segment of their therapy session to focus on during the research interviews. It is unclear as to the reasons for why such a disparity between perspectives exists within some therapy dyads but not within other therapy dyads. In the researcher's experience of being both therapist and client, one possible reason for this disparity could be due to the strength of the therapeutic relationship. It could be that therapy dyads who are in the early stages of building their therapeutic relationship may be less likely to identify the same events as helpful; once therapy dyads have built a strong therapeutic relationship, they may become more attuned to one another and therefore become more likely to identify the same event as helpful. A possible link between strength of the therapeutic relationship and client/therapist perspectives on what constitutes a significant therapy event was not specifically explored within the current research, and it is likely that further research is needed in order to explore this.

## **5.5 The schematic diagram**

The schematic diagram presented in section 4.3 of the 'Results' Chapter, depicted a speculative understanding of how the sub-themes identified for the client participant and therapist participant interviews may be connected. The connectedness of some of these themes have been discussed in the preceding sections, for example, the connection between therapist worry and protection, and clients receiving the message of hope.

Some further speculative connections would benefit from further exploration, and this section will therefore consider these.

It is suggested that the therapist approach influences the therapeutic relationship, the extent to which therapists empower their client, and the degree to which therapists experience worry and a paternal response. From a pluralism perspective, involving the client in goal setting, both empowers the client to have some control over their therapy as well as ensures the therapy focuses on what the client chooses to focus on (Cooper & McLeod, 2011). It may be that along with taking a client-led approach comes worry that, for example, therapists feel they are not directing the therapy session enough (Kannan & Levitt, 2017) or keeping as rigidly to a therapy model as they think they should (Wills, 2015).

It is further proposed, that the therapeutic relationship may influence the process of clients expressing their emotions to communicate. Certainly, in the current study, clients spoke about building trust with their therapist and reflected on how the trust helped them to be able to express their emotions. This supports existing literature by Greenberg (2014) in which, the therapeutic relationship in emotion-focused therapy is explored; the author asserts that, through the therapist providing an optimal environment characterised by therapist empathy, acceptance and congruence, and thus, a safe relationship, clients are facilitated to express and process their emotions.

In addition, the connection between the therapeutic relationship and the process of clients expressing their emotions to communicate, may be dependent upon making adaptations and having others in the therapy room. Whilst, clients in the current study did not specifically refer to their therapist making adaptations, the way in which the therapists reflected on the use of adaptations, suggested that they enabled clients to express themselves; this reflects guidance provided by the BPS (2016) on how to adapt psychological therapies for clients with IDs. Having a carer in the room with the client was reflected on in different ways by the therapists; sometimes this seemed to help clients to express themselves, but at other times this experience was reflected on as a barrier to clients expressing their emotions; whilst carers can promote client engagement

in therapy by, for example, helping with in-between session tasks, without ability or willingness, they may also become a barrier to engagement (Willner, 2006). Furthermore, the presence of carers in the therapy session may create a barrier to the client expressing themselves due to them feeling reluctant to share confidential material in front of their carer.

## **5.6 Involving people with intellectual disabilities in research**

Research involving people with IDs, although increasing, still remains quite limited. It is therefore important to carefully document the procedures involved during the research process for the current study in order for future research involving this client group to be encouraged and undertaken. It is hoped that such a discussion could contribute to a form of best practice for involving people with IDs in research. Consideration will be given to identifying potential participants, and the legal framework, as well as to thinking more broadly about involving people with IDs in research studies.

In order to identify potential client participants that could be approached to recruit to the study, close links were built and maintained with the recruited therapists working in the ID service. Therapists were given the inclusion criteria in order to help them identify any potential clients that could be approached to recruit to the study. Once therapists had received consent from their new client to be contacted by the researcher, initial consent meetings were then necessarily arranged promptly in order for the researcher to meet with the potential participant before they began their therapy sessions. This was a more challenging undertaking than initially envisaged due to the time commitment necessary, and it was vital that the researcher regularly communicated with the therapists so as to avoid any missed opportunities for approaching a potential client participant. Whilst this was not an impossible task, for future research, in order to maximise opportunities for recruiting participants, it would be recommended that the researcher be based for some part within the team from which participants are being recruited, or at least to be based geographically close.

The current study adopted a structured and systematic approach to assessing participants' capacity to consent to taking part in the research study. It was important to follow the Mental Capacity Act 2005, together with previous research guidance (Cameron & Murphy, 2006; National Institute for Health Research, 2016). In order to corroborate therapists' prior assessment of capacity, the following process of assessing capacity to consent to taking part in the research was adhered to: after presenting the participant information sheet to potential participants, they were encouraged to ask any questions they may have; they were then asked to describe what they thought taking part in the research would mean for them; potential participants were asked to think about what they thought the pros and cons may be for them taking part in the study, and these were then written down on paper for them to see; for some potential participants, a second consent meeting was then arranged in order for them to have the time to process the information they had been given about the study, and during the second consent meeting, their understanding about the study was re-checked; potential participants were then asked whether or not they would like to take part in the study. Throughout this process, the researcher paid close attention to the positive (including, eye contact, relevant elaboration, nodding, sitting forward) and negative (including, lack of eye contact, negative facial expression, agreeing without clear understanding) indicators for giving consent (Cameron & Murphy, 2006). Furthermore, consent was re-checked at the beginning of each research interview.

Patient and public involvement and engagement in research is becoming increasingly more recognised as a vital part of the research process (Staley, 2009). Whilst the current study did engage with individuals with IDs during the design phase in order to assess the viability of the research topic and design, as well as seek consultation on the study documents, it would be recommended to involve people with IDs in as many aspects of the research process as possible. Indeed, Staley, Abbey-Vital and Nolan (2017) found that research studies benefit from the input of patients and the public through researchers gaining important insights, and then using this new knowledge to make changes to their project designs accordingly.

## **5.7 Translation of insight gained through ID-focused research into other areas**

A number of unexpected benefits of undertaking research with people with IDs have been identified through the course of the current piece of research that warrant discussion. Whilst, the creation of colourful and adapted participant information sheets, consent forms, and other relevant resources are part of routine practice for researchers and clinicians working with people with IDs, they are perhaps lesser known to those working with non-ID populations. It is therefore important to highlight their usefulness when not only working with people with IDs, but also their usefulness to other client groups, for example children and young adults, those with English as a second language, or indeed, more generally for explaining research studies in lay terms to potential participants. Such insights and skills developed by those adapting, for example information sheets for people with IDs, could help those in other fields design study documents or disseminate research findings. Furthermore, in addition to research, such resources could be used in clinical practice where appropriate, for instance to aid clients agreeing counselling contracts, or consenting to treatments relating to physical health.

## **5.8 Quality in qualitative research**

Because of the epistemological differences between quantitative and qualitative research, there has been much debate about the applicability of the criteria used to evaluate the quality of quantitative studies for qualitative studies. Instead, Lincoln and Guba (1985), and Guba and Lincoln (1994) propose new criteria for assessing the quality of qualitative studies as alternatives to reliability and validity; they are credibility, transferability, dependability, and confirmability.

### ***Credibility***

Credibility requires the research study findings to be linked with reality in order to demonstrate the accuracy and truth of the study's findings. Therefore, to enhance the credibility of the study, the researcher clarified any bias they brought to the study by writing a section on reflexivity. They also continued to monitor their own subjective viewpoint by keeping a journal throughout the research process. Triangulation was a



further important technique used to ensure credibility. This involved identifying significant therapy events by both interviewing participants as well as utilising the Helpful Aspects of Therapy form; interviewing both client and therapist in order to explore a more complete understanding of significant therapy events; and interviewing participants at two different points in time. Furthermore, throughout the analysis stage, the researcher was alert to any discrepant findings, and these were presented as part of the results to enable discussion of contrary information.

### ***Transferability***

Transferability refers to how the researcher is able to demonstrate the applicability of the research study's findings to other contexts. To this extent, transferability has been enhanced by the researcher providing detailed information regarding the context and participants, as well as the discussion of thick descriptions generated by the research interviews. This will enable others to then make a judgement as to whether or not the findings are transferable and applicable to other social environments. For instance, it may be that therapists working in other ID services make a judgement that their service is similar to that from which the data for the current study was collected, and therefore decide the findings are transferable to their service. However, other therapists working with clients with severe IDs may decide that the findings would not be applicable due to the differences in the population with whom they work. Moreover, by providing detailed descriptions about the context and participants, others are able to make this judgement about transferability.

### ***Dependability***

Dependability refers to the extent to which the study could be repeated by other researchers and obtain similar findings to the original study. To ensure dependability, the researcher was transparent with regard to the method, and provided a detailed explanation of how the data was collected and analysed.

### ***Confirmability***

Confirmability is the extent to which the research study's findings involve neutrality. In addition to writing a section on reflexivity and keeping a reflective journal throughout the

research process to identify any bias brought to the research by the researcher, an audit trail was also established. This entailed the researcher detailing every step of data analysis performed in order to provide a rationale for the decisions made, and demonstrate the accurate portrayal of the responses provided by the participants within the study findings.

## **5.9 Implications for counselling psychology**

This study highlights that the significant therapy events methodology is an effective methodology to be adopted when involving people with IDs in research. Indeed, the current findings suggest that clients with IDs do experience significant therapy events. That being the case, this study highlights the need for therapists to work in such a way as to facilitate significant events in therapy with their clients. In doing so, for the current study, clients reported a strong therapeutic relationship, the ability to express their emotions, and experiencing hope that they can make changes. Importantly, clients experiencing significant therapy events have been found to experience better therapy outcomes (Timulak, 2010).

The current study highlights various factors that may be implicated in the facilitation of a significant therapy event. It is important for therapists to build a strong therapeutic relationship with their clients through listening, building trust, working collaboratively, and being empathic in their responses towards their clients. Therapists should make appropriate adaptations to therapy sessions to ensure their clients are able to express themselves through whichever means necessary; they should also consider their clients' preferred ways of communicating and ensure any necessary resources are readily available during therapy sessions in order to promote the clients' ability to independently communicate. Furthermore, it is important for therapists to be mindful about instilling hope in their client throughout the course of therapy. Whilst, of course working in the profession of psychology and counselling, it continues to be paramount for interventions to be followed that are evidence-based, it is also important to recognise the value of following the client; indeed, a client-led approach is encapsulated by pluralism (Cooper & McLeod, 2011), which is a research-informed approach. Furthermore, given the current

study found some disparity between client and therapist choice of significant therapy event, it may be important for therapists to be routinely asking clients what they found helpful at the end of each session, as this may enable the therapist to better respond to their clients' needs.

It is notable that, most client participants noticed a shift in the way they appraised a situation or the way in which they viewed themselves, and it is therefore important to open up conversation around the experience of change. Very limited process research has been undertaken with clients with IDs, and this piece of research makes an important contribution to the literature. This contribution is twofold: firstly, it demonstrates that process research is certainly possible to undertake with clients with IDs and illustrates some of the adaptations that can be made to research methodologies in order to make this a reality, for example, the use of video to prompt clients' recall of their session and adapting questionnaires. Secondly, it highlights a need for utilising process research with this client group. After such a focus on case study designs and some more recent focus on outcomes research, the way forward now is to explore the therapeutic process. In doing so, the process of change can be investigated, and psychotherapeutic approaches can be modified and adapted to facilitate positive change for clients with IDs.

In order for therapists to put the preceding recommendations into practice, it will also be necessary that services respond by encouraging and making the necessary provisions to enable them to do this. For example, enabling clients to have more sessions in their therapeutic contract to enable their therapist to follow their lead when it is appropriate to do so. The findings may also suggest the usefulness of providing therapists with more support, as indicated by their experience of worry and protection; this could be helpfully reflected upon during peer supervision groups. Furthermore, therapists could use supervision to reflect on balancing empathising, protecting and helping in order to promote the process of empowerment.

It is hoped that such recommendations could contribute to making psychotherapy more effective for clients with IDs. One such way of incorporating these recommendations into practice could be for them to contribute to developing a competency framework for

psychologists working with this client group, or indeed, adding to guidance, for example, produced by the BPS (2016) on providing psychological therapies to people who have IDs.

A further important contribution that this piece of research can make to clinical practice is to build upon the use of video-recording therapy sessions as a means for training therapists. Of course, the use of video was initially designed as a supervisory strategy developed by Kagan *et al* (1967) as a way of empowering counsellors to gain a better understanding of their client work in order for them to act upon these new understandings as appropriate. However, as a training tool, the use of video-recording client sessions is used less frequently, with the use of audio-recordings being favoured. The use of video-recording client sessions more frequently, as a supervisory strategy could be used once again, as a way of therapists reflecting on and learning from their practice. In addition, the use of video-recording therapy sessions could also have implications for training therapists and practitioners from other fields, particularly in supporting those who are unfamiliar or who are less confident with working therapeutically with people with IDs. There are therefore important implications of this training method for enabling those working in mainstream psychotherapeutic services to be able to work competently and confidently with clients with IDs.

Finally, it is hoped that this piece of research may contribute to increasing the number of research studies undertaken with clients with IDs in the field of counselling psychology. Specifically, this research could contribute to a framework of best practice for undertaking research with clients with IDs, and thus make this area of research less daunting to embark upon for researchers, while providing them with some practical guidance.

### **5.10 Limitations of the study**

This study was more akin to a feasibility/proof of concept study to ascertain whether the methodology would be effective for use with clients with IDs. Whilst a necessary first step, owing to the non-existence of research in the area of significant therapy events and clients with IDs, the sample size and qualitative design of the study make any wider

generalisations regarding the findings undesirable. It is also noted that all client participants had mild to moderate IDs as it was important that they could give informed consent to take part in the research. That being the case it is not known whether such findings would apply to people with IDs who are less able to express themselves. A further limitation of the study is that, although the Helpful Aspects of Therapy form did ask clients about helpful as well as unhelpful events in therapy, no unhelpful events were identified. It is unknown whether this was because clients completed the form in the presence of their therapist and felt reluctant to identify any unhelpful events or whether they simply did not experience any unhelpful events. It may be preferable in future research to enlist the help of an independent researcher who could assist clients with completing the Helpful Aspects of Therapy form to rule out the possibility of this occurring. In addition, if time allowed, it could have been interesting to look at clients' perceptions across the range of recorded sessions and their perceptions of where the most helpful aspects were, rather than focusing on their identified helpful event within the session selected by their therapist.

### **5.11 Recommendations for future research**

Given this piece of research was the first known study to move the ID research field forward into exploring the process of therapy for clients with IDs, it is important for future research to continue in this way by building the evidence base with research utilising process research methodologies. This can then contribute to our understanding of the many intricacies of psychotherapy with clients with IDs by providing rich accounts of the therapeutic process. In so doing, psychotherapy can be better adapted and tailored to meet the needs of this client group.

This study has highlighted the need for further research of significant therapy events with a larger sample of clients with different degrees of cognitive impairment. Furthermore, this study has identified new areas to explore, including examining the internal meaning making process for clients. If more were known about this process, therapists could become more aware of it, which would be likely to strengthen the therapeutic relationship, indicate the direction that therapy sessions could helpfully take, and

improve therapy outcomes. Similarly, perhaps if more were known about this internal meaning making process for clients, the disparity in choice of significant therapy event would be minimised, enabling therapists to respond more in the moment when such events are experienced.

The schematic diagram presented in section 4.3 of the 'Results' Chapter, depicted a speculative understanding of how the sub-themes identified in the current study may be connected. Further research could helpfully focus on the relationship between therapists holding worry and protection, while clients seemingly receive the message of hope. Furthermore, exploration of how making adaptations to therapy may influence a link between the therapeutic relationship and the process of the client expressing emotions to communicate, would be a fruitful avenue to explore.

At a later point, it would be important to develop a modified approach for delivering psychotherapy to clients with IDs based on the recommendations of the current research and of future research, as suggested above. This could then be studied as part of a large scale randomised clinical trial, with the intention of providing an evidence-based approach for therapists working with clients with IDs.

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## 6. Conclusion

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To the knowledge of the researcher, this is the first qualitative study to explore significant therapy events involving clients with IDs. In addition, this is the first known study to move the ID research field forward into exploring the process of therapy for clients with IDs rather than utilising the well-rehearsed case study and outcome research methodologies. The current findings suggest that clients with IDs do experience significant therapy events. Furthermore, the research enabled insights to be gained about the process of therapy for this client group and for exploration of the therapeutic factors that may be involved in facilitating a significant therapy event. The findings suggest that during sessions in which significant therapy events occurred, clients experienced a strong therapeutic relationship, the ability to express their emotions, hope that they can make changes, and a shift in the way they appraised a situation or the way in which they viewed themselves. The research found that clients may sometimes experience an internal meaning making process, which is an area that would benefit from further research. Therapists were found to build a strong therapeutic relationship with their client through listening, building trust, working collaboratively and being empathic. Therapists were also found to take a client-led approach and make adaptations to sessions to ensure their clients were able to express themselves. Some disparity between what clients and therapists selected as a significant therapy event was found, and it is likely that further research is needed in order to explore this. In addition, further research could helpfully focus on the relationship between therapists holding worry and protection, while clients seemingly receive the message of hope. It is hoped that the recommendations from this research can contribute towards developing a competency framework for psychologists working with clients with IDs, or add to existing guidance on providing psychological therapies to people with IDs, with the intention of making therapy more effective for this client group.

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## 8. Appendices

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### Part 1 Thesis

#### Appendix

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# Helpful Aspects of Therapy Form

## Question 1



Thinking about your therapy session today, what was the most helpful part? (This could be something that happened in the session, something you said or did, or something your therapist said or did).



## Question 2

Why was this helpful?





### Question 3

How helpful was this?

Please tick

Unhelpful



OK



Helpful



1	2	3	4	5	6	7	8	9



### Question 4

When in the session did this happen?

Please tick

At the start

In the middle

At the end



### Question 5



Did anything else particularly helpful happen during your therapy session today?



Yes

No

### Question 5 (a)



If yes, please rate how helpful this event was.

Please tick



Unhelpful

OK

Helpful



1	2	3	4	5	6	7	8	9

### Question 5 (b)



Please describe the event.





### Question 6



Did anything happen during your therapy session today which was unhelpful?

Yes

No

### Question 6 (a)



If yes, please rate how unhelpful this event was.

Please tick



Unhelpful

OK

Helpful



1	2	3	4	5	6	7	8	9



### Question 6 (b)

Please describe the event.



Thank you for completing this form.

## Appendix B – Client Participant Interview Schedule



University of the  
West of England

### Client Participant Interview Schedule

*“Thank you for agreeing to be interviewed about your experiences of helpful moments in therapy. In a couple of minutes, I will be playing back parts of the video of the session you have most recently finished. I’ll do this to help you remember what was going on during particular moments in the session. Clients and therapists often have many unspoken experiences during sessions, including thoughts, feelings, images, memories, and evaluations of the helpfulness of things said; we find it extremely interesting to learn about those unspoken experiences”.*

#### Event Identification

Read the HAT answers aloud back to the client participant to verify the information, to familiarise yourself with it, and to see if the client participant wishes to add anything.

Start the video of the session, and with the help of the client participant, locate the beginning of the helpful event.

If the client participant identifies all or most of the session as the helpful event, ask them to take a moment to think over the session to see if any part or topic now stands out as having been most helpful. If the client participant experiences difficulties with identifying the most helpful point in the session, leave the video running and support the client participant to stop/start the video at any point they choose to talk about the session and any moments they found helpful using the questions below.

#### Event Description

##### Context of Event

1. Can you describe the context of the event (its meaning and what led up to it).

##### Prompts:

- *Can you think of anything that happened earlier in your life that relates to this event?*
- *Can you think of anything about your current life situation that relates to this event?*
- *Do any of the problems that brought you to therapy relate to this event?*
- *Does anything that has happened to you in the past week or few weeks relate to this event?*
- *Does anything that has happened in previous therapy sessions relate to this event?*
- *Does anything about your therapist as a person relate to this event?*

- *Did anything happen earlier in the session that relates to this event?*
- *Did anything happen later in this session that relates to this event?*

### Your Experience During the Event

2. Can you describe what was happening for you during the event we just watched?

#### Prompts:

- *What were you feeling?*
- *What were you doing or trying to do?*
- *What was going through your mind? What were you thinking?*

### Most Helpful Things About the Event

3. Can you describe the most helpful things about the event.

#### Prompts:

- *What did your therapist do during the event that stands out in your mind as helpful?*
- *What did you do during the event that stands out in your mind as helpful to you?*

### Impact of Event

4. Can you describe the impact of the event (its effect on you and any specific impacts).

#### Prompts:

- *How did this event affect you? What impact did it have on you at the time?*
- *What is the most important idea or feeling you have gotten from this event we have been watching?*
- *What do you think might possibly change for you because of this event?*
- *What specific things might happen for you in the next month or so as a result of this event?*

### Identifying Further Events

5. Are there any other helpful events that occurred during the session?

If the client participant indicates there are further helpful events, identify the event and go through questions 1-4 with them.

### End of Interview

6. Are there any other parts of the video you think would be useful for us to watch and talk about?



7. Do you have any further comments or anything else that you would like to say that we have not talked about?

*“That is now the end of the interview; I would like to thank you for your time in taking part in the research”.*

## **Appendix C – Therapist Participant Interview Schedule**



### **Therapist Participant Interview Schedule**

“Thank you for agreeing to be interviewed about client-identified helpful moments in therapy. In a couple of minutes, I will be playing back parts of the video of the session you have most recently finished. I’ll do this to help you remember what was going on during particular moments in the session. Clients and therapists often have many unspoken experiences during sessions, including thoughts, feelings, images, memories, and evaluations of the helpfulness of things said; we find it extremely interesting to learn about those unspoken experiences”.

#### **Event Identification**

Locate the client-identified helpful moment(s) and play the video to the therapist participant.

#### **Event Description**

##### **Therapist Event Intentions and Feelings**

1. Can you describe your intentions during the event. Try to remember what you were working towards or trying to do in giving the responses you did in the event.

##### **Prompts:**

If required, to prompt the therapist participant, hand them the sheet of possible therapeutic intentions to look through and comment upon as relevant.

2. Can you describe what you were feeling and how you think you may have been coming across to your client during the event.

#### **Context of Event**

3. Can you describe the context of the event (its meaning and what led up to it).

##### **Prompts:**

- What general characteristics of your client or your client’s situation help to explain the event (including your decision to intervene as you did)?
- What general characteristics of your approach to therapy or you as a person are relevant to this event?
- What events in earlier sessions with this this client have led up to or influenced what happened in this event?

- What recent events in your client’s life have led up to or explain this event? (e.g. relevant recent positive change or stressful events outside of therapy)
- What other events earlier in this session helped bring about or explain this event?

### **Impact of Event**

4. Can you describe the impact of the event on the client.

#### **Prompts:**

- Did you notice a change in your client’s mood, manner, or level of involvement from beginning to end of the event? Please describe.
- Did this event have an effect on what happened later in the session? Please describe.
- Describe the impacts the event most likely had on your client (e.g. realised something new about self, clearer about feelings, felt therapist understands/doesn’t understand, progress towards knowing what to do about problems, etc).
- To what extent do you find your client’s choice of event surprising or expected?
- How do you think this event might possibly affect your client over the next month or so?
- What specific changes do you think are possible for him/her?

### **Identifying Further Events**

If there were further helpful moments identified by the client participant during their interview, locate the event on the video and go through questions 1-4 with the therapist participant.

### **End of Interview**

5. Are there any other parts of the video you think would be useful for us to watch and talk about?
6. Do you have any further comments or anything else that you would like to say that we have not talked about?

“That is now the end of the interview; I would like to thank you for your time in taking part in the research”.

### Possible Therapeutic Intentions

<b>Intervention</b>	<b>Description</b>
Set limits	To structure, make arrangements, establish goals and objectives of treatment, outline methods to attain goals, correct expectations about treatment, or establish rules or parameters or relationship
Get information	To find out specific facts about history, client functioning, future plans, etc.
Give information	To educate, give facts, correct misperceptions or misinformation, give reasons for therapist's behaviour or procedures
Support	To provide a warm, supportive, empathic environment; to increase trust and rapport and build relationship; to help client feel accepted, understood, comfortable, reassured, and less anxious
Focus	To help client get back on the track; to change subject or channel/structure the discussion if s/he is unable to begin
Clarify	To provide or solicit more elaboration, emphasis, or specification when client or therapist has been vague, incomplete, confusing, contradictory or inaudible
Hope	To convey the expectation that change is possible and likely to occur; that the therapist will be able to help the client; to restore morale; to build up the client's confidence to make changes
Cathart	To promote relief from tension or unhappy feelings, to allow the client a chance to let go or talk through feelings and problems
Cognitions	To identify maladaptive, illogical or irrational thoughts or attitudes (e.g. "I must be perfect")
Behaviours	To identify and give feedback about the client's inappropriate or maladaptive behaviours and/or its consequences
Self-control	To encourage the client to own or gain a sense of mastery or control over his/her own thoughts, feelings, behaviours, or impulses; to help client become more appropriately responsible for his/her own role
Feelings	To identify, intensify, and/or enable acceptance of feelings, to encourage or provoke the client to become aware of or deepen underlying or hidden feelings or affect or to experience feelings at a deeper level
Insight	To encourage understanding of the underlying reasons, dynamics, assumptions, or unconscious motivations for cognitions, behaviours, attitudes or feelings. May include an understanding of client's reactions to other's behaviours

Change	To build and develop new and more adaptive skills, behaviours, or cognitions in dealing with self and others. May include to instil new, more adaptive assumptive models, frameworks explanations, or conceptualisations. May include to give an assessment or opinion about client functioning that will help client see self in new way
Reinforce change	To give positive reinforcement or feedback about behavioural, cognitive or affective attempts at change in order to enhance the probability that the change will be continued or maintained; to encourage risk-taking and new ways of behaving
Resistance	To overcome obstacles to change or progress. May discuss failure to adhere to therapeutic procedures, either in past or to prevent possibilities of relapse in future
Challenge	To jolt the client out of a present state; to shake up current beliefs or feelings; to test validity, adequacy reality, or appropriateness of beliefs, thoughts, feelings or behaviours; to help client question the necessity of maintaining old patterns
Relationship	To resolve problems as they arise in the relationship in order to build or maintain a smooth working alliance; to heal ruptures in the alliance; to deal with dependency issues appropriate to stage in treatment; to uncover and resolve distortions in client's thinking about the relationship which are based on past experiences rather than current reality
Therapist needs	To protect, relieve or defend the therapist; to alleviate anxiety

**Appendix D – Favourable opinion from the Research Ethics Committee**



**Health Research Authority**  
**South West - Central Bristol Research Ethics Committee**

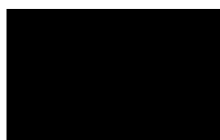
Whitefriars  
Level 3, Block B  
Lewin's Mead  
Bristol BS1 2NT  
Email: nrescommittee.southwest-bristol@nhs.net

Telephone: 0117 342 1335  
Fax: 0117 342 0445

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval.**

02 August 2016

Miss Sarah Wills  
Student  
University of the West of England



Dear Miss Wills

<b>Study title:</b>	<b>Significant therapy events: An interpretative phenomenological analysis of psychotherapy with clients with learning disabilities</b>
<b>REC reference:</b>	<b>16/SW/0187</b>
<b>Protocol number:</b>	<b>N/A</b>
<b>IRAS project ID:</b>	<b>199240</b>

The Research Ethics Committee reviewed the above application at the meeting held on 29 July 2016. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Naazneen Nathoo,

nrescommittee.southwestbristol@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### **Ethical opinion**

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

### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Confirmation was required that any session could be used (for the interview) even after undertaking other sessions.
2. Members considered consent should be obtained from the therapist to be audio and video recorded. This should be included in the therapist's consent form.
3. The following standard wording must be included in all consent forms for audit/inspection:

"I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from [company name], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records."

***Wording may be revised slightly to make it relevant to this study.***

**You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations.*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Ethical review of research sites

#### *NHS Sites*

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Summary of discussion at the meeting

- **Social or scientific value; scientific design and conduct of the study**



Members noted that the therapist would be asked to select a session near the beginning and one nearer the end. The interview would take place a couple of days after, before the next session. Members wanted to know whether it would be possible to use a past session for the interview even if other sessions had been undertaken after the selected session. It might be possible that the therapist felt a particular session had not gone well, conducted a few more sessions, and then decided that one of the previous sessions had, in fact, been better.

*You replied you had not thought of that particular scenario. However, as video recording would be available, it should not be a problem to select an appropriate session to use for the interview.*

- **Informed consent process and the adequacy and completeness of participant information**

Members were impressed with the participant information sheet, which included pictures.

**Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.**

### **Approved documents**

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity letters UMAL EL PL 15-16]		20 July 2015
Interview schedules or topic guides for participants [Client Participant Interview Schedule]	1.0	28 May 2016
Interview schedules or topic guides for participants [Therapist Participant Interview Schedule]	1.0	28 May 2016
IRAS Application Form [IRAS_Form_13062016]		13 June 2016
IRAS Checklist XML [Checklist_13062016]		13 June 2016
IRAS Checklist XML [Checklist_20062016]		20 June 2016
Letter from sponsor [Sponsor Letter]	1.0	15 June 2016
Letters of invitation to participant [Email of Invitation to Therapist Participants]	1.0	23 May 2016
Non-validated questionnaire [HAT Form]	1.0	29 May 2016
Non-validated questionnaire [Therapist Participant Demographics]	1.0	23 May 2016
Non-validated questionnaire [Client Participant Demographics]	1.0	23 May 2016
Other [Indemnity letters UMAL PI 15-16]		20 July 2015
Participant consent form [Client Participant Consent Form] **	1.0	29 May 2016
Participant consent form [Client Participant Consent to being Contacted]	1.0	29 May 2016
Participant consent form [Therapist Participant Consent Form] **	2.0	17 June 2016
Participant information sheet (PIS) [Client Participant Information Sheet]	1.0	29 May 2016
Participant information sheet (PIS) [Therapist Participant Information Sheet]	1.0	30 May 2016

Referee's report or other scientific critique report [A54-1 Assessment of scientific quality]	1	01 February 2016
Research protocol or project proposal [Project Proposal]	3.0	23 February 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1.0	14 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV TW]	1.0	13 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV GC]	1.0	13 May 2016

\*\*See above.

## **Membership of the Committee**

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

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

## **After ethical review**

### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

## **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-thehra/governance/quality-assurance/>

## **HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

**16/SW/0187**

**Please quote this number on all correspondence**

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

Yours sincerely



**pp. Dr Julie Woodley Chair**

E-mail: nrescommittee.southwest-bristol@nhs.net

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

*"After ethical review – guidance for researchers" [SL-AR2 for other studies]*

*Copy to: Mrs Leigh Taylor  
Andy Harewood, Somerset Partnership NHS Foundation Trust*

## South West - Central Bristol Research Ethics Committee

### Attendance at Committee meeting on 29 July 2016

#### Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Kay Barnard	Ex-research scientist	Yes	
Dr Robert Beetham	Retired Consultant Clinical Biochemist	Yes	
Ms Susan Bradford	Solicitor	Yes	
Dr Ian Davies	Consultant in Cardiac Anaesthesia & Intensive Care	Yes	
Mr Richard Gibson	Administrator	No	
Mr Alexander Howard	Humanist Funeral Celebrant	Yes	
Dr Adrian Kendrick	Consultant Clinical Scientist	No	
Ms Sally Morgan-Fletcher	Clinical Scientist	No	
Mr Brian Pixton	Retired solicitor	No	
Dr Colette Reid	Consultant in Palliative Medicine	Yes	
Dr Margaret Saunders*	Head of BIRCH, Bioengineering, Innovation & Research Hub,	No	
Mr Adam Turner	Pharmacist	Yes	
Dr Julie Woodley	Senior Lecturer/ Chair of Faculty Ethics Committee	Yes	

#### Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Flo Darch	
Mrs Naazneen Nathoo	REC Manager
Ms Karen Tanner	Dept of Clinical Research



## Health Research Authority

### South West - Central Bristol Research Ethics Committee

Whitefriars  
Level 3, Block B  
Lewin's Mead  
Bristol BS1 2NT

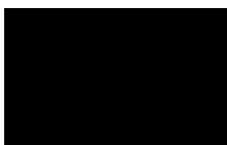
Email: nrescommittee.southwest-bristol@nhs.net

Telephone: 0117 342 1335

Fax: 0117 342 0445

17 August 2016

Miss Sarah Wills  
Student  
University of the West of England



Dear Miss Wills

**Study title:** Significant therapy events: An interpretative phenomenological analysis of psychotherapy with clients with learning disabilities

**REC reference:** 16/SW/0187

**Protocol number:** N/A

**IRAS project ID:** 199240

Thank you for your email of 03 August 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 02 August 2016

#### **Documents received**

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
IRAS Checklist XML [Checklist_03082016]		03 August 2016
Other [Email]		03 August 2016
Participant consent form [Client Participant Consent Form]	2.0	03 August 2016
Participant consent form [Therapist Participant Consent Form]	3.0	03 August 2016

#### **Approved documents**

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity letters UMAL EL PL 15-16]		20 July 2015
Interview schedules or topic guides for participants [Client Participant Interview Schedule]	1.0	28 May 2016
Interview schedules or topic guides for participants [Therapist Participant Interview Schedule]	1.0	28 May 2016
IRAS Application Form [IRAS_Form_13062016]		13 June 2016
IRAS Checklist XML [Checklist_13062016]		13 June 2016
IRAS Checklist XML [Checklist_20062016]		20 June 2016
IRAS Checklist XML [Checklist_03082016]		03 August 2016
Letter from sponsor [Sponsor Letter]	1.0	15 June 2016
Letters of invitation to participant [Email of Invitation to Therapist Participants]	1.0	23 May 2016
Non-validated questionnaire [HAT Form]	1.0	29 May 2016
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Other [Email]		03 August 2016
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Participant information sheet (PIS) [Therapist Participant Information Sheet]	1.0	30 May 2016
Referee's report or other scientific critique report [A54-1 Assessment of scientific quality]	1	01 February 2016
Research protocol or project proposal [Project Proposal]	3.0	23 February 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1.0	14 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV TW]	1.0	13 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV GC]	1.0	13 May 2016

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**16/SW/0187**

**Please quote this number on all correspondence**

Yours sincerely



**Naazneen Nathoo REC Manager**

E-mail: [nrescommittee.southwest-bristol@nhs.net](mailto:nrescommittee.southwest-bristol@nhs.net)

Copy to: *Mrs Leigh Taylor*  
*Andy Harewood, Somerset Partnership NHS Foundation Trust*

## Appendix E – Health Research Authority approval



# Health Research Authority

Miss Sarah Wills  
Student at the University of the West of England

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)



06 September 2016

Dear Miss Wills

### Letter of HRA Approval

<b>Study title:</b>	<b>Significant therapy events: An interpretative phenomenological analysis of psychotherapy with clients with learning disabilities</b>
<b>IRAS project ID:</b>	<b>199240</b>
<b>REC reference:</b>	<b>16/SW/0187</b>
<b>Sponsor</b>	<b>The University of the West of England</b>

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.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from [www.hra.nhs.uk/hra-approval](http://www.hra.nhs.uk/hra-approval).

### **Appendices**

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

### **After HRA Approval**

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](#), and emailed to [hra.amendments@nhs.net](mailto:hra.amendments@nhs.net).
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

### **Scope**

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

### **HRA Training**

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **199240**. Please quote this on all correspondence.

Yours sincerely

Dr Claire Cole  
Senior Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

*Copy to: Mrs Leigh Taylor, (Sponsor Contact)  
Andy Harewood, Somerset Partnership NHS Foundation Trust (Lead NHS  
R&D Contact)*

## **- List of Documents**

The final document set assessed and approved by HRA Approval is listed below

<i>Document</i>	<i>Version</i>	<i>Date</i>
Contract/Study Agreement [HRA Statement of Activities]	1	06 September 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity letters UMAL EL PL 15-16]		20 July 2015
Interview schedules or topic guides for participants [Client Participant Interview Schedule]	1.0	28 May 2016
Interview schedules or topic guides for participants [Therapist Participant Interview Schedule]	1.0	28 May 2016
IRAS Application Form [IRAS_Form_13062016]		13 June 2016
Letter from sponsor [Sponsor Letter]	1.0	15 June 2016
Letters of invitation to participant [Email of Invitation to Therapist Participants]	1.0	23 May 2016
Non-validated questionnaire [HAT Form]	1.0	29 May 2016
Non-validated questionnaire [Therapist Participant Demographics]	1.0	23 May 2016
Non-validated questionnaire [Client Participant Demographics]	1.0	23 May 2016
Other [Indemnity letters UMAL PI 15-16]		20 July 2015
Other [HRA Schedule of Events]	1	06 September 2016
Participant consent form [Client Participant Consent Form]	1.0	29 May 2016
Participant consent form [Client Participant Consent to being Contacted]	1.0	29 May 2016
Participant consent form [Client Participant Consent Form]	2.0	03 August 2016
Participant consent form [Therapist Participant Consent Form]	3.0	03 August 2016
Participant information sheet (PIS) [Client Participant Information Sheet]	1.0	29 May 2016
Participant information sheet (PIS) [Therapist Participant Information Sheet]	1.0	30 May 2016
Referee's report or other scientific critique report [A54-1 Assessment of scientific quality]	1	01 February 2016
Research protocol or project proposal [Project Proposal]	3.0	23 February 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1.0	14 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV TW]	1.0	13 May 2016
Summary CV for supervisor (student research) [Academic Supervisor CV GC]	1.0	13 May 2016

## **██████████ - Summary of HRA Assessment**

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.**

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

**Mrs Leigh Taylor or Miss Sarah Wills**

### **HRA assessment criteria**

<b>Section</b>	<b>HRA Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will act as the agreement between the sponsor and the participating organisation.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this

<b>Section</b>	<b>HRA Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
			research study
4.3	Financial arrangements assessed	Yes	As detailed in the Statement of Activities no funding will be provided to sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	Researcher confirmed: Study data including the video-recordings will be stored in a 7-Zip encryption folder on the University of the West of England secure server which gets automatically backed up. Additionally data will be stored in a lockable filing cabinet located at the University of the West of England. No study data will be stored at the Chief Investigator's home address.
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

## **Participating NHS Organisations in England**

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

There is one site type for this study. All study activities as detailed in the Schedule of Events will take

place at site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). The HRA will work with these organisations to achieve a consistent approach to information provision.

## **Confirmation of Capacity and Capability**

*This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.*

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research.**

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

## **Principal Investigator Suitability**

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

The Chief Investigator will be responsible for all research activities at site.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

### **HR Good Practice Resource Pack Expectations**

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

The Chief Investigator will require a Letter of Access on the basis of a research passport from their University. This should confirm standard DBS clearance and occupational health clearance.

### **Other Information to Aid Study Set-up**

*This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

**Appendix F – Therapist Participant Information Sheet**



University of the  
West of England



**Significant Therapy Events: An Interpretative  
Phenomenological Analysis of Psychotherapy with  
Clients with Learning Disabilities**



**Participant Information Sheet**



## What is the research about?

Thank you for your interest in this research exploring significant therapy events. The research is being done to explore helpful therapy events. We know that helpful therapy events are linked to good outcomes for clients attending therapy sessions. We want to learn more about helpful therapy events for clients with learning disabilities to help make therapy sessions better for them.

## Who are the researchers?

My name is Sarah Wills and I am a Counselling Psychologist in training at the University of the West of England, Bristol. I am completing this project for my doctoral research. My research is supervised by Dr Tony Ward and Dr Gary Christopher (see below for their contact details).

## Who can participate?

Participants should be working in the community team for adults with learning disabilities in Somerset Partnership NHS Foundation Trust. They should be either:

- A qualified counselling psychologist, clinical psychologist, counsellor or therapist with other similar qualification, accredited by a reputable professional body (e.g. BPS, HCPC, BABCP, BACP, etc); or
- A trainee counselling or clinical psychologist undertaking an accredited programme of study

Additionally, participants should have a minimum of one year's experience of offering psychotherapy to clients with learning disabilities.

## Who has reviewed this research?

This research has been scrutinised and approved by the Faculty Research Degrees Committee at the University of the West of England. This research has been approved by the Health Research Authority and has been registered with Research and Development within Somerset Partnership NHS Foundation Trust.

## Do I have to take part?

No, you don't. It is your choice whether you want to take part and you can always change your mind.

## What does participation involve?

You will participate in this research as part of a therapy dyad; you will therefore be asked to inform the researcher when you are about to start therapy sessions with a client matching the specified client participant inclusion criteria, who then goes on to consent to take part in the research.

Every therapy session will be video recorded using a small video camera that you will be asked to position in the corner of the room. After each therapy session you will ask your client to complete a short questionnaire asking for them to identify any helpful or important moments that occurred during the session.

You will select one therapy session out of the first few sessions based on the information your client provided in the questionnaire as well as whether you thought there were helpful moments during the session. Before the next therapy session, you and your client will be invited to participate individually in a qualitative interview, that is, you will both be interviewed separately. A qualitative interview is a 'conversation with a purpose'; you will be asked to answer questions in your own words. We will first locate your client's identified helpful moment on the video recording of the therapy session and watch this together. I will ask you questions that focus on exploring their identified helpful moment in therapy.

You will later be asked to select a further therapy session out of the final few sessions. You and your client will again be interviewed separately before the next therapy session; this interview will follow the same procedure as before.

All interviews will be audio recorded and I will transcribe (type-up) the interviews for the purposes of analysis.

If you would like to take part in the research, I will arrange a convenient time with you for us to meet. I will ask you to read and sign a consent form. You will also be asked to complete a short demographic questionnaire; this is for me to gain a sense of who is taking part in the research. I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have.

## What are the client participant inclusion criteria?

Clients with a mild to moderate learning disability who are about to start therapy with you. They should have reasonable expression and comprehension skills and be able to give informed consent to taking part in the study.

## Are there any risks involved?

We don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. Remember to advise me at any point during the interview, if you would like a break or for the interview to stop.

In addition, we have provided information about some of the different resources which are available to you. Within Somerset Partnership NHS Foundation Trust the Well at Work Service can offer staff emotional support; they can be contacted on 01278 450874. If you prefer to access support that is external to Somerset Partnership NHS Foundation Trust, South Somerset Mind provides a list of counselling services that can be accessed; the following website lists free or low cost counselling services in the local area:

<http://www.southsomersetmind.co.uk/useful-links.asp>.

## What are the benefits of taking part?

Whilst there is no expectation that individual participants will directly benefit from the research, it is possible that you may indirectly experience some benefit.

You may benefit from reflecting on the therapy session during the interview; this type of recall technique was originally developed as a training method for therapists to become more skilled during therapeutic work.

Furthermore, taking part in the research will provide you with the opportunity to participate in a research project on an important psychological issue and it is hoped that this research will help to improve therapy for people with learning disabilities.

## How will the data be used?

The purpose of video recording the therapy sessions is to help you talk about your client's identified helpful moments in therapy during your two interviews. The video recordings will not be analysed and will be destroyed in line with the 1998 Data Protection Act once my research project is complete.

Your interview data will be anonymised (i.e., any information that can identify you will be removed) and analysed for my research project. This means extracts from your interview may be quoted in my thesis and in any publications and presentations arising from the research. The demographic data for all of the participants will be compiled into a table and included in my thesis and in any

publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data. After five years, all remaining data generated by the research project will be destroyed.

### How do I withdraw from the research?

If you decide you want to withdraw from the research please contact me via email: [sarah3.wills@live.uwe.ac.uk](mailto:sarah3.wills@live.uwe.ac.uk). Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

### Can I get independent advice about taking part in research?

The Patient Advice and Liaison Service (PALS) can offer independent advice about taking part in research generally; their contact details are:

PALS  
Somerset Partnership NHS Foundation Trust

01278 432022  
[pals@sompar.nhs.uk](mailto:pals@sompar.nhs.uk)

### Further questions?

If you have any questions about this research please contact me:

#### **Sarah Wills**

University of the West of England  
Frenchay Campus  
Coldharbour Lane  
Bristol  
BS16 1QY

[sarah3.wills@live.uwe.ac.uk](mailto:sarah3.wills@live.uwe.ac.uk)

Or you can contact my research supervisors:

**Dr Tony Ward**

University of the West of England  
Frenchay Campus  
Coldharbour Lane  
Bristol  
BS16 1QY

0117 328 3109  
[tony.ward@uwe.ac.uk](mailto:tony.ward@uwe.ac.uk)

**Dr Gary Christopher**

University of the West of England  
Frenchay Campus  
Coldharbour Lane  
Bristol  
BS16 1QY

0117 328 2196  
[gary.christopher@uwe.ac.uk](mailto:gary.christopher@uwe.ac.uk)

**Thank you for taking the time to read this information sheet.**

## Appendix G – Therapist Participant Consent Form



University of the  
West of England

### Consent Form

**Title of Project:** Significant therapy events: An interpretative phenomenological analysis of psychotherapy with clients with learning disabilities

**Name of researcher:** Sarah Wills

*Please initial box*

1. I confirm that I have read the information sheet dated 30.05.2016 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that the therapy sessions that I participate in with the client participant will be video recorded.
3. I understand that the research interviews that I participate in will be audio recorded.
4. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the University of the West of England, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
6. I agree to take part in the above study.

\_\_\_\_\_  
*Name of Participant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Name of Person  
taking consent*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

Would you like to receive a copy of the results once the research is complete?  
(please tick):

Yes	
No	

If yes, please provide your preferred contact details below and I will ensure I send you a copy of the results once the research is complete:

Email: \_\_\_\_\_ and/or

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*When completed: 1 for participant; 1 for researcher site file.*

# Helpful Moments in Therapy: Experiences of Clients with Learning Disabilities and their Therapist



My name is Sarah Wills and I am a Counselling Psychologist in training at the University of the West of England.



I am completing some research exploring helpful moments in therapy.





I would like to meet with you to talk about this research to see if you would like to take part.



Would you like to meet with me to discuss this research?



Yes



No

If yes, please provide your name and telephone number and I will contact you to arrange a time for us to meet:



---



**Thank you for taking the time to read this form.**

Appendix I – Client Participant Information Sheet



# Helpful Moments in Therapy: Experiences of Clients with Learning Disabilities and their Therapist



**Participant Information Sheet**



### **What is research?**

Research is a way we try to find out the answers to questions.



### **Why is this project being done?**

This research is being done to explore helpful moments in therapy.



We know that helpful moments in therapy are linked to good outcomes for clients attending therapy sessions. We want to learn more about helpful moments in therapy for clients with learning disabilities to help make therapy sessions better for them.



**Who are the researchers?**

My name is Sarah Wills and I am a Counselling Psychologist in training at the University of the West of England.



**Why have I been asked to take part?**

You have been asked to take part because you are about to begin therapy within the Community Team for Adults with Learning Disabilities.



**Did anyone else check the study is OK to do?**

Before any research is allowed to go ahead it has to be checked by a group of people to make sure that the research is fair.



**Do I have to take part?**

No, you don't. It is your choice whether you want to take part and you can always change your mind.

## What will happen to me if I take part?



1. I will first check whether you are happy to take part.



2. I will then ask you to sign the consent form.



3. Every therapy session you attend will be video recorded.



4. After every therapy session, you will be asked to complete a short questionnaire.



5. After session 1, 2 or 3, you will be invited to participate in an interview with the researcher.



6. You will watch the video recording of your therapy session and talk about what was helpful.



7. Your therapist will participate in a separate interview and watch the video recording of the therapy session.



8. You will be invited to participate in a 2<sup>nd</sup> interview when you are nearly ready to finish all of your therapy sessions.



9. You will watch the video recording of your therapy session and talk about what was helpful.



10. Your therapist will participate in a separate interview and watch the video recording of the therapy session.



11. Your interviews will be audio recorded.



12. I will transcribe (type-up) the interviews for the purpose of the analysis.





### **Will anything about the research upset me?**

We don't anticipate any risks to you with participating in this research; however, there is always the potential for research participation to raise upsetting issues.

Remember to tell me at any point during the interviews if you would like a break or for the interview to stop.



### **How do I get support if I feel upset?**

You can let your therapist or one of the researchers know. South Somerset Mind provides a list of resources of support accessed via: <http://www.southsomersetmind.co.uk/useful-links.asp>



### **Will taking part help me?**

The study will not help you right now. But we hope it will help us to learn and improve therapy for people with learning disabilities.



### **Will my information be kept private?**

All your information will be kept private. If at any point during the interviews, you talk about harm to yourself or anyone else, I will tell your therapist and/or other professionals involved in your care.



### **What happens when the research study stops?**

The research will be talked about and written down but no one will know that you took part. Extracts from your interviews may be quoted in my thesis and in any publications and presentations, once any information that can identify you has been removed.



Once the study is complete, all information (except video recordings) will be kept for five years.



### **What will happen to the video recordings of my therapy sessions?**

The video recordings are intended to help you and your therapist talk about your helpful moments in therapy during your two interviews. The video recordings will not be analysed and will be destroyed once my research project is complete.



**What do I do if I don't want to take part in the research anymore?**

If you decide you want to withdraw from the research, please contact me via email:

[sarah3.wills@live.uwe.ac.uk](mailto:sarah3.wills@live.uwe.ac.uk)



**Can I get independent advice about taking part in research?**

The Patient Advice and Liaison Service (PALS) can offer independent advice about taking part in research; their contact details are:



PALS  
Somerset Partnership NHS  
Foundation Trust

01278 432022

[pals@sompar.nhs.uk](mailto:pals@sompar.nhs.uk)



### **Further questions?**

If you have any questions about this research, please contact my research supervisors:

#### **Dr Tony Ward**

University of the West of England

0117 328 3109

[tony.ward@uwe.ac.uk](mailto:tony.ward@uwe.ac.uk)



#### **Dr Gary Christopher**

University of the West of England

0117 328 2196

[gary.christopher@uwe.ac.uk](mailto:gary.christopher@uwe.ac.uk)



**Thank you for taking the time to read this information sheet.**



## Appendix J – Client Participant Consent Form



# Helpful Moments in Therapy: Experiences of Clients with Learning Disabilities and their Therapist

## Consent Form



Thank you for agreeing to take part in this research on helpful moments in therapy.



I am a Counselling Psychologist in training at the University of the West of England. I am collecting this data for my doctoral research.



Please read the following statements. I understand that:



Yes



My therapy sessions will be **video recorded**



Yes



I will be interviewed **twice** about my therapy sessions



Yes



During my interviews I will **watch** my video recorded session with the researcher



Yes



My **therapist** will also be interviewed about my two therapy sessions and will watch the video recordings



Yes



My name and other personal details will **not** be used in the study write-up



Yes



All recordings and interview transcripts will be stored **securely**



Yes



I can **change** my mind and say 'no' and my therapy sessions will be the same



Yes



My **medical notes** and **data collected** during the study may be looked at by people from the University of the West of England, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research



Yes

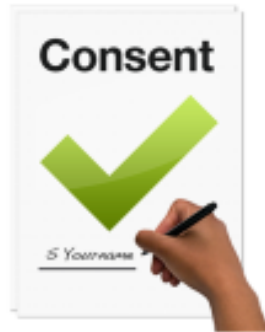


I give **permission** for these individuals to have access to my records



Yes





Please sign this form to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research:

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



Would you like to receive a copy of the results once the research is complete?



Yes



No

If yes, please provide your address and I will ensure I send you a copy of the results:



Your Name  
36 Any Street  
New Town  
Countyshire  
PS5 00D



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thank you and please return the signed copy of this form to me.**

**Appendix K – Analysis of a selection of interview transcripts**

<p><b>Key:</b> Descriptive comments (normal text)  <i>Linguistic comments (italic)</i>  <u>Conceptual comments (underlined)</u></p>
---

Emergent Themes	Original Transcript	Exploratory Comments
<p>Expressing self to be heard</p> <p>Emotions as painful</p>	<p><i>Transcript extract from interview with CP1 during interview 1.</i></p> <p>I: Um hm so thinking about sort of feeling anxious and feeling uptight, what sort of kind of thoughts do you think what what was kind of going through your mind at that point when you were feeling anxious and uptight?</p> <p>CP1: Um it was I don't want to be here.</p> <p>I: Ah I see, so in the session you kind of you felt...</p> <p>CP1: No.</p> <p>I: Oh, not in the session but...could you say more about that?</p> <p>CP1: Not be here at all.</p> <p>I: Ah I see. And that's what you were thinking about in the session?</p>	<p><u>Doesn't want to be there in the session because of anxiety or is there a deeper meaning?</u></p> <p><i>Use of 'no' to assert self</i>  <u>Wanted to be heard and understood</u></p> <p><i>Use of 'at all' to emphasise point.</i>            Not wanting to be here at all</p>

Emergent Themes	Original Transcript	Exploratory Comments
<p>The thought turned around</p> <p>The internal process as helpful</p> <p>Wanting to here for others as a sudden realisation</p>	<p>CP1: Yeah.</p> <p>I: Right ok. And then something did that thought change after you'd kind of talked through...</p> <p>CP1: Yeah it changed.</p> <p>I: Ah. What did it change to?</p> <p>CP1: That I want to be here.</p> <p>I: Ah ha.</p> <p>CP1: I want to be here. I want to be with *** (partner's name omitted) for the rest of my life. I want to be there for my mum, because my mum's not well...and that gets me down...</p>	<p>The thought completely changed</p> <p>Wanting to be here for important others</p> <p><i>Very clear language. <u>Reflecting some internal process of gaining clarity</u></i></p>

Emergent Themes	Original Transcript	Exploratory Comments
	<p><i>Transcript extract from interview transcript with CP3 during interview 1.</i></p> <p>I: So, what were you doing or trying to do?</p>	

Emergent Themes	Original Transcript	Exploratory Comments
<p>Showing feelings as odd</p> <p>The identity of showing feelings as confusing</p> <p>The work of letting all emotions out</p>	<p>CP3: Well quite a few things, like [pause] really showing my feelings, that sounds really odd [laughs].</p> <p>I: That sounds odd? Ok.</p> <p>CP3: Yeah, I do know why I'm saying that.</p> <p>I: Oh, what's odd about it do you think?</p> <p>CP3: Men don't show their feelings much and I'm a man well I'm like in the middle it's like I'm willing to see like um...I like showing my feelings, I like I know a lot of men don't like crying in front of girls, I nearly did not in that session, off camera thank God [both laugh] um...yeah, I forgot what I was talking about, getting ahead of myself.</p> <p>I: Yeah so you were saying about what you were what you were doing or trying to do so you'd said that you were you were trying to show your feelings.</p> <p>CP3: Show my feelings um...letting everything out everything what I can remember but there is still a lot of things that I'm learning um...so we've got another what ten, twelve more sessions I can't remember and I've all that hopefully at the end of it I'll be more calm, don't get angry coz I've said all my feelings, every worry and end of it I probably don't need help and I can't wait [laughs] I literally can't wait.</p>	<p>Showing feelings</p> <p><u>Odd like he doesn't feel he should show feelings</u></p> <p>Belief that men don't show feelings <u>Internal confusion that believes men don't show feelings, he's a man but he does like showing feelings – confusion over identity</u></p> <p>Trying to show feelings by letting everything out</p> <p>Hopeful for a positive therapy outcome</p>

Emergent Themes	Original Transcript	Exploratory Comments
<p>The paradox of trust being hard but trusting therapist</p> <p>Having trust as being happier and relaxed</p> <p>Trust as being unfamiliar</p> <p>The therapist being understanding as important</p>	<p>I: Uh mm...ok um...so what was going through your mind and what what were you thinking?</p> <p>CP3: Um...[pause] I don't know. How was I feeling earlier? More calm, happier, trust and that's very very hard with me I can't trust no one.</p> <p>I: Hm mm...but it felt like you were starting to trust ***[therapist's name omitted]?</p> <p>CP3: Mm hm...yeah that's it more happy and relaxed.</p> <p>I: Ah so a thought might have been that actually I'm starting to trust this person?</p> <p>CP3: Mm...yeah it's odd.</p> <p>I: Ah ha ok um...ok so can you describe the most helpful thing about the event, so what did ***[therapist's name omitted] do during the event that stands out in your mind as being helpful?</p> <p>CP3: Listening, caring, and understand understanding. Um...like telling me um...you're not alone but not saying it, that's how I feel, she...</p> <p>I: Ah, so what did she do for you to feel that?</p>	<p>Trust is hard <u>But confusion because starting to trust therapist</u></p> <p>Trust = more happy and relaxed</p> <p><u>Use of 'odd', trust – it's odd that he's starting to trust someone – like that hasn't happened before – has no-one listening stopped him from trusting before?</u></p> <p><u>Repetition of 'understanding' shows the importance of this</u> Therapist was listening, caring and understanding</p>

Emergent Themes	Original Transcript	Exploratory Comments
Hope	CP3: I don't know just like listening and talking to me so that's how and like I thought I always think like maybe she's telling me, I might be wrong here, that you are not alone, maybe there is loads of other people out there who feel exactly the same that's what I think to myself.	Therapist listened and talked to show client they are not alone. <u>Use of 'not alone' gave client hope – if others experience difficulties he is not the only one</u>

Emergent Themes	Original Transcript	Exploratory Comments
<p>Noticing client's body posture as important</p> <p>Immediacy as a helpful concrete intervention</p> <p>Reflecting positive change to client as helpful</p>	<p><i>Transcript extract from interview transcript with TP2 during interview 2.</i></p> <p>I: So what general characteristics of your client or you client's situation help to explain the event including your decision to intervene as you did?</p> <p>TP2: Um...just the fa I think I said it then it was just actually your body posture's changed, the way that you're talking has changed, the way that your facial expressions have changed, I think it was kind of pointing out to him um...the change that I was observing in his behaviours and he was talking about going into find a new job um...and also kind of reiterating that um...seeing it from previous earlier sessions there's been an overall change in how he's been feeling and how he's been doing what he's been doing.</p>	<p>Noticing client's body posture</p> <p>Using immediacy with client to help him notice/understand <u>Seems to be helpful using something more concrete, so what client is doing/changes in his behaviour – easier for him to see</u></p>

Emergent Themes	Original Transcript	Exploratory Comments
<p>Therapist self-criticism</p> <p>Therapist infancy as underplaying own skills</p> <p>A need for therapist to be doing rather than listening</p> <p>Therapist as walking in client's shoes</p> <p>The eventual acknowledgement of giving space and listening as helpful</p> <p>Building the therapeutic relationship first</p>	<p>I: Mm hm...and what general characteristics of your approach to therapy or you as a person are relevant to this event?</p> <p>TP2: Um...I think may potentially I think it demonstrates my um...kind of my infancy in therapy because actually I've probably maybe let him I don't know allowed him to speak I don't I think as a therapist I'm I don't know it maybe I've let I let him speak too long or didn't kind of stop him to kind of clarify certain bits or um...coz there was one bit where he went off in a bit of a tangent um...to pull him back I may may not have had the confidence to do that. Um...</p> <p>I: And yet this is a helpful point for him as well...</p> <p>TP2: Yeah yeah which is interesting um...yeah, I suppose I just gave him that time to kind of talk and listen to him and then reiterate what he was saying and also um...point out the positives in what he was saying.</p> <p>I: Ok. Um...so what events in earlier sessions with this client have led up to or influenced what happened in this event and you may already have covered some of this.</p> <p>TP2: Um...I think kind of developing that therapeutic relationship in earlier um...earlier sessions and provided him that space to talk um...yeah, I think that's it.</p>	<p>Therapist self-criticism <i>emphasised by use of 'infancy'</i></p> <p><u>Criticising own ability – underplaying skills. Is it not ok to let clients go off on a tangent? Why is this not helpful for client?</u></p> <p><u>Parallel process during interview of therapist becoming negative and interviewer pointing out positives in a similar way to the therapist/client interaction during the session</u></p> <p>Acknowledging giving space and listening are helpful to client</p> <p>Building the therapeutic relationship in earlier sessions</p> <p>Proving client with space to talk</p>

Emergent Themes	Original Transcript	Exploratory Comments
<p>Reflecting positive change as giving hope to client</p> <p>Empowering the client</p> <p>Discussion of positive reaction of significant others as helpful</p>	<p>I: Ok. Um...and recent events in your client's life have led up to or explain this event um...so again things like relevant recent positive change or stressful events outside of therapy?</p> <p>TP2: Um...I think positive change again I think the hypnotherapy and the acupuncture and him showing that um...to stop the smoking it showed him that he had the confidence and the ability to stop something and achieve one of his goals um...so coming into this session I think it also and also trying to get a job I think he was kind of may he just showed his parents actually he can do something he can change his behaviour um...and I think that was quite encouraging for him and seeing the changes in his parents' kind of approach to him I think and also seeing how happy they were when they saw how hard he was working and um...I think that made that encouraged him even more to kind of go and find a job or go to the job centre.</p>	<p>Positive change as a recent event for client</p> <p>Events showed client they could achieve their goal</p> <p><u>Giving hope to client</u></p> <p><u>'He can do something' -empowering – client can do it himself</u></p> <p>Client noticing change in parents and how they were happy and proud of him</p>

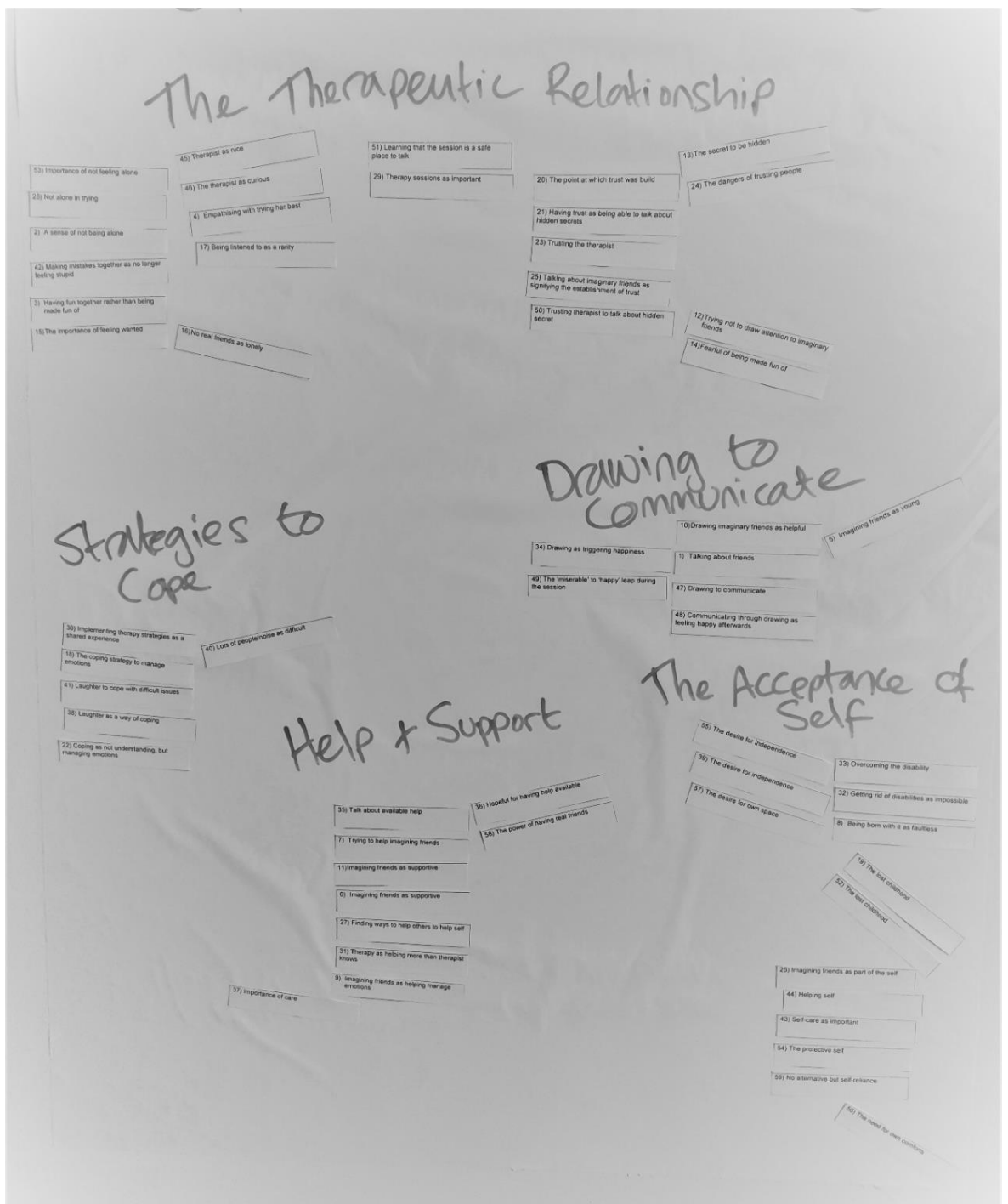
Emergent Themes	Original Transcript	Exploratory Comments
<p>Client as better understanding self</p>	<p><i>Transcript extract from interview transcript with TP3 during interview 1.</i></p> <p>TP3: Yeah, I think he definitely well he said he had a better understanding of his anger, all of the questions that I ask him including in</p>	<p>Client gained a better understanding of their anger</p>



Emergent Themes	Original Transcript	Exploratory Comments
<p>Therapy as collaborative</p> <p>Guiding, not directing client</p> <p>Therapist difficult of knowing</p> <p>Therapeutic relationship as protective</p> <p>Testing the therapeutic relationship to build it</p>	<p>that session he says 'oh I never thought about that before' and then he panics for a second and thinks he doesn't know the answer so we just say oh I say 'lets just think about it together' then he's able to come up with an answer so that's helping him to problem solve in the sense that his problem is he doesn't understand why he's angry so he's problem solving being able to think about that in a guided way but hopefully he carry that over outside of the sessions think think thinking along those lines. So a better understanding of his anger and of his abilities as well a bet a greater recognition of his ability to up first articulate and I say that because speech is so important to him being able to speak properly his his goal in speech and language therapy is to be able to speak normally which is being explored with her, speech and language therapist because that won't happen due to the way his mouth is formed um...so a a better ability to be able to articulate himself and to learn that people can learn to understand him um...and just trying to wonder if um...I think it was the session after that he started asking me personal questions but I just had to explain that it was good not to know about me because the sessions were all about him but that's not relevant um...just building that relationship I guess that is an example of the fact of his testing what the relationship is and what it means where he stands and that, I'm rambling on...</p> <p>I: No that's fine, that's good. Um...and you said a little bit about this um...but to what extent do you find your client's choice of event surprising or expected?</p>	<p>Thinking about things together rather than asking client a question to answer by themselves</p> <p><u>Being collaborative 'together'</u></p> <p>Adapting the session and how they work together</p> <p><u>Use of 'guided' -not fully enabling client to do it by himself – still there but more in the background – more about working together</u></p> <p><u>Use of 'that won't happen' -she knows something client doesn't – I wonder how difficult it might be knowing he cannot achieve his speech goal when he believes he can? Does she feel more protective over him as a result?</u></p> <p>Client testing the therapeutic relationship</p>

Emergent Themes	Original Transcript	Exploratory Comments
<p>The unmet need as being recognised</p> <p>Therapy as feeding a need</p>	<p>TP3: I thought it was expected, I thought he would choose that because he seems so high up in mood higher in mood after he had felt so proud of himself for coming up with this expression HSD anger and so that I was expecting that. Because I think doing that all of it everything I've described taps into the underlying one of the underlying things that one of his underlying needs which is a need to um...well not need but a gap in his self-esteem and his self-confidence yeah so, I suppose a need but so that's feeding into that the whole therapy process is helping that as well as exploring where his anger comes from...</p>	<p>Expected client to choose this session because they seemed so proud and happy afterwards</p> <p><i>'taps into', 'underlying', <u>like there is a need hidden away that needs to be recognised and met</u></i></p> <p><i>'feeding', 'need' – <u>as if there is a need that needs feeding</u></i></p> <p>Therapy is helping client with self-esteem as well as anger</p>

**Appendix L: Map of initial themes for Client Participant 4**



### Appendix M – Table of initial themes for Client Participant 4

Themes	Page No.	Key words
<i>The therapeutic relationship:</i>		
Being listened to as a rarity	7	actually listen
The point at which trust was build	8	only [therapist] knows
Having trust as being able to talk about hidden secrets	9	I wanted to
Trusting the therapist	12	I trusted her
The dangers of trusting people	12	can't trust people
Therapist as nice	28	she's nice
The therapist as curious	29	watching me draw
Trusting therapist to talk about hidden secret	31	tell her now
Importance of not feeling alone	33	I'm not like on my own
<i>Drawing to communicate:</i>		
Talking about friends	1	friends
Drawing imaginary friends as helpful	4	help me, when upset
Drawing as triggering happiness	19	happy
Drawing to communicate	29	I wanted [her] to see it
Communicating through drawing as feeling happy afterwards	31	I was happy
The 'miserable' to 'happy' leap during the session	31	miserable, smiling
<i>Strategies to cope:</i>		
The coping strategy to manage emotions	7	really upset to happy
Coping as not understanding, but managing emotions	11	help me find funny side
Implementing therapy strategies as a shared experience	17	they've done
Laughter as a way of coping	22	it is quite funny
Lots of people/noise as difficult	23	really busy
Laughter to cope with difficult issues	25	I was actually laughing
<i>The acceptance of self:</i>		
Being born with it as faultless	3	born like it
The lost childhood	8	start being naughty
Getting rid of disabilities as impossible	18	can't get rid of it
Overcoming the disability	18	try and beat it
Helping self	27	help me
The lost childhood	33	I had a bad teenager

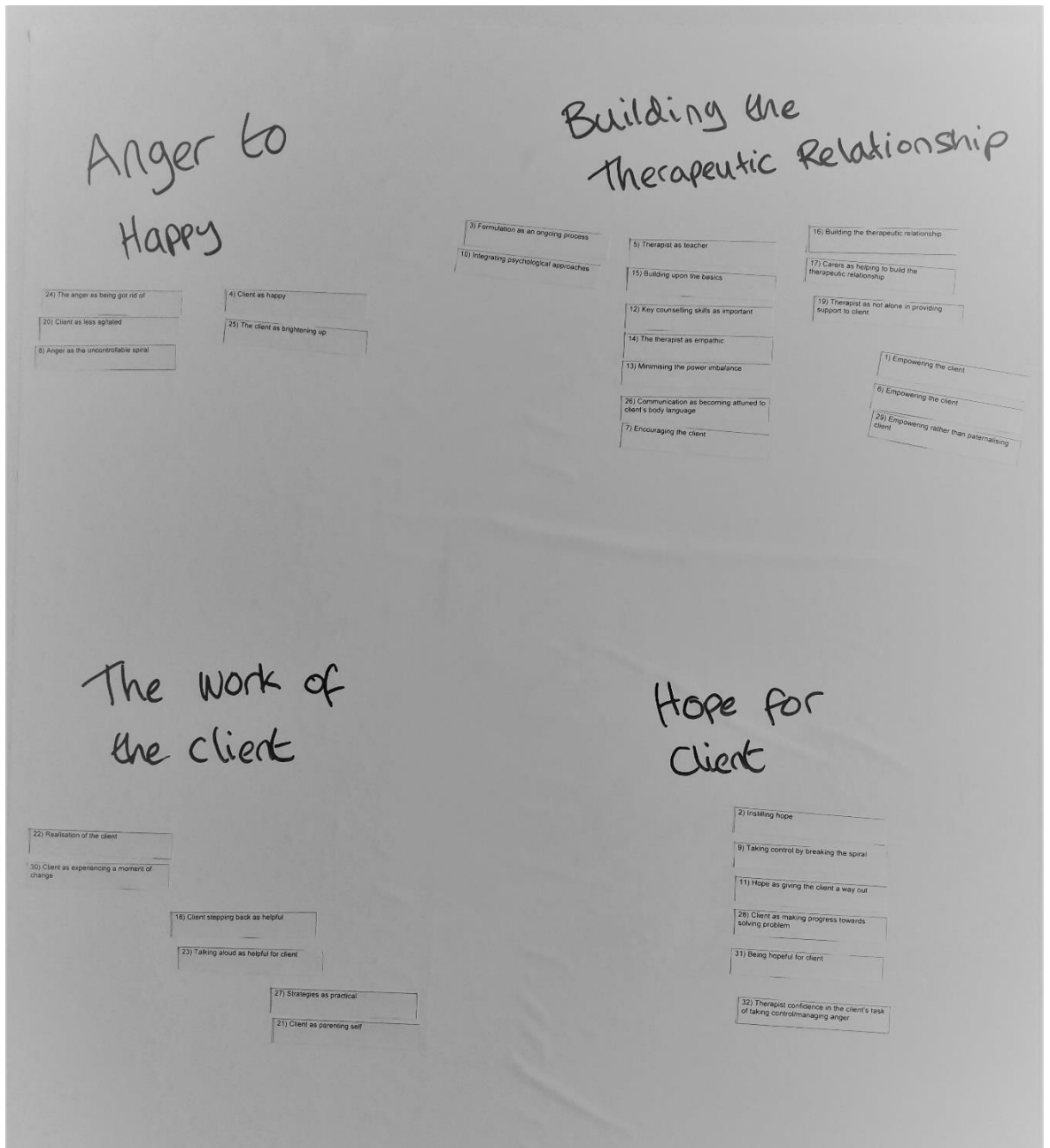
Themes	Page No.	Key words
<i>Help and support:</i>		
Trying to help imagining friends	3	I try and help them
Imagining friends as helping manage emotions	4	they help me
Finding ways to help others to help self	15	I want to help them
Therapy as helping more than therapist knows	17	she doesn't know that
Hopeful for having help available	20	schools for people
The power of having real friends	37	could just do anything

## Appendix N – Master table of themes for client participants

Themes	CP/Int.	Key words
<p><i>Expressing emotions to communicate:</i></p> <p>Emotions Talking The process of expressing emotions Expressing emotions Angry to happy Anger to calmness Drawing to communicate Helpful adaptations The challenge of (not) talking Letting emotions out</p>	<p>CP1/1 CP1/1 CP3/1 CP2/1 CP4/1 CP2/2 CP4/2 CP4/1 CP2/2 CP3/2</p>	<p>very depressed it helps me talk I was talking talking about my anger it did cheer me up no point getting annoyed I wanted [her] to see it I didn't know that it helps to talk to someone normal really angry</p>
<p><i>The experience of hope:</i></p> <p>Hope Hopeful for a job Hopeful for future Therapist and client hope Past experiences/future hopes The past and current work of the client</p>	<p>CP1/1 CP2/2 CP3/2 CP2/1 CP4/1 CP3/1</p>	<p>getting out every day hopefully a job probably don't need help how to get round it one day I will learn worse if don't get it sorted</p>
<p><i>The uniqueness of therapy and the therapeutic relationship:</i></p> <p>Building the therapeutic relationship Togetherness The therapeutic relationship The therapeutic relationship Help and support The meaning of therapy The uniqueness of therapy Opening up</p>	<p>CP3/1 CP2/1 CP4/2 CP4/1 CP4/2 CP2/2 CP2/1 CP3/2</p>	<p>She listened to every word how my life is, not perfect I trusted her start letting stuff out could just do anything positive side of everything very positive own test saying things now</p>
<p><i>Strategies to cope:</i></p> <p>Focus on coping strategies Helpful strategies Doing something Strategies to cope Coping with strategies</p>	<p>CP2/1 CP4/1 CP1/1 CP4/2 CP2/2</p>	<p>how to calm me she's helping me that I done it help me find funny side not trying to engage</p>

Themes	CP/Int.	Key words
<p><i>Client realisation – the shift:</i></p> <p>Focus on positives  The acceptance of self  Client realisation (internal process)  Dependence/independence  Understanding the anger</p>	<p>CP2/2  CP4/2  CP1/1  CP4/1  CP3/2</p>	<p>no more downward spirals  try and beat it  I want to be here  because I've got a disability  making me do it to survive</p>

**Appendix O – Map of initial themes for Therapist Participant 2**





**Appendix P – Table of initial themes for Therapist Participant 2**

Themes	Page No.	Key words
<i>Building the therapeutic relationship:</i>		
Empowering the client	1	get him to identify
Therapist as teacher	2	trying to teach him
Encouraging the client	2	a bit more encouraging
Integrating psychological approaches	3	CAT, CBT
Key counselling skills as important	3	I was listening
Minimising the power imbalance	3	help him structure
The therapist as empathic	4	been through a lot
Building the therapeutic relationship	4	get to know him
Carers as helping to build the therapeutic relationship	4	help me understand
Communication as becoming attuned to client's body language	6	his facial expressions
Empowering rather than paternalizing	7	he is able to manage
<i>Hope for client:</i>		
Instilling hope	1	how he could change
Taking control by breaking the spiral	3	breaking that spiral
Hope as giving the client a way out	3	if he could change thinking
Client as making progress towards solving problem	7	able to manage anger
Being hopeful for client	8	he might be able to
Therapist confidence in the client's task of taking control/managing anger	8	he may be able to rationalise
<i>The work of the client:</i>		
Client stepping back as helpful	5	he could step back
Client as parenting self	5	self-soothe himself
Realisation of the client	6	gave him that realisation
Talking aloud as helpful for client	6	talk it out aloud
Strategies as practical	7	practise these
Client as experiencing a moment of change	8	moment of change
<i>Anger to happy:</i>		
Client as happy	2	was really happy
Anger as the uncontrollable spiral	3	works himself up
Client as less agitated	5	less agitated
The anger as being got rid of	6	project that out
The client as brightening up	6	brighten up

## Appendix Q – Master table of themes for therapist participants

Themes	TP/Int.	Key words
<i>The uniqueness of therapy and the therapeutic relationship:</i>		
Building the therapeutic relationship Therapeutic relationship	TP2/1 TP2/2	I was listening Developing therapeutic relationship
Building the therapeutic relationship Building the therapeutic relationship The value of the therapeutic relationship The value of therapy Engagement and disengagement	TP3/1 TP4/1 TP4/2 TP4/1 TP3/2	think about it together building that trust feels totally accepted worked on trust he was more comfortable
<i>The balance between paternalism/beneficence:</i>		
Giving hope Hope and hopelessness Hope for client Positive outcome Improvement and independence Empowering and disempowering Helpful/(feeling) unhelpful Paternalism, worry and hope The pessimistic therapist Managing risk Worry, protection and paternalism The inside/outside therapy contrast	TP2/2 TP1/1 TP2/1 TP3/1 TP1/2 TP1/1 TP2/2 TP1/2 TP4/1 TP1/1 TP3/2 TP3/1	he can do, can achieve quite a simple idea how he could change better understanding of anger mood had gone up he could change something space to talk I'd been worried I didn't do any of that keep him safe I was worrying about that negative experience of care
<i>Making adaptations:</i>		
Adapting communication Adaptations Focus on (thinking about) adaptations Importance of time Focus on strategies and adaptations	TP4/2 TP1/2 TP3/2 TP1/2 TP4/1	I'm looking at her drawing Kept it quite simple give him time to speak get that emotion out had to be in the room
<i>Awareness of client emotions:</i>		
Anger to happy The work of the client Emotions of therapist and client The struggles and benefits of communication	TP2/1 TP2/1 TP3/1 TP1/2	brighten up talk it out aloud he was much happier not hugely articulate

Themes	TP/Int.	Key words
<p><i>Therapist approach:</i></p> <p>The work of the therapist  Being client-led  The balance between therapy as active/passive  Getting on board with the therapy model  Helpful therapist responses</p>	<p>TP4/2  TP4/2  TP3/1  TP1/1  TP4/1</p>	<p>let's manage risk  I just went with it  allow him space  CBT, give him something  thank you for having tried</p>
<p><i>Meaning making:</i></p> <p>The lost helpful event  Events  Focus on significant therapy event  Client and therapist meaning making  Meaning making  The work of the client</p>	<p>TP3/2  TP1/2  TP4/2  TP3/2  TP1/1  TP2/1</p>	<p>surprising  it is quite surprising  suddenly, grabs pen  hadn't thought of that  being a bit more passive  moment of change</p>

**SIGNIFICANT THERAPY EVENTS:  
AN INTERPRETATIVE PHENOMENOLOGICAL  
ANALYSIS OF PSYCHOTHERAPY WITH CLIENTS WITH  
INTELLECTUAL DISABILITIES**



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## Journal Abstract:

### Significant therapy events with clients with intellectual disabilities

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**Purpose:** The purpose of this research is to explore significant events in psychotherapy with clients with intellectual disabilities (IDs).

**Design/methodology/approach:** Four therapy dyads, each consisting of one client and one therapist, were recruited. Following the Brief Structured Recall procedure (Elliott & Shapiro, 1988), semi-structured interviews focused on helpful events in psychotherapy, using video of particular sessions as a stimulus to help prompt recall of that session.

**Findings:** Using interpretative phenomenological analysis, five super-ordinate themes were identified: 'The Uniqueness of the Therapeutic Relationship'; 'Using adaptations to Express Emotions'; 'Client Behaviour/Therapist Behaviour'; 'Hope and Paternalism'; and 'Meaning-Making'. The results provide additional evidence that significant therapy events occur for clients with IDs. Furthermore, the research enabled insights to be gained about the process of therapy for this client group and for exploration of therapeutic factors that may be involved in facilitating a significant therapy event.

**Research limitations/implications:** This study highlights the need for therapists to work in such a way as to facilitate significant events in therapy. Whilst this study was a necessary first step, owing to the non-existence of research in this area, the sample size and qualitative design may limit any wider generalisation of the findings.

**Originality/value:** Significant events have not previously been explored in psychotherapy with clients with IDs. This research could therefore make an important contribution to our understanding of the process of psychotherapy for this client group.

**Keywords:** Mental health, intellectual disabilities, significant therapy events, psychological therapy, interpretative phenomenological analysis, qualitative

**Article Classification:** Research paper

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## Journal Article:

# Significant therapy events with clients with intellectual disabilities

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## Introduction

### *Development of psychotherapy for people with intellectual disabilities*

People with a disability face a number of challenges, such as the physical or organic aspects of disability, attitudes from society, and self-stigmatisation (Becket & Taylor, 2016). Furthermore, the Learning Disabilities Mortality Review Annual Report (Norah Fry Centre for Disability Studies, 2018), identified the persistence of health inequalities for people with intellectual disabilities (IDs), highlighting the need for further action in order to meet the health needs of this client group. Additionally, people with IDs experiencing mental health difficulties have historically been excluded from psychotherapies due to their degree of intellectual impairment (Bender, 1993). However, research has shown that individuals with IDs can recognise and experience emotions in a similar way to the non-ID population (Bermejo, et al., 2014); this indeed suggests that this client group has the ability to gain insight and develop self-awareness, factors that contribute to therapeutic change (Lacewing, 2014). Since the publication of the psychotherapy and learning disability report (Royal College of Psychiatrists Council, 2004), the evidence base has steadily grown, and substantial case study evidence exists for a number of psychotherapeutic approaches. Throughout this paper, psychotherapy has been taken to refer to all psychological approaches as follows.

Psychodynamic therapy addresses the unconscious content of a client's psyche. By helping clients become aware and bring unconscious feelings into their consciousness, the aim is to alleviate psychological tension. Whilst case study evidence exists (Jackson & Beail, 2013), in a review of the evidence, Beail (2016) found no randomised controlled trials (RCTs); only one further controlled trial conducted by Birchard et al. (1996) was identified in which a significant increase in emotional development in the therapy group

compared to the control group was found. Skelly et al. (2018) conducted an open trial of psychodynamic psychotherapy in which treatment fidelity was checked and cases excluded as appropriate. They found clients did not improve while waiting for therapy and significantly improved while attending therapy; large pre-post effect sizes were reported, and improvements were maintained at six-month follow-up.

Another psychotherapeutic approach adapted for clients with IDs is cognitive behaviour therapy (CBT). CBT aims to help clients manage overwhelming problems by changing the way they think and behave in order to improve their mood (Beck, 2011). A growing number of case studies exist evidencing positive improvements for clients engaging in CBT (Wright, 2013). In a review of the available evidence for RCTs, Jahoda (2016) found only one, which was conducted by Willner et al. (2013); however, no reduction in scores of self-reported anger was found.

Cognitive analytic therapy (CAT) involves clients exploring the underlying causes of their current difficulties. In doing so patterns of relating to others are identified, enabling the client to move forward by discovering ways of doing things differently. In a review of the evidence base, Beard et al. (2016) found over 25 published papers predominantly made up of either case studies or reflective essays. Very few of these papers reported outcome data and none contained pre-post data; however, some did report evidence of client change in revising relational patterns (Wills & Smith, 2010).

Mindfulness and acceptance-based therapies, draw upon meditation and Buddhism. Rather than attempting to change particular thoughts or behaviours, the aim is for clients to change how they experience the world by bringing their awareness to the present moment through being curious and non-judging. In a review of the evidence, Gore and Hastings (2016) found, in addition to case studies, one RCT in which clients were randomised to either meditation intervention or to a waiting list control group (Singh et al., 2013). The authors found that physical and verbal aggression reduced to zero levels at six-month follow-up, with a large effect size reported; although this shows encouraging data, this was conducted at feasibility level, with further research required.



Dialectical behaviour therapy (DBT) provides support for clients who experience intense emotions in certain situations. DBT involves supporting the client to identify and build upon their strengths, as well as learning different ways of thinking. Lippold (2016) reviewed the evidence base and found case studies, with some reporting on outcome data in which improvements were evidenced (Lew et al., 2006). Studies reporting pre-post data are lacking. Morrissey and Ingamells (2011) report preliminary outcomes based on six clients who showed significant reductions in distress; however, the fidelity of the model is questionable with the impact of medication not being separated out.

Furthermore, solution-focused brief therapy (SFBT), which involves maintaining a focus on achieving the client's vision of solutions has case study evidence available, with some reporting on outcomes (Rhodes, 2000); however, it is difficult to rule out other factors that may have contributed to reported improvements. Lloyd et al. (2016) found one published controlled trial in which a group of clients receiving six sessions of SFBT were compared to a control group receiving care as usual (Roeden et al., 2014); intervention fidelity was assessed, and cases were excluded as necessary. The SFBT group improved significantly compared to the control group, and improvements were maintained at six-week follow-up.

Thus, it is clear that such psychotherapies have been the focus of investigation, illustrating how they have been adapted in services for people with IDs. There is certainly a growing evidence base, and the level of evidence for psychotherapies varies from case studies for less established studies, to small scale RCTS. There are a few studies that demonstrate ineffectiveness, and the controlled studies that exist suggest that therapy is beneficial compared to waiting list and 'treatment as usual'. However, for many psychotherapy approaches, the evidence is preliminary, and further research spanning a range of designs is required rather than a reliance on case studies.

### ***Significant therapy events research***

The term 'significant therapy events' was first coined by Robert Elliott in the 1980s; these are segments of individual therapy sessions, typically lasting between 4-8 minutes, in which clients experience significant moments of help or change. Significant therapy

events are an important area to explore since the occurrence of such events during the course of psychotherapy are linked to positive therapy outcomes for the client. Rather than relying on participants' memories during an interview, a method called Brief Structured Recall (Elliott & Shapiro, 1988) is often used whereby clients and therapists separately watch a video-recording of the therapy session in order to identify and reflect on any significant events during the therapy session.

In a review of the significant therapy events research within the non-ID population, Timulak (2010) found that research has focused on a range of factors including, type of events, match between client and therapist perspectives of events, and significant events in different therapies. The impacts of client-reported significant events focused on contributions to therapeutic relationship and therapeutic outcomes. Moreover, the review revealed the complexity of the process involved in significant events, highlighting the vital need to use a more creative methodology to explore the therapeutic process. Many examples have been given regarding the different types of therapy within which significant therapy events occur, including psychodynamic therapy and CBT. This therefore seems to provide further evidence for the presence of common factors (Wampold, 2015), whereby significant therapy events can be thought of as representing such common therapeutic factors, but in greater levels of concentration. Given the many benefits of investigating significant therapy events, it seems important to consider how such events may manifest during the course of psychotherapy with clients with IDs, since little is known about the process of psychotherapy with this client group and how positive change occurs.

***Significant therapy events research: involvement of clients with intellectual disabilities***

Lloyd and Dallos (2008) explored the experiences of families who have a child with IDs. Seven families engaged in an initial appointment using SFBT. Along with completing the Helpful Aspects of Therapy form, participants were interviewed using structured recall. The following three super-ordinate themes were identified: solution-focused brief therapy brought to mind the idea of 'making the best of it'; examination of wishful thinking; and therapeutic relationship. This suggests, that even with a one session approach, the therapeutic relationship is a key therapeutic factor, and indeed, seems to

be associated with client-identified significant therapy events. However, although the authors employed a methodology resembling some aspects of significant therapy events research, it only explored accounts of therapy from the client; by not interviewing the therapist, an important aspect of the process of therapy was not explored. Furthermore, whilst some of the initial sessions involved the child with IDs, the research interviews were conducted only with the mothers; therefore, the experiences of clients with IDs were not explored using the significant therapy events research methodology.

In a feasibility study by Burford and Jahoda (2012), clients with IDs engaging in CBT had their therapy sessions video-recorded. In a qualitative interview, clients were asked to review tapes of their fourth and ninth CBT session. Clients reported a number of helpful aspects of their therapy sessions, including: they can express themselves in sessions; they can say how they are feeling; and they feel understood. Again, this research did not specifically follow the significant therapy events methodology, since the interviews focused more generally on clients reviewing their therapy sessions, and therapists were not subsequently interviewed. It does however, provide evidence that this approach to interviewing clients with IDs is feasible.

A further criticism of the studies by Lloyd and Dallos (2008) and Burford and Jahoda (2012) is the absence of situating the findings within an attachment theory framework, despite identifying the quality of the therapeutic relationship as a super-ordinate theme, and identifying emotional expression and feeling understood as helpful aspects. Indeed, although developed for parents and children, the Circle of Security<sup>®</sup> model (Cooper et al., 2005) is similar to the psychotherapy process and the therapeutic relationship; by the therapist 'being with' the client during their experience of emotions, the client can learn to trust, move on and feel less overwhelmed by their emotions. In order to develop more comprehensive understandings of the psychotherapy process for clients with IDs, attachment theory is undoubtedly an important theory to draw upon.

### ***Aims***

Hence, to date, no research could be found that explores how clients with IDs may experience significant events during psychotherapy. It has become clear from the

research that the exploration of significant therapy events has made a vital contribution to furthering our understanding of therapeutic change and positive treatment outcomes for clients engaged in therapy. This creates huge potential in terms of implications for future practice with regard to psychotherapy with people with IDs. The aim of the current study is to examine client-identified significant events in psychotherapy and explore the lived experience of psychotherapy with clients with IDs.

## **Methodology**

### ***Research design***

Taking a phenomenological theoretical stance to understanding significant events in psychotherapy, the research is concerned with meaning and the perspectives of the client and therapist participants. From this theoretical perspective, it was necessary to adopt a qualitative strategy; data was collected by conducting qualitative interviews with each participant on two separate occasions.

The Helpful Aspects of Therapy (HAT) form was completed by client participants at the end of each therapy session. The HAT form is a self-report measure, developed by Llewelyn (1988) as a means for identifying helpful and hindering events in psychotherapy. Following consultation with individuals with IDs, this form was adapted by simplifying the language used, including visual images, and making the Likert scales clearer. These adaptations were made to maximise the ease with which client participants could complete the form.

The Brief Structured Recall procedure (BSR) (Elliott & Shapiro, 1988) was followed. This involved the researcher watching the video of the therapy session with the client and therapist separately whilst asking further questions about the session; the emphasis was placed on the client identifying events to be focussed on. Two different interview schedules were used; for the client participant interview, an adapted version of the Client Event Recall Form (Elliott, 1986; 1989) was utilised, containing sections on the context of

the event, the participant's experience during the event, the most helpful things about the event, and the impact of the event. For the therapist participant interview, an adapted version of the Therapist Event Recall Form (Elliott, 1990) was followed, containing sections on therapist event intentions and feelings, the context of the event, and the impact of the event.

### ***Participants***

A purposive sampling procedure was used to recruit participants to the study. The inclusion criteria for client participants included: identified as having mild to moderate IDs; able to give informed consent; and over the age of 18 years. The inclusion criteria for therapist participants included: working in a Community Learning Disability Team; qualified or trainee psychologist, counsellor or therapist; minimum of one year's experience of offering psychotherapy to clients with IDs, or transferable skills.

Four therapy dyads, each consisting of one therapist participant and one client participant, were recruited to the study. Client Participant 1 completed therapy, however, withdrew from the research study, and therefore completed only one research interview. All other participants took part in two research interviews each, giving a total of 15 transcripts for analysis.

### ***Procedure***

The study commenced, following a favourable opinion from the NHS Research Ethics Committee and approval from the Health Research Authority.

Therapists matching the inclusion criteria were approached and consented in the first instance. Participants were then asked to notify the researcher when they were due to start therapy with a client matching the inclusion criteria. For each therapy dyad, once the therapist had been identified and a possible client had been found, the therapist was requested to ask the client during their assessment session if they were happy to be contacted by the researcher about a study; a consent meeting was then arranged between the researcher and the client before therapy was due to start.

All therapy sessions with each therapy dyad were video-recorded, and at the end of each session, the HAT form was completed by the client. By referring to the completed HAT forms, therapist participants were asked to select one session out of the first few sessions on which to focus the first interview. A qualitative interview was then scheduled with the client participant, and the therapist participant interview followed shortly afterwards. Later in the therapy, therapist participants were then asked to select one session out of the final few sessions on which to focus the second interview; similarly, a second qualitative interview was then scheduled with the client participant, and the therapist participant interview followed shortly afterwards. Therefore, two therapy sessions for each therapy dyad were included in the study.

In accordance with the BSR procedure, the researcher played the recording of the session to the client until the event was located; the client was asked to describe the context of the event, the event itself and its impact. In a separate interview, the researcher played the identified event for the therapist, asking them to describe the context of the event, their intentions during the event and its impact on the client. This data collection procedure was then followed for each therapy dyad for each of the selected sessions. Because of the focus on the participants' perspective and the need for interpretation to make sense of their perspective, interpretative phenomenological analysis (IPA) was selected to analyse the interview data. The following procedure described by Smith et al. (2009) was followed: initial case familiarisation by reading and re-reading the transcript; initial descriptive, linguistic and conceptual comments made in the right-hand margin; preliminary theme identification written in the left-hand margin; emergent themes developed; search for connections across emergent themes; continue the analysis with the other cases; and looking for patterns across cases involving further refinement of the themes into a master table of super-ordinate themes and sub-themes.

## **Results**

Five super-ordinate themes and eleven sub-themes were identified from the analysis.

***Theme 1: The Uniqueness of the Therapeutic Relationship – “...I’m saying things now that I would never say to anyone...” (CP3).***

The first super-ordinate theme encapsulates participants’ experience of the relationship they had with one another at the point of experiencing a significant therapy event.

*Sub-theme 1a: ‘To talk and be heard’.* Client Participants seemed to be alluding to the therapeutic relationship in their narrative by exploring what it was like to talk to their therapist. One participant reported “...it was just nice to talk to someone outside the family, to talk to a stranger how I was feeling” (CP1). Another participant explained “...she listened to every single word um...if she didn’t understand what I was saying she normally asked me anyway ‘so you’re on about this or are you on about this’, so I’d be like ‘no it’s this’ or ‘it’s that’” (CP3).

*Sub-theme 1b: ‘Importance of building trust’.* Building trust with the therapist seemed to be key for enabling clients to talk more easily and freely. One participant reported “...now I know [therapist] I don’t get so anxious” (CP1). Another participant described “...as I get to know you I trust you and then that’s when I start letting stuff out” (CP4).

*Sub-theme 1c: ‘Walking in the client’s shoes’.* The use of empathy was also spoken about in terms of helping to build the therapeutic relationship. One participant reflected “...trying to understand that actually yes he has been through quite a lot and there are people that will can make you feel angry...” (TP2).

***Theme 2: Using Adaptations to Express Emotions – “I wanted [therapist] to see it” (CP4).***

This theme reflects how client participants were able to express their emotions to their therapist, and how therapist participants focused on describing the adaptations they made in order for their client to communicate.

*Sub-theme 2a: ‘The process of expressing emotions’.* This sub-theme reflects the importance client participants placed on expressing their emotions. One participant described “Um...get getting out how I was feeling off my chest” (CP1). Another participant spoke about drawing in their therapy session as a way of being able to express

themselves “...sometimes I like just drawing on my own and have no-one see you, but obviously I want at that time I wanted [therapist] to see it” (CP4).

*Sub-theme 2b: ‘The shift in emotions’.* Client participants reflected on noticing a change in their emotions from beginning to end of the significant therapy event. One participant reflected “...I was really angry, really annoyed, really fed up and as I talking about it and talking how I felt and yeah I reckon it is leads up to what I’m talking about...I felt more happier um...coz I let it out my feeling...” (CP3). Therapist participants seemed to become more attuned to their client’s emotions; “...he did seem pleased to be able to to realise that there was something he could do” (TP1).

*Sub-theme 2c: ‘Making adaptations’.* Therapist participants spoke about adapting the therapy to suit the needs of their client. One participant described “...so, I’m just looking at her drawing and I’m just saying I I need to go with this because she’s trying to communicate something to me with drawing with the with this people and what’s happening to them that um...that she can’t put into words...” (TP4). Another participant reported “Um...trying to give him time to speak” (TP3).

***Theme 3: Client Behaviour/Therapist Behaviour – “...and she just started spontaneously drawing and I went with it” (TP4).***

This theme illustrates the behaviours of the client and therapist during the time surrounding the significant therapy event.

*Sub-theme 3a: ‘Focus on coping strategies’.* Learning about coping strategies to manage difficult emotions was spoken about by all client participants. One participant described “Um...talk about strategies and how to calm down by listening to music and things” (CP2). However, some participants spoke about some of the difficulties of using coping strategies outside of therapy and how their dependence on others sometimes made it difficult; “...I was like I couldn’t walk away from it because I had to wait for mum to give me a lift...” (CP2).



*Sub-theme 3b: 'Therapist approach'*. Therapist participants spoke about the type of approach they followed when working with their client. Participants seemed to allude to taking more of a client-led approach; "...we had been using the big paper for the maintenance cycles and she just started spontaneously drawing and I went with it" (TP4).

***Theme 4: Hope and Paternalism – "I always think like maybe she's telling me, I might be wrong here, that you are not alone..." (CP3).***

This theme encapsulates the tension between hope and paternalism, with client participants reflecting on their experience of having hope, whilst therapist participants alluded to the need to manage more of a beneficence/paternalism balance.

*Sub-theme 4a: 'The message of hope'*. All client participants spoke about experiencing hope during their therapy. One participant reported "Um...it was helpful what she said and how she um...said to how to get round it and that's when I thought 'yeah'..." (CP2). Another participant reflected "...I always think like maybe she's telling me, I might be wrong here, that you are not alone, maybe there is loads of other people out there who feel exactly the same..." (CP3).

*Sub-theme 4b: 'Worry and protection'*. However, in contrast, some therapist participants spoke about a need to protect their client; such responses could be likened to that of a paternal response. For instance, one participant reflected "I was worrying about the risk at the same time because when he feels very low he does self-harm..." (TP3). Another participant reported "...it had been helpful so I wanted to kind of draw that out um...draw out all the positives to help keep him safe..." (TP1).

***Theme 5: Meaning-Making – "...I want to be here. I want to be with [partner] for the rest of my life" (CP1).***

This theme refers to making sense of the significant therapy event as well as the impact of the event.

*Sub-theme 5a: 'Client realisation – the shift'*. Client participants spoke about experiencing moments of change during therapy in which they noticed a shift in the way they

appraised a situation or the way in which they viewed themselves. One participant described their thought changing; “That I want to be here...I want to be with [partner] for the rest of my life. I want to be there for my mum, because my mum’s not well...” (CP1). Perhaps because this meaning-making process appeared to be internal, Therapist Participant 1 perceived their client to be passive; “Um...I think he’s being a bit more passive in this session than he has been in in the last few sessions...” (TP1). Client Participant 4 alluded to experiencing some acceptance of themselves; “...coz obviously my disabilities, I can’t get rid of it, all I can do is try and beat it, which is what I have been doing...” (CP4).

## Discussion

The purpose of this research was to explore significant events in psychotherapy with clients with IDs. Indeed, the results suggest that clients with IDs do experience significant therapy events. Furthermore, the research enabled insights to be gained about the process of therapy for this client group and for exploration of therapeutic factors that may be involved in facilitating a significant therapy event. Significant therapy events have not previously been explored in psychotherapy with clients with IDs, however, it has been possible to make comparisons with research focusing more broadly on the experience of psychotherapy, as well as make comparisons with research carried out within the non-ID population.

Clients spoke positively about talking in therapy, but more specifically they reflected on being heard and understood by their therapist. Framed within attachment theory, people with IDs may be at a greater risk of developing insecure strategies through not having their needs met as children; for instance, being emotionally rejected by carers may make them likely to expect such rejection from their therapist or the receipt of intermittent care is likely to make them anxious as to whether they will be heard by their therapist. Therefore, being heard and understood could be thought of as a new encounter, that contrasts to their everyday lives in which interactions are frequently marked by a lack of reciprocity and the presence of power imbalances (Jingree et al., 2005). Indeed, therapy

itself is also not balanced in terms of the power dynamics, and this is especially true for clients with IDs. Clients spoke at length about being able to successfully express their emotions, which supports the existing literature (Burford & Jahoda, 2012). Clients also spoke about receiving the message of hope from their therapist. However, only one previous study involving clients with IDs could be found that referred to clients experiencing hope; Pert et al. (2013) found clients to be cautiously optimistic about the outcomes of their therapy. The absence of hope in previous research could be a reflection of past literature not focusing on significant therapy events. Indeed, significant therapy events research within the non-ID population has found hope to be implicated (McVea et al., 2011). All clients in the current study reflected on the impact that the significant therapy event had on them, noticing a shift in the way they appraised a situation or viewed themselves. This is consistent with findings in Cahill et al. (2013), whereby helpful impacts, included 'problem clarification' in which clients gained an understanding of what needed to change through working on it in therapy. However, because therapists in the current study were not always aware of this meaning-making process for clients, it seems it could sometimes be an internal process that clients are not able to articulate. Indeed, internal meaning-making is different for clients and therapists (Yalom, 1989), and whilst shared meaning-making may not be expected, finding ways to open up this dialogue where it relates to the client's meaning-making could be a fruitful area to explore in future research.

Therapists spoke about building a strong therapeutic relationship with their client; this supports the existing literature on working collaboratively (Lloyd & Dallos, 2008), showing clients empathy and remaining attuned to the client's frame of reference (Balmforth & Elliott, 2012). Making adaptations in order for clients to communicate and express their emotions was also focused on by therapists, which supports existing literature in which adaptations to therapy are described (Willner & Goodey, 2006). Referring to their therapeutic approach, therapists alluded to being client-led; in a similar way to person-centred approaches, therapists alluded to focusing on their client and the way in which they perceived their world. Although therapists spoke about wanting their clients to experience hope during therapy, they also worried about their client and felt a need to

protect them. It seems that therapists may have been holding on to worry in order for their clients to experience hope.

### ***Implications for clinical practice***

This study highlights the need for therapists to work in such a way as to facilitate significant events in therapy with their clients through building a strong therapeutic relationship, making appropriate adaptations to ensure their clients can express themselves, being mindful about instilling hope, and adopting a client-led approach to provide opportunities for clients to use their initiative. It is notable that, most clients noticed a shift in the way they appraised a situation or viewed themselves, and it is therefore important to open up conversation around the experience of change. In addition, to echo the implications of the research conducted by Skelly et al. (2018), it may be helpful to have more flexibility within therapeutic contracts to enable clients with IDs to have more sessions in order for a strong therapeutic relationship to be built, as well as providing the space for a client-led approach to foster client independence and moments of insight. Furthermore, therapists could use supervision to reflect on balancing empathising, protecting and helping in order to promote the process of empowerment.

### ***Limitations of the study***

Whilst this research was a necessary first step, owing to the non-existence of research in this area, the sample size and qualitative design may limit any wider generalisations of the findings. It is also noted that all client participants had mild to moderate IDs; it is therefore not known whether such findings would apply to people with IDs who are less able to express themselves. A further limitation of the study is that, whilst adaptations to the HAT form were necessary in order for clients to independently complete, it was not possible to quantitatively determine whether these adjustments improved the quality of responses. Furthermore, clients completed the HAT form in the presence of their therapist, which may have made them reluctant to identify any unhelpful events. In addition, if time allowed, it could have been interesting to look at clients' perceptions across the range of recorded sessions and their perceptions of where the most helpful aspects were, rather than focusing on their identified helpful event within the session selected by their therapist.

### ***Future research***

This study has highlighted the need for further research of significant therapy events with a larger sample of clients with different degrees of cognitive impairment. Furthermore, new areas to explore, include examining the relationship between therapists holding worry during therapy sessions, while clients seemingly receive the message of hope. In addition, future research should seek to examine the internal meaning-making process for clients. If more were known about this process, therapists could become more aware of it and adopt strategies for exploring this change process with clients, which would be likely to strengthen the therapeutic relationship, indicate the direction that therapy sessions could helpfully take to meet client goals, and improve therapy outcomes. It would also be important to thoroughly investigate the efficacy of a client-led approach and quantitatively measure its impact on the prevalence of significant therapy events and therapy outcomes by means of an RCT.

### **Conclusion**

The current findings provide additional evidence that significant therapy events occur for clients with IDs. Furthermore, the findings also support Bender's (1993) critique of the historic exclusion of people with IDs from accessing psychotherapy; indeed the 'therapeutic disdain' towards people with IDs has an increasingly questionable evidence base. In addition, using the significant therapy events methodology was shown to be feasible with this client group, and enabled insights to be gained about the process of therapy for clients with IDs, as well as exploration of the therapeutic factors that may be involved in facilitating a significant therapy event.

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## Appendices

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### Part 2 Journal Article

#### Appendix

R	Description of the journal being targeted for submission of article: <i>Advances in Mental Health &amp; Intellectual Disabilities</i> .....	227
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## **Appendix R – Description of journal being targeted for submission of article**

The journal being targeted for submission is '*Advances in Mental Health and Intellectual Disabilities*'. This is a peer-reviewed journal publishing research and information specifically focusing on addressing the mental health needs of people with intellectual disabilities. The journal contains a range of articles, including current research, developments in service delivery, policy, case studies, and resource reviews.

Other journals that were considered included, *British Journal of Learning Disabilities*, and *Journal of Applied Research in Intellectual Disabilities*. Both are international peer-reviewed journals specific to the needs of people with intellectual disabilities. The targeted journal, *Advances in Mental Health and Intellectual Disabilities*, has been selected over others because of its specific remit of publishing articles from researchers, practitioners and academics who deliver practice to people with intellectual disabilities with additional mental health needs. Although both the *British Journal of Learning Disabilities*, and *Journal of Applied Research in Intellectual Disabilities* include mental health within their remit, they also include a diverse range of other areas, including challenging behaviour, quality of life, medication, staff stress, and employment, to name but a few. That being the case, it is hoped that, by submitting the article to *Advances in Mental Health and Intellectual Disabilities*, it may have greater impact in terms of reaching a larger audience of practitioners working specifically in mental health services offering psychological therapies to people with intellectual disabilities.

The journal publication guidelines stipulate that articles must be in Microsoft Word format, and be between 3000 and 6000 words in length; this includes all text including references, tables and figures. Abstracts should be of no more than 250 words in length; this includes keywords and article classification. Furthermore, a title of not more than eight words should be provided. In addition, authors must use the Harvard referencing style. Submissions are made using ScholarOne Manuscripts, which is an online submission and peer review system. Each article is initially reviewed by the editor, and then sent to two independent referees for double blind peer review.

## Appendix S – Evidence of journal article submission

7/9/2018

ScholarOne Manuscripts



Advances in Mental Health and Intellectual Disabilities

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Advances in Mental Health and Intellectual Disabilities

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