

**PSYCHOANALYTIC PSYCHOTHERAPY  
WITH PEOPLE WITH LEARNING  
DISABILITIES**

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**University of Sheffield**

**2004**

*Psychoanalytic*

*Psychotherapy With People*

*With Learning Disabilities*

DECLARATION:

*I declare that the content of this thesis is original and this work has not been submitted to any other institution or for any other qualification*

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## ABSTRACT

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*This thesis focuses on the practice of providing psychoanalytic and psychodynamic therapy to adults with learning disabilities.*

*Part 1 reviews the literature in the area, examining published case studies and technical papers relating to the practice of providing psychoanalytic and psychodynamic psychotherapy to adults with learning disabilities. A consistent therapeutic frame was identified, but reports of therapists' practice were sparse, inconclusive and varied.*

*Part 2 reports a qualitative study exploring the practice of psychoanalytic/psychodynamic psychotherapists, experienced in providing therapy to adults with learning disabilities. Interview transcripts were analysed using a Grounded Theory methodology. A consistent account of practice was emergent, and a model implicating the role of philosophical notions of disability and their impact on practice was proposed. The nature of the proposed model was considered with respect to its difference from other psychoanalytic models used in the provision of therapy to non learning-disabled adults and children.*

*Part 3 describes the salient stages of the research process and the key learning points for the author. The author reflects on the process of carrying out the research with respect to doing future research and identifies areas for improvement to his present practice.*

*Dedicated with love and thanks to Emma for  
making it all worthwhile; and mum and dad for all  
the love and opportunities I've been given.*

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# CONTENTS

<b>1. LITERATURE REVIEW</b>	<b>1-33</b>
<i>- Individual Psychoanalytic/Psychodynamic Psychotherapy Practice with People with Learning Disabilities.</i>	
<b>2. RESEARCH REPORT</b>	<b>34-105</b>
<i>- Towards a model of individual psychoanalytic/psychodynamic psychotherapy with people with learning disabilities</i>	
<b>3. CRITICAL APPRAISAL</b>	<b>106-116</b>
<b>4. APPENDICES</b>	<b>117-170</b>
i) <u>Formats:</u>	
<i>1- Editorial Policy for Contributors to "Mental Retardation"</i>	118
<i>2- Letter of approval of journal from research sub-committee</i>	120
ii) <u>Ethical Approvals:</u>	
<i>3- Research-Committee Approval Letter</i>	122
<i>4- Ethics Committee Approval Letter</i>	124
<i>5- Certificate of Non-Clinical-Trial Insurance</i>	126
iii) <u>Measures:</u>	
<i>6- Details of categories (150)</i>	128-155
<i>7- Details of recurrent categories (78)</i>	156-159
iv) <u>Other:</u>	
<i>8- Criteria for full membership of IPD</i>	160
<i>9- Copy of participant invitation letter</i>	162
<i>10- Copy of information sheet</i>	164
<i>11- Copy of participant consent form</i>	166
<i>12- Copy of interview schedule</i>	168
<i>13- Copy of transcriber confidentiality form</i>	170

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# LITERATURE REVIEW

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## Individual Psychoanalytic/Psychodynamic Psychotherapy Practice with People with Learning Disabilities.

### Abstract:

*The present review examined case studies and technical papers relating to the process and practice of individual psychoanalytic or psychodynamic psychotherapy with people with learning disabilities (IQ<70) published between 1981 and 2004. Practice was delineated into the nature of the therapeutic frame, and the action of therapists within sessions. The nature of the therapeutic frame was discussed with reference to the available literature, noting the need for flexibility around settings and session duration whilst maintaining the consistency of the frame required to ensure provision of a secure base. The action of therapists was considered in three stages: information gathering, formulation/ recontextualisation, and communication of interpretations. Common practice was identified whilst acknowledging the paucity of descriptive practice in the literature, particularly with regards to the formulation of material into interpretations. The varied nature of psychoanalytic and psychodynamic therapies, and the narrow representation of this review were considered, and areas for further research identified.*

### CONTENTS:

Introduction	ii
Search Strategies	iv
Review	vi
Summary	xx
Discussion	xxii
Summary Table	xxv
References	xxix



## INTRODUCTION:

Whilst psychological interventions with adults with learning disabilities have a long and established association (Hodges, 2003), there is a paucity of literature around psychoanalytic and psychodynamic psychotherapy with this group (Sinason, 1992). That literature which is available in the public domain has tended to focus on the specific issues, difficulties and unique considerations of providing psychotherapy to people with learning disabilities (Sinason, 1992; Hodges, 2003), described case accounts of work with learning disabled clients (Sinason, 1992) or reported outcome studies detailing the efficacy of the work (Beail, 1989; 1995; 1998; Frankish, 1989). Other literature has offered psychoanalytic perspectives on learning disability (Brandon, 1989; Sinason, 1992; DeGroef & Heineman, 1999) and detailed the history of the psychoanalytic movement with this group (Sinason, 1992; Bender, 1993; Hodges, 2003). However, descriptions of the practice and process of psychoanalytic/psychodynamic psychotherapy with this population are noticeably scarce, and many people assert that a traditional model of psychotherapy is not appropriate or plausible for use with people with learning disabilities (Tyson & Sandler, 197; Brown & Pedder, 1979). The present review aims to examine the available literature around psychoanalytic/psychodynamic psychotherapy with people with learning disabilities for evidence of practice in order to identify the nature and process of psychoanalytic/psychodynamic psychotherapy with this population.

Sinason (1992) claims that many published accounts of psychoanalytic psychotherapy with people with learning disabilities have been ambiguous as to the nature or degree of impairment presented by clients, and further confused by a lack of consensus, consistency and clarity in the terminology used to describe people with learning disabilities and the nature of their impairments. In addition, she asserts that much work in the area has not been effectively disseminated through the profession and has been

effectively lost. There is a general consensus that the earliest published account of psychoanalytic therapy with someone with a clear organic learning disability was Neville Symington's paper "*The psychotherapy of a subnormal patient*" (1981), in which he reported his own therapeutic work with a man with an IQ of 59 (Sinason, 1992; Beail, 1998). In order to explore practitioners' approaches to psychotherapy with people with learning disabilities, the present review studied case reports written from 1981 onwards with respect to the process of psychotherapy (as opposed to the theory, outcome or other consideration), and technical papers relating to the practice of psychotherapy with this population.

#### Search Strategy:

Case studies and technical papers were identified through:

- Reference or inclusion in key texts:
  - Brandon, D. (1989) *Mutual Respect: Therapeutic Approaches to Working with People with Learning Difficulties*
  - Sinason, V. (1992) *Mental Handicap and the Human Condition: New Approaches from The Tavistock*, Free Association Books, London
  - Waitman, A. & Conboy-Hill, S. (1992) *Psychotherapy and Mental Handicap*, Sage, London
  - De Groef, J. & Heinemann, E. (1999) *Psychoanalysis and Mental Handicap*, Free Association Books, London
  - Hodges, S. (2003) *Counselling Adults with Learning Disabilities*, Palgrave Macmillan, Hampshire
  - Simpson, D. & Miller, L. (2004) *Unexpected Gains: Psychotherapy with people with learning disabilities*, Karnac, London
- Searches on Web of Science and WebSPIRS databases, including Psych-Info, and searches of the internet (World Wide Web) using "Google" and "Yahoo" search engines (Keywords: psychoanalytic, psychodynamic, psychotherapy, learning disabilities, learning difficulties, mental retardation, mentally handicapped, intellectual impairment)
- Manual search for materials and papers.
- Consultation with leading clinicians, writers and researchers in the area.

The focus of the review was individual psychoanalytic or psychodynamic psychotherapy with adults with learning disabilities. For the purposes of the review, a person was defined as having a learning disability if they had a full-scale IQ score of less than 70. Papers were included in the review if an element of the intervention they described was labelled as psychoanalytic or psychodynamic in nature and was delivered in the form of an individual therapy. Group therapies were excluded. These criteria allowed for the inclusion of eclectic and integrated approaches, but in such cases only that element of the therapy which related to psychoanalytic/psychodynamic therapy was considered in the review. Literature was excluded from the review if there was no description or elucidation of practice or process.

In total, 13 papers were included in the review, along with 16 case examples described in the key texts above.

## REVIEW:

Whilst Neville Symington's (1981) account of psychotherapy with a man with intellectual impairments was notable for its clear description of the client's intellectual impairments and account of his journey through therapy, the description of his own therapeutic practice was less clear. He describes meeting with "Harry Smith" (pseudonym), 33, in a 1:1 relationship, once each week, at his (Symington's) place of work for two years. Through descriptions of their experience together, he depicts himself being non-directive, not directly answering Harry's questions, and suggesting possible meaning to Harry's behaviour, dialogue, and way of relating to him – a process he describes as interpretation. He also describes himself using gestures and metaphor to convey concepts to Harry, and cites that he typically remained seated in his chair throughout sessions, even though Harry often moved around the room. As background to the case, he describes that prior to the onset of formal therapy he met with Harry's mum and dad and with the staff at Harry's place of work in order to gather more information and "assess the situation".

Symington's (1981) account delineates two distinct concepts representing his therapy practice in this case. The first of these is the boundary of the therapy, often referred to as the "therapeutic frame" (Bütz, Bowling & Bliss, 2000), the second concept being his behaviour and actions within that frame (process).

### - The Therapeutic Frame:

The frame Neville Symington (1981) describes is represented by the frequency (once weekly), location (a private room at his place of work), and context (1:1) of the therapy. In addition, the description of his interaction with Harry's staff team and mum and dad reflects something of the dynamic boundaries of his work. Joan Symington (1988) describes similar boundaries to her frame when reporting her analysis of "Simon", "a

*mentally-handicapped youth aged 16 years who had an IQ of 50*". Like Neville Symington (1981) before her, she describes involvement with Simon's parents prior to the therapy in an information gathering capacity. The therapy itself consisted of frequent meetings (once a week initially, increasing to five times weekly), occurring at a consistent time each week, in a 1:1 setting at her place of work. In her account she also gives an idea of the term of therapy, describing that at the time of writing, Simon had been in analysis for 19 months.

Other case descriptions mirror these therapeutic boundaries, but reflect wide variation with respect to the term of therapy. In an account of seven cases of psychotherapeutic involvement with people with mental handicaps, Frankish (1989) described psychotherapy taking place weekly or bi-weekly for one hour, at the same time, on the same day where possible, with terms varying from nine months to more than thirty months; Simpson (2002) reported clinical material from his psychotherapeutic treatment of "Sam", a 15 year-old boy with a severe learning disability, reporting once weekly, 1:1 therapy, over a period of 30 months at Simpson's place of work; and Sinason (1992) described seven accounts of 1:1 therapy with children and adults with intellectual disabilities. Beail (1995; 1998) described accounts of open-ended therapy in a series of outcome studies in which the frames described were otherwise consistent with that reported above (once-weekly, 1:1, at the therapist's place of work, same time and day each week).

Beail (1989) goes into more detail around the setting of therapy, when he reports a process of therapy he describes as rooted in Freudian theory, but heavily influenced by the work of Melanie Klein. In describing the frame, he asserts that therapy should ideally take place away from the person's home, but notes that this may not be possible for a variety of reasons. In a case description in which therapy was necessarily conducted in a person's home, he notes the consequences and barriers to therapy which

resulted. He asserts that the therapy room should be light, warm and comfortable, with a couch or comfortable seating, on which the client can choose to lay or sit, and stresses that in either case, the therapist and client should not face each other. In concordance with the frame proposed by the authors above, he asserts that the setting, session times and frequency should remain constant. With respect to the therapeutic frame, Beail's (1989) account describes similar flexibility around the setting of therapy to that proposed by Berry (2003), who recounts his involvement with 4 adults with learning disabilities living in a specialist community-living setting. In the case of "Gerald" a 33 year-old man with diagnoses of cognitive and personality disorders and a history of violence, he describes the frame of therapy being consistent with the predominant descriptions above with regards to frequency (typically once each week) and duration (30 to 60 minutes), but divergent with regards to the setting, which whilst typical in being 1:1, was unusual in that it occurred in a car. Berry's (2003) rationale for this was similar to that described by Beail (1989), in that traditional boundaries (sitting together in a room for 50minutes) were impossible due to Gerald's inability to tolerate the space. He asserts that it was only by modifying the frame, that he was able to have a relationship, which facilitated a therapeutic experience taking place. In the other cases he described, there were different adaptations to the traditional therapeutic boundaries, such as the removal of restraints and boots, and the participation in activities such as making drinks and going for walks. In each case the adaptations were to the context and setting of the therapy rather than to the frequency or duration of the therapy, which reflected typical psychoanalytic boundaries. Notably, once adaptations were made, these were held consistent over the term of the therapy. Despite the adaptations of the therapeutic setting, a consistent feature was that the therapy was always conducted 1:1 even when the therapist had involvement of some sort with a person's care/support network.

Beail & Newman (2004) describe a typical therapeutic frame in their outline of the principles of psychodynamic counselling and psychotherapy for mood disorders with people with mental retardation, but note a need for flexibility around the duration of sessions. They assert that sessions typically occur once weekly, at the same time, same day each week, in the same room. However, whilst describing typical sessions lasting for 50 minutes, they assert that this should be reduced to accommodate people with low tolerance for the full duration. In this respect, they introduce the concept of having flexibility around the duration of therapy sessions, to accommodate the needs of individual clients similar to the flexibility described by Beail (1989) and Berry (2003) around the setting of therapy. Hodges (2004) asserts a similar need to balance flexibility with consistency which she proposes be maintained with respect to the therapy room, and the day and time of sessions.

The accounts above show high levels of concordance with respect to the boundaries and therapeutic frame described. In many respects the boundaries described reflect that of a typical psychoanalytic or psychodynamic therapy frame, wherein "*a standard protocol using repetitive routines and predictability*" is utilised (Hurley et al, 1996). The emergent model in respect of the frame is one where the person and therapist meet in a 1:1 relationship, for between 30 and 60 minutes at the therapist's place of work, in the same place, on the same day and at the same time each week.

Despite this general consistency, there was some variation around the frequency of sessions and term of therapy. Reports of frequency varied from a more typical once weekly (Beail, 1989; 1995; 1998; Sinason, 1992; Beail & Newman, 2004; Hodges, 2003), to more intense twice or five times weekly therapy/analysis (Symington, 1988; Frankish, 1989), with therapy terms described ranging from nine to thirty months. These variances were interpreted as depending on individual client needs, which were also

cited in explaining a need for flexibility around the setting of therapy and the duration of sessions (Beail, 1995; 1998; Berry, 2003; Beail & Newman, 2004).

Another salient feature of the therapeutic boundaries described in many of the accounts, was that carers and family members were often involved in the therapeutic process in some capacity, distinguishing the proposed therapeutic frame from that typically applied in psychoanalytic psychotherapy with non-learning disabled adults (Hurley et al, 1996). Bütz, Bowling & Bliss (2000) take a slightly different view of this, asserting that the boundaries of the therapy frame applied with people with learning disabilities are salient not for their divergence from generic psychoanalytic psychotherapy boundaries, but because the robustness of the frame is *“even more critical with [this clinical population because of the risks of] acting-out in a behavioural sense [following] violation in the routine and expected events of psychotherapy”*. This assertion was made based on a conceptualisation of the frame, which did not include the involvement of carers and family members. They acknowledged that third party involvement was a salient feature of working with people with learning disabilities with respect to the confidentiality of the work, but saw this as distinct from the boundaries of the frame. This differs from the conceptualisation applied in this review, which incorporates the boundary of confidentiality and the other implications of third party involvement within the overall therapeutic frame, and identifies this as a major difference between therapy with people with learning disabilities and that with non-learning-disabled adults. In their account of psychotherapy with people with learning disabilities, Bungener and McCormack (1994) assert the importance of managing the relationship with carers, and of the potential threats to confidentiality, which arise in the work.

In contrast to the general conformity around the nature of the therapeutic frame reported above, Morrissey & Jackman (1998) describe different therapeutic boundaries in their account of applying an integrative mainstream psychotherapeutic approach to clients



with learning disabilities. This approach incorporated individual psychoanalytic psychotherapy alongside body psychotherapy (Reich, 1945) and Gestalt approaches (Perls et al, 1951). The analytic component of the approach was described as being supported by behavioural strategies (e.g. positive programming, TEACCH, creative daily schedule), which aimed to address clients' needs and promote "*development and progression [around] work, leisure, family etc.*". It was asserted that these behavioural strategies established and maintained the "*therapeutic environment*". The psychotherapist within this approach was described as working in "*synergy*" with clinical psychologists, applied behaviour analysts and speech and language therapists. The authors assert a need to provide an "*undiluted therapeutic space*", and propose that the therapist should liaise only with the co-ordinator of the programme and meet with significant others including the clients' families only with the permission or presence of the client. They propose that families be informed of the therapeutic process so that they are more able to tolerate its impact, and that in some cases may need to have a named person other than the therapist, who they can talk to about the boundaries of the therapy. In convergence with the boundaries described in the accounts cited above, they describe that therapy typically takes place weekly, and add that sessions are of a specified duration (usually between 20 and 50 minutes).

### Therapeutic Action:

Neville Symington's (1981) account of his practice with "Harry" identifies him pursuing three central activities in the therapy sessions: the gathering of information; the recontextualisation/formulation of the material; and the communication of potential meaning to the person.

#### 1. Information Gathering:

Joan Symington (1988) describes a similar process to Neville Symington (1981) of gathering information - attending to what was said and done in sessions, but described also making drawing and modelling materials, and toys available to clients. She also described attending to Simon's physical mannerisms, facial appearance, vocal peculiarities, and her own affect (counter-transference) to inform her of as much material as possible. Similarly to Neville Symington (1981), she also described gathering information from outside of the sessions gained from meeting with Simon's parents. Beil & Newman (2004) describe the role of counter-transference in the process of gathering information. Asserting the importance of therapists attending to their own feelings, fantasies and reactions, they state that therapists "*... must be prepared to accept these as meaningful elements in the communication between clients and therapist*".

Beil (1989) considers in greater detail the verbal process of gathering information in therapy, reporting that he encourages clients to "*say whatever comes into their minds, however silly or upsetting*" (Free-Association). He then describes a process called "*clarification*" by which he asks questions and rephrases concepts to develop his understanding of the material. Beil (1989) and Sinason (1992) also describe making use of phantasy and dream material in order to gain information about unconscious processes.

Like Joan Symington (1989), Beail & Newman (2004) acknowledge the often limited expressive communication skills of people with learning disabilities, and propose that multiple modes of communication be attended to by therapists to maximise communication, citing “*verbal statements, utterances, non-verbal behaviours and the use of expressive materials...such as paper and pens and representative objects such as figures.*” They also describe a process of listening to verbal material in which they attend to factual content, words used and also what is unsaid, clarifying meaning where necessary, through asking open questions. An important practice conveyed was of not interrupting clients, and holding in memory, points which need to be taken up and explored further (Beail & Newman, 2004). Similar to the practice described by Joan Symington (1988), attending to non-verbal communication (facial expression, gestures and posture) was also asserted. This approach was supported by Simpson’s (2002) account in which he describes attending very closely to “Sam’s” play with a collection of dolls and behaviour in sessions, in addition to the verbal material and counter-transference experience. In respect of this he describes an experience of being identified with as though he were Sam’s father, a process of projective identification.

Berry (2003) describes asking clients how they are feeling and what they have done in the past week, as a means of opening dialogue between them, and in convergence with other descriptions, describes attending very specifically to non-verbal communications.

Morrisey and Jackman’s (1998) account of an integrative therapy proposes a series of techniques and actions for therapists working with people with learning disabilities. With regards to information gathering, they describe a technique called *Amplifying*, (Brazelton, 1974), as a means of establishing discourse through verbalising what someone is doing. The authors assert that amplifying can involve

three levels of varying abstraction, the first of these is describing the events occurring, the second introduces a subjective view of what the person is communicating, and the third is a subjective opinion about how the person is feeling. It is described as "*essential in working with people who are non-verbal*". In addition, they propose making use of drawings, body reading (attending to tension or boundness in the body), counter-transference feelings and transference experiences, which are described as the therapist's experience of everything which the client brings to the relationship (Bungener & McCormack, 1994).

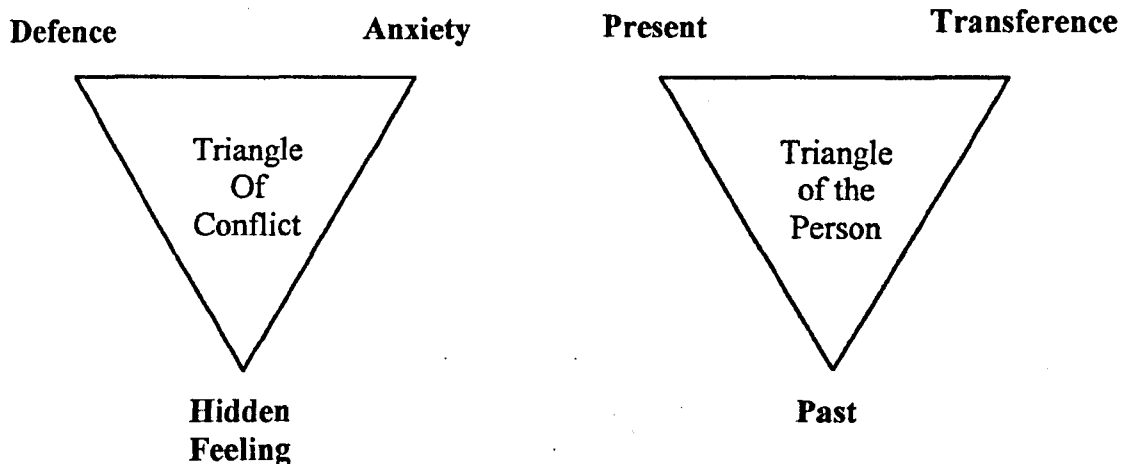
In terms of the gathering of information in psychotherapy with people with learning disabilities, the literature asserts the use of a broad range of strategies. Typically, information is gathered from within the confines of the therapeutic relationship, but this is not exclusively the case, Symington (1981) and Symington (1988) both described making use of information gathered in meetings with clients' carers and parents. Without exclusion, all case descriptions described gathering information from, verbal communication and non-verbal communication in the form of body language, in-session behaviour and counter-transference feelings. In addition to this, some reports described the provision of drawing and modelling materials, and toys (particularly dolls) as useful in enabling non-verbal expressive communication to take place (Symington, 1988; Hodges, 2003; Morrissey & Jackman, 1998).

## 2. Recontextualisation/Formulation:

In Neville Symington's (1981) paper in which he reports a therapy with "Harry Smith", he describes himself attempting to understand the meaning behind the information he gathers. From a psychoanalytic and psychodynamic perspective a general aim has been described as the attempt to understand the latent unconscious meaning behind the "*generally assumed and consciously intended context*" (Smith, 1987). Symington's account (1981) was sparse in its elucidation of this process of understanding, describing clearly the communication of interpretations but neglecting the process through which they developed. This manner of reporting therapy cases was predominant in the literature, with many therapists failing to describe the route to which they arrived at the meaning they communicate (e.g. Sinason, 1992; Berry, 2003; Simpson, 2003). In terms of Bion's (1962) notion of containment, in which information from one person ( $\alpha$ ) is taken in by another, processed in some way and given back in a more helpful form ( $\beta$ ), it is the process of changing  $\alpha$  to  $\beta$  which is missing in many of the accounts. Beail (1989) and Beail & Newman (2004) attempt to demystify the area, using the framework of Malan's triangles (1979) to describe a process of understanding the material gathered. Malan's (1979) depiction of the process of psychodynamic therapy utilised two triangles which Beail and Newman (2004) describe (See Fig1). The first of the triangles represents a framework of conflict between, defensive strategies, which serve to protect the person from the anxiety they feel about a hidden (unconscious) feeling. Beail and Newman (2004) describe that the therapist attempts to identify the hidden (unconscious) feelings by noticing defences, identifying anxieties and interpreting potential meaning by triangulation of the information available (linking information together). This triangulation process involves making links between stages of the conflict, and also between life stages, represented by the second of

Malan's triangles, the "Triangle of the Person". This depicts the origin of the information: the setting in therapy (the transference), the person's present living environment, and the person's past (usually with parents) (See Fig1).

Figure1 – Malan's Triangles of Conflict & Person (1979):



Beail (1989) develops the idea of identifying defensive strategies in the material, noting common defences in people with learning disabilities initially described in relation to children by Melanie Klein (1975): splitting, projection, introjection and projective identification. He also describes two less common defences: denial and idealisation; and reports no evidence of repression based on his work with people with learning disabilities.

The model proposed (Malan, 1979; Beail & Newman, 2004) is one in which the therapist identifies the key concepts of the triangle of conflict (Malan, 1979), and makes links between them. This facilitates the development of a formulation which includes a latent unconscious element which was previously unknown. Triangulation of evidence supporting the formulation from each of the stages of the concept of the person, gives credibility to the formulation and it is at this point that the interpretation is communicated to the client (Beail & Newman, 2004).

Many accounts of therapy, described the notion of interpreting (Symington, 1981; Symington, 1988; Beail, 1989; Sinason, 1992; Beail & Newman, 2004), whereby the

therapist would speculate about what latent unconscious meaning there might be in clients' verbal and non-verbal actions. However, this interpretation was typically described in terms of a communication, neglecting to explain its development:

*"... he clowned a great deal so that people laughed at him and thought him more of a fool than he was. I interpreted that he felt there was something wrong with him and that he was extremely anxious lest people did laugh at him for that..." (Symington, 1981)*

In-depth psychoanalytic formulations were common in the literature but no explanation as to their development, or recontextualisation of the material was described (Symington, 1988; Sinason, 1992; Berry, 2002)

Beail (1989) acknowledged the two stages of interpreting meaning to clients. The first step being to analyse the material and hypothesise meaning in the therapist's mind, the second to communicate the interpretation to the client (Beail, 1989).

Generally there was very little evidence in the literature of a process of formulation or recontextualisation of information. That which was proposed and described was based on the development of links between the aspects of Malan's two triangles of conflict and person, in order to build up evidence from the material, supportive of interpretations which would lead to identification of latent unconscious processes.

### 3. Communication of Meaning:

In much of the literature, authors described themselves communicating (interpreting) meaning behind people's behaviour, but in many cases neglected to detail how this was done (Symington, 1988; Sinason, 1992; Berry, 2003; Simpson, 2004). This process of therapy was noted as particularly salient with people with learning disabilities – where adequately communicating complex or abstract ideas is hindered by client's intellectual and receptive impairments (Hodges 2004; Beail 1989), and was seen as a central tenet to psychoanalytic and psychodynamic work with people with learning disabilities (Symington, 1988; Beail, 1989; Hodges, 2003; Beail & Newman, 2004). Beail & Newman (2004) discuss distinctions between psychoanalytic approaches with regard to the timing of communicating interpretations. They assert that whilst a Freudian approach would limit the giving interpretations to those times when clients are in a state of positive transference, Kleinian approaches promote the giving of interpretations in times of negative transference. In support of the latter approach, they report that Klein (1975) found that interpretations showed their greatest positive impact when given at times of maximum anxiety (greatest negative transference). They also cite pragmatic reasons for not deferring interpretations until a time of positive transference, describing the risk of learning disabled clients forgetting material due to memory difficulties, and noting their propensity to split off and disown aspects of themselves and their experience (primitive defensive strategy) which might be anxiety provoking (Beail, 1989; Sinason, 1992). They assert that in this situation, waiting for a time of positive transference runs the risk of material and potential linkages being lost or disowned. Beail and Newman (2004) also assert that interpretations be delivered in brief statements, using simple language. A proposal supported by others in the literature (Symington, 1981; Beail, 1989; Sinason, 1992; Hodges, 2004).



In Neville Symington's account (1981), he describes communicating concepts to Harry verbally, whilst also physically marking positions on a wall with his hand, to represent how intelligent different people perceived Harry to be. In this respect, Symington (1981) was using a physical/visual aid in order to communicate an abstract concept (what someone else thought of Harry). Morrissey & Jackman (1998) report a similar practice, describing the therapist typically communicating verbally, but also asserting the value of visual prompts (drawings) to convey complex information (e.g. sequences of events). In terms of verbal communication, many authors acknowledged the difficulty Symington (1981) described with Harry, of conveying complex and abstract concepts to people with limited receptive communication skills, and intellectual impairments. The use of Metaphor was reported by a number of participants (Symington, 1981; Sinason, 1992; Simpson, 2002; Hodges, 2003), described as an attempt to ground concepts in something tangible for the client. Often metaphors linked to something the client had introduced e.g. a toy they were playing with, or to a situation they were very familiar with (Symington, 1981; Sinason, 1992). However, the literature also asserts caution in this, noting the difficulties people with learning disabilities can have in distinguishing between abstract and literal material (Hodges, 2003); Beail & Newman, 2004). In respect of this, Hodges (2003) reports the work of Parsons and Upson (1986), which found that people with learning disabilities had a tendency to take things literally and concretely, and who suggested that distinctions were made explicitly between doing and feeling.

In many of the accounts, authors described communicating a concept which did not require formulation or consideration, and which served to communicate what was happening in the room or to précis verbal material (Symington, 1981; Beail, 1989; Simpson, 2002; Berry 2003; Beail & Newman, 2004). Beail & Newman (2004)

describe this process as *reflecting*, and note its value in communicating attentiveness, maintaining connection with and checking out understanding with clients. Hodges (2003) similarly notes the value of reflection, describing the attentiveness it conveys. Beail (1989) describes a similar process of *confrontation*, by which the therapist repeatedly draws attention to what a client is doing in sessions (e.g. blaming themselves for everything). He describes this process of noticing acting against the unconscious drive to repeat the same behaviours over and over.

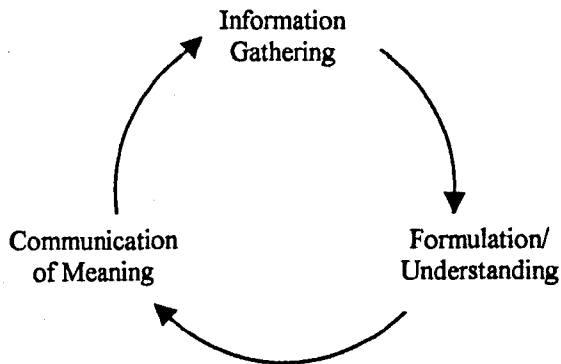
Hodges (2003) raised the issue of working with people with little or no receptive or expressive language skills. She asserts that speaking to clients can still hold beneficence, citing the value of tone of voice and posture, linking to work around the use of tone and rhythm with people with autism by Alvarez (1992). She also describes a process of mirroring in which the therapist copies physical movements and verbalisations shown by clients in sessions citing that this leads to a greater sense of attachment and unity.

Generally, the literature identified that practitioners use predominantly verbal communication to express salient features of clients' verbal and non-verbal behaviour and interpretations of what the material might represent in terms of latent unconscious processes. It acknowledged the receptive language skills of many people with learning disabilities, and described the application of gestures, visual aids and metaphor in conveying complex and abstract information.

### Further Considerations:

Whilst the process of therapy considered has been presented as sequential, Beail & Newman (2004) draw attention to the circularity of the process of therapy, describing fluid movement between the three stages of information gathering, understanding and communicating meaning. They assert that many interpretations lead to further information being introduced, which informs the understanding they have of the person (See Fig2).

Figure 2 – The Circular Process of Therapeutic Intervention. Based on Beail & Newman (2004):



Whilst the present review considered an active process of psychoanalytic and psychodynamic practice, much of the literature reflected an experiential therapy in which the therapeutic action was achieved through engagement in a safe experience with another person (Sinason, 1992; Simpson, 2002; Berry, 2003). This contrasted with a more formalised therapy, which attempted to identify the process of developing awareness of previously unconscious aspects of the client (insight) (Beail, 1989; Sinason, 1992; Hodges, 2004; Beail & Newman, 2004). Through his description of two different therapies with “John” and “Michael”, Beail (1989) delineates the two types of therapy and their differing modes of action. One was the interpretative approach - which formed the focus of this review, and the other was a more experiential therapy, which

enabled clients to experience something which was absent from their early development (e.g. containment, secure attachment). Berry (2003) reported four cases of psychodynamic therapy, in which he describes attempting to make the client feel safe and connect to them, responding affectively and showing an understanding of their needs. The process of this experiential element to psychodynamic therapy was difficult to delineate from the published accounts, being typically described in terms of philosophies and goals.

*"...my first objective was to offer him...a 'feeling of safety'"*

Berry, 2003

This element of therapy may be partially explained in terms of the therapeutic frame, but was largely neglected in this review.

## SUMMARY:

This review aimed to identify accounts of the process and practice of psychoanalytic and psychodynamic therapy with people with learning disabilities from published case studies and technical papers. Many accounts described eloquently the presentation of clients and psychoanalytic formulations of their difficulties (Symington, 1981; Symington, 1988; Sinason, 1992), but there was a paucity of literature which identified the practice of therapists engaged in this work. Taking Neville Symington's paper (1981) as a starting point, the review identified two distinct domains in which the process could be considered: The therapeutic frame, and the activity within the frame. The active part of therapy was then delineated into three stages: information gathering, formulation/recontextualisation of the material, and communication of meaning (interpretation).

Within the literature there was a general consensus around the boundaries making up the therapeutic frame, but this was balanced by assertions that flexibility be afforded with respect to the setting, duration and term of therapy. The main assertion around the frame was that it was consistent, occurring on the same day, same time, same place, with the same frequency and in the same setting.

Clear accounts of the practice of therapists were rare in the literature and largely required detection from descriptions of clients' presentations in therapy. Emerging from the literature was a process of gathering information which drew on multiple sources. The predominant source of information was expressed verbal material clients communicated in sessions. However, acknowledging difficulties in expressive communication, many therapists also provided expressive aids such as drawing/modelling materials and toys (particularly dolls and animals). In addition, therapists also described making use of non-expressive information communicated in sessions such as behaviour, body language, body tension, and counter-transference

feelings. In some cases, information was also sought from third parties (carers and family members).

The process of formulating information and recontextualising material in order to identify unconscious latent meaning was notably absent from much the available literature. Beail (1989) and Beail & Newman (2004) described the use of Malan's triangles of conflict and person (Malan, 1979) to describe a process of making links between defences, anxieties and latent unconscious feelings, and triangulating evidence from the transference (relationship with therapist), and information from clients' present and past in order to validate hypotheses. These were then communicated in the form of an interpretation. This communication by the therapist to the client was described as predominantly verbal, but authors acknowledged the receptive language difficulties which many people with learning disabilities have, and described the additional use of gesture, metaphor and visual aids were described as commonplace to convey complex and abstract information.

## DISCUSSION:

After proclaiming that his model of psychotherapy required "...a certain measure of natural intelligence and ethical development", Freud (1904) asserted "I do not regard it by any means impossible that by suitable changes in the method we may succeed in overcoming this contra-indication". Bütz, Bowling & Bliss (2000) considered the modifications therapists applied to a standard psychoanalytic technique when providing therapy to people with learning disabilities, and supported Hurley et al. (1996) who assert "there is, in fact, strong consensus about the types of modifications needed" for psychotherapy to be useful with the mentally retarded population. The modifications cited were: a simplification of language used; adaptations of the frame; the use of a more directive and active approach; and changing the way the working relationship is built to take account of the different experience and perceptions of people with learning disabilities (Hurley et al, 1996; Bütz, Bowling & Bliss, 2000). The present review supports some aspects of this opinion and not others. From the evidence available in the literature, the simplification of language is a common practice when working with this population; equally, adaptations to the frame were described in the literature, particularly in respect to the setting of therapy and duration of sessions. An area of divergence with Hurley et al (1996) and Bütz, Bowling & Bliss (2000), was around the application of a more direct and active approach, which was not identified as an emergent practice in this review. It is prudent however to note that the present review did not contrast the practice of psychoanalytic/psychodynamic therapy with people with learning disabilities, with that of practice with non learning-disabled adults. Subsequently, the use of the word "more" with regards to the directness, or level of activity of therapists is difficult to quantify. The final modification asserted by Hurley et al (1996) and Bütz, Bowling & Bliss (2000) was a change in the working relationship

between therapist and client. Again this is difficult to gauge due to the absence of comparative data, but within published accounts there was clear variation and flexibility in relationships as therapists adapted their practice to accommodate the differing needs of clients (Beail, 1989; Berry, 2003).

Many authors contributing to the literature do so with an explicit and genuine desire to disseminate information about the provision of psychoanalytic and psychodynamic therapies to people with learning disabilities (Beail, 1989; Sinason, 1992; Frankish, 1989). However a stark absence from the literature they produce is a clear account of what they do. Many accounts describe the theories on which their practice is based (Beail, 1989, Sinason, 1992) and describe formulations in detail (Berry, 2003; Simpson, 2004; Symington, 1981; Symington, 1988), but absent to describe how those theories and formulations were implemented in the therapy, in order that the therapeutic effects they cite can occur. The therapists' position in descriptions often reads as that of an observer, theorist, describing client's behaviour but not their own (Symington, 1988). As a relatively new therapeutic practice, it is likely that many of the contributors worked with non-learning disabled adults and children prior to their reported work with learning-disabled adults (Sinason, 1992). It is plausible therefore that they assume readers of their work have prior knowledge of generic adult or child psychoanalytic therapy practice.

A major critique of this review was the paucity of published literature reporting psychoanalytic or psychodynamic therapy with learning-disabled adults. It may have been prudent to widen the inclusion criteria to enable the literature around therapy with children with disabilities and group therapy to be considered. However, the rationale for the criteria selected was that there was a very specific audience for the review and that the same specificity should be reflected in the data. Indeed, the inclusion of integrative



therapies introduced analogous practice into the review (Morrissey & Jackman, 1998). This specificity has the consequence that the review is quite limited in its generalisability and relevance to wider audiences. It is reasonable however to suppose that there may be some value to other practitioners of therapy with atypical populations. This is particularly relevant to populations who have impaired or diminished capacity compared with the typical non-disabled adult population on which psychotherapy models are largely developed e.g. children, physically disabled adults, older adults, non-English speaking groups, sensory impaired groups. A further critique of the review was the use of Neville Symington's paper (1981) as a template for considering therapy practice. Its use in this way was based on its recognition as the first unambiguous account of psychotherapy with a person with a learning disability (Sinason, 1992; Beail, 1998). The rationale was that the use of this paper (Symington, 1981) as a benchmark, would enable developments from that point onwards to be identified in the literature. On examination of published accounts, it became clear that there was great variation in the practice of therapists reporting under the title of psychoanalytic or psychodynamic. There may subsequently have been exclusion of important descriptions of other forms of psychoanalytic or psychodynamic practice, which did not fit into the template of therapy proposed (therapeutic frame, information gathering, formulation, communication). The nature of the experiential therapeutic experiences described were certainly not considered to the same degree as the more formal model.

This review was an attempt to identify accounts of psychotherapeutic practice with adults with learning disabilities in the published literature. By collating evidence from multiple technical papers and case study descriptions, a general account was partially emergent. However there remains an absence of a clear account of practice in the area particularly around the process of formulation. Whilst acknowledging the diversity required in providing psychoanalytic psychotherapy to this clinical population, the

present review reveals a need for further investigation into the practice of therapists delivering therapy, so that effective dissemination of research and sharing of practice may be achieved.

SUMMARY TABLES:

Reference	Therapeutic Frame					
	Setting	Frequency	Duration	Term	3 <sup>rd</sup> Parties	Consistency
Symington, N. (1981)	1:1 in Therapy Room at therapist's place of work	Once Weekly	N/A	2 years	Parents involved during initial information gathering stage	N/A
Symington, J. (1988)	1:1 in Therapy Room at therapist's place of work	Once weekly increasing to five times weekly	N/A	19 months+	Parents involved during initial information gathering stage	N/A
Beail, N. (1989)	1:1 in therapy room if possible (light, warm, comfortable). Chair or couch. Not face-to-face	Once Weekly	N/A	3years+	N/A	Time, Day, Place, frequency
Frankish, P. (1989)	N/A	Once or Twice Weekly	1 hour	9months to 2.5 years	N/A	Time and Day
Sinason, V. (1992)	1:1 in therapy room at therapist's place of work	Once Weekly	N/A	Open-ended, Long-Term	N/A	Time, day, place
Bungener & McCormack, (1994)	N/A	Once Weekly	N/A	N/A	Carers and Family involvement needs to be managed and client consent gained	N/A
Beail, N. (1995)	1:1 Couch or Chair	Once Weekly	N/A	Open-ended	N/A	Time & Day

Beail, N. (1998)	1:1 Couch or Comfortable Chair	Once Weekly	1 Hour	3 – 38 months	N/A	Frequency, Time and Place
Morrissey & Jackman (1998)	1:1 integrative therapy alongside other interventions (behavioural)	Once Weekly	20 – 50 minutes	N/A	Other professional involved. Carers included only with client consent	N/A
Bütz, Bowling & Bliss, (2000)	1:1	N/A	N/A	N/A	N/A	On-time, Same room
Simpson, D. (2002)	1:1 in Therapy Room at therapist's place of work	Once Weekly	N/A	2.5 Years	N/A	N/A
Hodges, S. (2003)	1:1 in Therapy Room	Once Weekly	1 hour	N/A	Network (carers, professionals and family)	Day, time, place, room.
Berry, P. (2003)	1:1 in variety of settings: Car, kitchen, therapy room. Chair or couch	1-3 time weekly	30 minutes to 1 hour	N/A	N/A	N/A
Beail & Newman (2004)	1:1 in therapy room couch or chair. Not face-to-face	N/A	30, 40 or 50 minutes. (Typically 50 minutes)	N/A	Pre-Assessment meeting with support agencies	Room, Time, Day

Reference	Therapeutic Practice		
	Information Gathering	Recontextualisation/Formulation	Communication of Interpretation
Symington, N. (1981)	Verbal and Behavioural Information in sessions. Way of relating in sessions. Information from meeting with Parents and staff.	N/A	Verbal, gestures, metaphor
Symington, J. (1988)	Verbal & Non-verbal (mannerisms, vocalisations, facial expression). Toys and expressive materials available. Information from meeting with parents. Counter-transference	N/A	Verbal
Beail, N. (1989)	Verbal material (Free associations, Dreams & Phantasy material). Questions & Clarification; Non Verbal material: Counter Transference	Malan's Triangles. Linkages between observed defences, anxieties and hidden latent meaning; and life stages.	Simple Language, At times of Negative Transference.
Frankish, P. (1989)	N/A	N/A	N/A
Sinason, V. (1992)	Free Association, Phantasy & Dream Material. Counter Transference, Behaviour,	N/A	N/A
Bungener & McCormack, (1994)	Verbal & Non-verbal, Counter-transference. Information from staff and carers	N/A	Simple Language
Beail, N. (1998)	Free Association, Phantasy & Dream Material	N/A	N/A
Morrissey & Jackman (1998)	Verbal, Body Language, Expressive play and drawings. Body reading (Tension & Boundness) 3 <sup>rd</sup> Party Report. Amplifying	N/A	Simple Language, Reflection, Drawing

Bütz, Bowling & Bliss, (2000)	N/A	N/A	Simple Language, More Direct
Simpson, D. (2002)	Verbal, and behavioural particularly play with toys and dolls.	N/A	Verbal, Metaphor
Hodges, S. (2003)	Verbal, expressive materials (drawing and modelling, Toys and dolls	N/A	Verbal, tone of voice, reflection, brief, simple language, metaphor, concrete. Non-verbal, posture, gesture, mirroring
Berry, P. (2003)	Verbal – questions Non-verbal – behaviours and demeanour	N/A	Verbal, Reflecting
Beail & Newman (2004)	Verbal – utterances, statements, phantasy dream material Non-verbal, body language, expressive materials, representative play, Counter-transference	Malan's Triangles. Linkages between observed defences, anxieties and hidden latent meaning; and life stages.	Verbal – Brief Statements, Simple Language, Reflection

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*Towards a model of  
individual psychoanalytic  
psychotherapy with people  
with learning disabilities*

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## ABSTRACT

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**Aims/Objectives:** *The present study explored the practice of individual psychoanalytic and psychodynamic psychotherapy with adults with learning disabilities. Acknowledging the absence of a clear account for the provision of psychotherapy to this group of people, and a paucity of literature in the area, the study aimed to establish whether practitioners could identify a clear and consistent account of their practice, and to develop a model of psychotherapy with people with learning disabilities which adequately described the practice of people providing therapy to this group.*

**Design/Methodology:** *Employing a grounded theory qualitative analysis strategy (Glaser & Strauss, 1967) the author analysed transcripts of interviews carried out with practitioners experienced in providing psychotherapy to adults with learning disabilities (N=8).*

**Results/Conclusions:** *A consistent account of a process for delivering psychotherapy to learning disabled adults was emergent from the data. In developing a model of psychotherapy, the importance of philosophical notions of disability, attachments & relationships and trauma was recognised. Links between philosophies and practice were proposed and a speculative model based on these presented.*

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## CONTENTS

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ABSTRACT	35
INTRODUCTION	36
AIMS OF THE STUDY	42
METHODOLOGY	43
ETHICS	47
RESULTS	48
▪ Psychotherapy Practice Overview	51
▪ Overall Model Of Psychotherapy	88
DISCUSSION	89
CRITIQUE	99
CONCLUSION	102

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## INTRODUCTION

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*“...a certain measure of natural intelligence and ethical development are required...[BUT] I do not regard it by any means impossible that by suitable changes in the method we may succeed in overcoming this contra-indication...”*

Sigmund Freud (1904) – In a paper discussing the assessment of handicapped patients’ suitability for treatment

NOTE: In this paper Freud does not refer to individuals with learning disabilities directly but rather to those people with psychoses

Taking Freud’s words as a starting point for psychoanalytic involvement with people with learning disabilities, Bender (1993) describes psychoanalysts subsequently showing “*therapeutic disdain*” towards this group. He speculates that they adopted rigid “*rules of exclusion to remove the less attractive of those needing help*” and that Freud’s “*rule of thumb based on clinical experience*” was taken as law because it suited practitioners who had “*little inclination to spend hundreds of hours with a person with a learning difficulty*”. Sinason (1992) gives a slightly different perspective on this when she refers to “*psychoanalytic indifference*” regarding work with people with learning disabilities, suggesting a less intentional reason for psychoanalysts not working with people with learning disabilities. Hodges (2003) concurs with Bender and Sinason that following Freud’s comments there was a long abstinence of psychoanalytic and psychodynamic therapists from working with people with learning disabilities. However, she attributes this to the theoretical, political and societal contexts regarding disability present through much of the 20<sup>th</sup> century rather than to the individual gratification served by exclusion that Bender proclaims or indifference proposed by Sinason. Symington (1981) offers a further explanation for the lack of psychotherapy carried out with this group, proposing therapeutic abstinence as a defensive strategy aimed at preventing harm to the self-image of therapists. He suggests that when treating

a "subnormal patient, [therapists] are reminded only too poignantly of [their] own mental retardation", and suggests that their subsequent avoidance of these feelings are wholly understandable. Hodges (2003) gives some support to this notion when she discusses the feelings of fear and guilt engendered when working with people with learning disabilities and the desire of professionals to distance themselves from this.

Despite the widely agreed paucity of therapeutic work and research into psychoanalytic therapy with people with learning disabilities until the early 1980's (Beail, 1989; Sinason, 1992; Hodges, 2003), exceptions are cited in much of the pertaining literature (Bender, 1993; Sinason, 1992; Hodges, 2003). However, that which Hodges (2003) describes as "*pockets of psychodynamic work*", Sinason (1992) attributes to "*moments of curiosity*" (as opposed to dedicated work in the area) and it is not until Symington's (1981) paper in which he reports his own therapeutic work with a man with an IQ of 59, that there is a clear account of psychoanalytic therapy with someone with an organic learning disability. Prior to this, Sinason (1992) claims that published accounts were ambiguous with regard to the nature or degree of impairment presented by clients, and further confused by a lack of consensus, consistency and clarity in the terminology used to describe people with learning disabilities and the nature of their impairments. In addition, she asserts that the work that was taking place was not effectively disseminated through the profession and was effectively lost. Sinason (1992), Bender (1993) and Hodges (2003) all agree that in the absence of psychoanalytic therapy other psychological approaches dominated therapeutic work with people with learning disabilities, particularly behaviourism. Hodges (2003) attributes this to its "scientific" and research friendly approach, whilst Bender (1993) traces its origins back to the influence of the Institute of Psychiatry, which he sees as the pre-eminent post war training course for clinical psychology. He asserts an opinion that the Institute of

Psychiatry attempted to “*deny any validity to psychodynamic approaches and thus make clinical psychology synonymous with behavioural approaches, and psychotherapy synonymous with behaviour therapy*” in order that the medical profession may maintain its dominant stronghold over therapeutic techniques. The application of non-analytical “talking therapies” with people with learning disabilities, such as non-directive, client-centred approaches and group therapies are also discussed in the literature. Regarding person-centred approaches, Bender (1993) and Sinason (1992) both describe how the growth in the popularity of these therapies was not reflected in their application with people with learning disabilities because of the views of the non-directive schools’ figurehead Carl Rogers. Sinason (1992) asserts that “*those who were interested in working in client-centred ways in America were held back by Carl Rogers’s opinion (1957) that client-centred therapy was not suitable for handicapped people*”, whilst Bender (1993) proclaims that Rogers completely failed to recognise that people with a learning disability might benefit from therapy: “*[Rogers] never considered people with learning disabilities as citizens who might wish to use a therapists services – and had a right to exercise this wish. They simply do not exist in Rogers’ world*”. Regarding group therapy, Bender (1993) intonates that this may be “*...especially suited to people whose central problem is a damaged identity rather than specific symptoms*”, but describes how the eminent purveyors of this therapy: Bion, Foulkes, Main and Maxwell Jones (De Board, 1978) were not inclined or motivated to develop methods to include people with learning disabilities.

Within the literature there is a clear consensus (Beail, 1989; Frankish, 1989; Sinason, 1992; Bender, 1993; Hodges, 2003) that with regard to psychoanalysis there was a paucity of published research and therapeutic work involving people with learning disabilities until Symington’s (1981) paper, and that subsequently (though perhaps not

resulting from this) there has been an increase in the use of psychoanalytic techniques with this client group. Hodges (2003) attributes this to a gradual "*climate change towards people with learning disabilities*" throughout the 20<sup>th</sup> century. She identifies the creation of the Welfare State and specifically the NHS in 1948 as crucial in shifting the perception of people with learning disabilities from being seen as "*less than human*" and at times "*a threat to society*", to being "*patients with health care needs*". Additionally, she notes the role of subsequent government legislation such as the 1971 White Paper: "Better services for the Mentally Handicapped", the Education Act (1971) (which stated that no child was "ineducable"), and "The National Health Service and Community Care Act" (1990) as influential in driving changes which directed the attention of health professionals to the mental health of people with learning disabilities and their capacity for change. The work of Wolfensberger (1972) in the field of Normalisation and the rise of self-advocacy groups such as People First are also credited by Hodges (2003) with promoting equity of service provision and the rights and needs for equal access to mental health services.

Sinason (1992) looks at factors arising from within the mental health arena, which led to developments in psychoanalytic involvement with people with learning disabilities. A key development she identifies was the shift in the perceptions of analysts regarding the impact of disability on emotional functioning. She notes comments made by the American psychoanalyst and psychiatrist Irving Phillips (1966) proclaiming that the lack of psychotherapeutic services for people with learning disabilities was due to a "*misconception that behavioural or emotional problems were a function of mental retardation*" (Sinason, 1992). The importance of "*differentiating disturbance from the coexisting handicap*" in the development of psychoanalytic involvement with this group is reiterated by her reference to John Stoke's assertion that it is "*useful to distinguish between cognitive intelligence and emotional intelligence*" (Stokes, 1987). As well as

identifying some specific research relating to psychoanalysis and learning disability (mostly relating to disability resulting from emotional disturbances rather than organic learning disability) (Chidester & Menninger, 1936; Klein, 1924; Clark, 1933; Miller, 1933; Mahler, 1942; Bourne, 1955; Mundy, 1957), Sinason (1992) also identifies the development of psychoanalytic services for people with psychosis as important. She draws on the comments of French psychoanalyst Maud Mannoni (1965) when she notes that just as schizophrenia had once been believed to be inaccessible to analysis and was subsequently admitted into the "*analytic kingdom*" "*there should also be a similar extension to certain cases of mental handicap*" (Sinason, 1992). Indeed she draws attention to the relevance to people with learning disabilities, of a large body of research and development involving analysis with other clinical populations (particularly work with children, people with physical disabilities and people with autism)(Spitz, 1953; Bowlby, 1951; Robertson, 1951; Klein, 1924; Bion, 1959). By the 1980's this had grown into a body of "evidence" from which psychoanalysts could derive speculative theoretical underpinnings to working with people with learning disabilities.

In looking at the theoretical aspects of psychoanalytic work with people with learning disabilities, Sinason (1992) casts her net far and wide, going back to the theories of Sigmund Freud at the start of the century. She asserts, "*all his major theories are relevant and some have particular resonance for handicap*" before outlining the particular relevance of his theories of secondary gain (Freud, 1901) and somatic compliance (Freud, 1905). Subsequent theories of emotional handicap (Klein, 1924; 1931; 1952) and regression to a foetal stage (Clark, 1933) are highlighted along with numerous other theories developed in the 20<sup>th</sup> century such as the attachment theories of Bowlby (1951), Spitz (1953) and Robertson (1951), and the concepts of shifting

states of handicap and ego splitting (Klein, 1924; Bion, 1957, 1959; and Sinason, 1990). Hodges (2003) cites three main psychoanalytic theorists particularly relevant to psychoanalysts working with people with learning disabilities: Sigmund Freud, Melanie Klein and Wilfred Bion. She notes the significance of the development of the understandings of transference and counter transference, identifying the particular importance of understanding the concepts of: *projective identification* (Bion, 1959), *object relations* (Klein, 1923), *paranoid-schizoid and depressive positions* (Klein, 1923), *holding* (Winnicott, 1962), and *maternal containment and infantile projection* (Bion, 1959) in working with people with learning disabilities. Whilst, these descriptions of psychoanalytic theories relevant to working with people with learning disabilities have clearly been driven by a desire to disseminate information about an area of work which the authors feel passionately about, an operational definition is noticeably absent. Subsequently there is no record that what is termed “psychodynamic” or “psychoanalytic” practice reflects a cohesive therapeutic approach by practitioners. If, as Freud (1904) intimated, traditional psychoanalysis requires some modification prior to its application with this client group, then what are these modifications, and are all practitioners using the same modifications? As the application of psychodynamic therapy with people with learning disabilities grows, it feels important that a model of practice is identified which can be used to inform future research, and be shared with other practitioners. Importantly, good practice guidelines laid out by the Department of Health in its “*A First Class Service*” guidance paper (1997), identified an agenda for quality improvement within the NHS based on evaluation and assessment of clinical practice. This requires in the first instance, that interventions be clearly defined. The present study aims to interview practitioners of psychoanalytic/psychodynamic therapy with people with learning disabilities in an attempt to identify a general model of their work.



## *AIMS OF THE STUDY*

1. To establish whether practitioners can identify a clear and consistent account of psychoanalytic/psychodynamic psychotherapy practice with people with learning disabilities.
2. To generate a working model which adequately describes the practice of psychoanalytic/ psychodynamic psychotherapists working with people with learning disabilities.

## METHODOLOGY

In order to explore the areas of investigation a qualitative design was employed. Data was collected through interviewing practitioners with experience providing analytic psychotherapy to people with learning disabilities. Interviews were taped and transcripts analysed using grounded theory (Glaser & Strauss, 1967; Strauss & Corbin 1998) - a recognised and robust qualitative method of data analysis (Morse & Richards, 2002).

### Identification of Appropriate Research Methodology:

Grounded theory was chosen over other qualitative methodologies (e.g. IPA), as the aim of the study was to identify the practice of therapists working in the area. This is a particularly appropriate application of grounded theory as it aims to “*understand the action on a substantive area from the point of view of the actors involved*” (Glaser, 1998). This contrasts with many other qualitative methodologies such as IPA, which are more focussed on identifying the *essence* of an experience (Denzin & Lincoln, 1998). Grounded theory is distinct from other qualitative methodologies as it aims to facilitate the development of a model of an area based on linkages between emergent data (Glaser, 1998), which was a particular aim of this study. Subsequently IPA and other qualitative methodologies were rejected in favour of a methodology designed to identify a model of what happens in a substantive area.

**NB:** It was not possible to generate first-hand data from tapes or direct observations of therapy as this would contravene the privacy and confidentiality ethos’ of the psychoanalytic model.

### Grounded Theory Methodology:

Based on the ideas of Glaser & Strauss (1967), the key goal of grounded theory is “*the creation of new concepts*”. The analysis aims to develop theories, which are grounded in and have an “*intimate relationship with data*” (Strauss, 1987). The methodology suggests that studies are small-scale and focussed, with researchers aiming to learn from

participants by analysing data, drawing out themes and generating ideas. From this, concepts and linkages are made between the data and ideas, which are then analysed for their interplay with the data, the researcher seeking integration and synthesis, which might generate theoretical insight.

Grounded theory is embedded in the idea of exploring processes and change. It is “*a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area*” (Glaser, 1992). It attempts “*to understand the action on a substantive area from the point of view of the actors involved*” (Glaser, 1998), making it a particularly appropriate tool for use in this study.

The actual grounding of theory is the third stage of a 3-stage conceptual perspective analysis. The first level is the data. The second level the conceptualisation of data into categories and their properties, theory (the third stage) potentially arising from linkages made between themes, concepts and categories arising from the data (Glaser, 1998).

A key feature of grounded theory is the constant comparison of data sets (in this case interview data with interview data). The results of this comparison are coded to identify **categories** (roughly equivalent to themes or variables) and their properties (in effect their sub-categories). Data are collected (i.e. further interviews carried out) and analysed until such point that there is “*saturation*” in the categories arising from coding. At this point data collection is stopped and **core concepts** generated. Over-arching, **abstract themes**, which link these core concepts, are then developed, and links proposed between categories and themes in the hope of developing a model.

Within the field of grounded theory, less structured interviews are widely deemed preferable to more structured interviews as the data generated is less constrained (Morse & Richards, 2002).

### Recruitment of Participants:

Participants were selected for inclusion using criteria mirroring that of full membership for the Institute of Psychotherapy & Disability (IPD) (See Appendix 8), as such, each participant held *"a qualification to Master's level or above in psychotherapy or a discipline relevant to learning disabilities"* and had *"provided therapy, with supervision, to [at least] 10 people"*. This was for ease of identification, and in order to ensure the quality and homogeneity of the sample. At the time of the study, the institute consisted of 40 full members. After gaining the support of the directors of the IPD, members practicing psychoanalytic and psychodynamic psychotherapy with people with learning disabilities were invited to be interviewed through an open letter (See Appendix 9). Accompanying the invitation was an information sheet outlining the study (See Appendix 10) and a signature sheet requesting consent to be approached directly for inclusion in the study. Of the volunteers (N=14) interviews were arranged with 10 participants based on their availability for interview between January and April 2004; and their level of experience working psychoanalytically with adults with learning disabilities (a combination of early pioneers and more recent applicants of psychoanalytic methods to people with learning disabilities psychotherapists was sought). Of this sample (N=10), data from one participant was excluded due to their not working psychoanalytically/psychodynamically with people with learning disabilities, and one participant's data was not adequately recorded. The final sample (N=8) consisted of 2 males and 6 females, 3 of whom had been pioneers of psychoanalytic psychotherapy with adults with learning disabilities in the 1980's leading to the creation of the IPD in May 2000. The other 5 participants were *"2nd generation"* practitioners applying psychoanalytic therapy techniques to adults with learning disabilities.

NB: Institute members had previously stated a desire for a study of this sort at one of their biannual meetings, and indicated a willingness (in principle) to take part.

### Data Collection:

Volunteers (N=14) were contacted via their preferred means (letter, email or telephone) and interviews arranged with 10 participants at times and places convenient for them between January and April 2004. Interviews were carried out at participants' places of work in each case. Directly preceding each interview, the background and aims of the study were reiterated. Participants were then given the opportunity to ask questions, before recording their consent to take part in the study, and for the interview to be recorded onto cassette tapes (See Appendix 11).

Participants were interviewed by the author and asked to provide a narrative of their typical practice sequentially from beginning to end. Interviews were semi-structured, based around an open interview schedule (See Appendix 12) Data from cassette tapes were transcribed by a third party in three stages following completion of interviews 1-3; 4-6 and 7-10. In line with Grounded Theory methodology, later interviews incorporated questions relating to themes raised in previous interviews. Saturation of themes was found after analysis of the first 5 interviews, with no additional categories emerging from the coding process. Interviews 6, 7 and 8 were already arranged with participants and these were carried out in order to test for non-conformant, analogous data.

#### A Note on the Researcher's Perspective:

The analysis of qualitative data involves an unavoidable degree of subjective processing (Denzin & Lincoln, 1998). The researcher's perspective in this study was one of being a postgraduate psychologist in clinical training, with an interest in psychoanalytic psychotherapy and learning disabilities both independently and in relation to each other. In carrying out interviews with participants and analysing subsequent interview data, the researcher will have made connections and linkages between data and categories based on their level of understanding and subjective orientation. In addition, the influence of participants' accounts may not have been equal, due to subjective biases introduced by the perceived reputation and experience of some of the participants over others. The impact of this is considered more fully in the critique (See Page 101).

### Ethical Approval Process:

Prior to commencement of the study, a proposal was submitted to the Clinical Psychology Unit's Research Committee, University of Sheffield for peer review (See Letter of Approval– Appendix 3). Following this, an application was made to the Psychology Department's Ethics Committee, in line with local NHS research governance requirements (See Letter of Approval – Appendix 4).

NOTE: As participants were not interviewed with regards to work carried out for the NHS, and NHS resources were not used in any part of the study, ethical approval from the centralised NHS ethics committee (COREC) was not required.

Information sheets outlining the study (See Appendix 10) were sent to participants with the initial contact letter and again at interview. The sheets asserted the right of participants to withdraw from the study at any time, and described measures to protect the anonymity and confidentiality of information provided. Participants were given the opportunity to ask questions and given the researcher's contact details.

Prior to interview, participants were instructed not to communicate identifying features of clients they had worked with. If identifying information was cited, then this was removed from the data during analysis of transcripts. The transcriber was instructed not to discuss interview data, with particular reference to the identities of clients discussed or participants. In order to reinforce this, they were asked to sign a confidentiality agreement prior to being given the interview tapes (See Appendix 13). The transcriber was also advised of the potential for having emotional responses to the content of the interviews, and made aware that the researcher was available to support them in seeking help should difficult to manage feelings result from the transcribing process.

Anonymity of participants was protected by not placing any identifying information on tapes which were simply labelled: "Participant1, Participant2 etc.". Interview tapes and transcripts were locked securely in a drawer when not in use and destroyed following the conclusion of the study.

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## *RESULTS*

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### ANALYSIS SUMMARY:

#### 1. Initial Analysis:

- a. Coding The Data: The initial stage of the analysis was the coding of data into categories. These codes arose from notes made during the interviews and from the subsequent interview transcripts. After 5 interviews saturation of emerging categories occurred, with 150 categories identified (See Appendix 6).
- b. Accumulation of Central, Recurrent Codes: Analysis of the categories identified in the initial analysis enabled accumulation of recurrent codes and a reduction in the number of categories required to adequately describe the data from 150 to 78 categories (See Appendix 7). Using these 78 recurrent categories it was possible to identify a consistent sequential process of psychotherapy (See p51)

#### 2. Secondary Analysis:

- a. Development of Core Concepts: Interpretation of the 78 central categories identified in the initial analysis, led to the development of 24 core concepts, which reflected the underlying premise' behind the recurrent categories identified in the second stage of the initial analysis. The concepts fell into two distinct groupings: those which reflected the practical aspects of psychotherapy with people with learning disabilities, and those reflecting the philosophies underpinning the work. (See Page 54)
- b. Development of Abstract Themes: Consideration of the nature of the core concepts identified above, enabled their delineation into 4 over-arching, abstract themes which encapsulated the core-concepts identified:

- Relationships
- Person
- Theory
- Reality

3. Development of a Model Grounded in the Data: Through consideration of the potential linkages between the recurrent categories, core concepts and abstract themes, a model of psychodynamic/psychoanalytic psychotherapy was developed (See Page 88 for details).

## ANALYSIS DETAILS:

1. Initial Analysis: (For full details of coding and accumulation of 78 recurrent categories, see Appendices 6 & 7)

From the accumulation of recurrent categories referring to the practice of psychotherapy, it was possible to identify a consistent sequential process of psychotherapy (See p.51)

Participants described the process of psychotherapy as consisting of 3 stages:

- i. Pre-Therapy Phase: This initial phase entailed consideration of the person's history, reason for referral, consent issues, potential risks and benefits, practicalities (transport, escorts, timing) and support available. Typically third Party networks were included in this phase of therapy, but in some cases the process was one of private contemplation by the therapist.

*"I'd be looking at things like consent... you know is this person coming of their own volition or are they just doing as their told"* Interview6;P3;L187

- ii. Assessment Phase: This phase was described as a process of assessing the dyad's (therapist and person) ability to tolerate the therapeutic environment with each other.

*"I would be asking the patient: "Do you feel you can be on your own with me?"* Interview2;P3;L99  
*"Assessment is... about assessing yourself and what you can bear"* Interview2;P5;L167

It was asserted that assessment was not a means of screening the person for their ability to make therapeutic gains but rather the ability of the dyad to share an experience together.

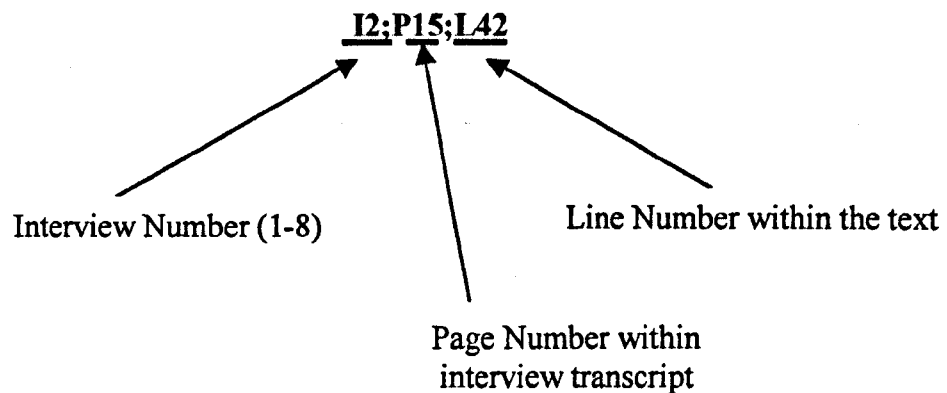
*"there is no assessment hoop, 'does this person manage an interpretation, what level of insight is there'"* Interview2;P5;L165



iii. Therapeutic Phase: The main therapeutic phase was described as consisting of a beginning, a period of attachment, and an ending. It was described as a process of joining and separation within the confines of an intimate, safe relationship in which the person could have an alternative experience of another person, which could lead to alternative thoughts about themselves, the world, and their place in it.

*"I'd be wanting to, give some alternative internal working models [an experience] which could be internalised by the person that they could use in their relationships in the future, and outside of therapy."*  
Interview8;P2;L45-49

Key to location of supporting evidence in the data (See Appendix 6 for an example):



PSYCHOTHERAPY PRACTICE OVERVIEW:

	<b>Supporting Evidence</b>
Therapist considers route of person to therapy: history, reason for referral, consent issues, potential risks and benefits, practicalities and support available. May be in liaison with the person's 3 <sup>rd</sup> Party Network.	I1;P1;L29 I2;P2;L35 I4;P7;L214 I6;P15;L501 I6;P2;L66 I7;P4;L108
Therapist and person meet to assess both of their abilities to tolerate the therapeutic environment. Therapist checks out person's understanding of therapy and clarifies nature of the work, commitments and boundaries.	I1;P2;L40 I2;P5;L158 I3;P1;L17 I6;P6;L185 I7;P5;L138
Therapist & person meet 1:1 (dyad), in a private place, away from the person's home, or work environment.	I1;P2;L40 I2;P5;L164 I3;P1;L13 I4;P2;L37
Dyad meets weekly at same place, time, room each week for 50minutes (sometimes 30mins)	I1;P2;L44 I2;P5;L170 I2;P9;L304 I3;P1;L14 I5;P4;L118
Dyad interacts face to face	I2;P16;L536 I5;P9;L293 I8;P3;L84
Therapist gives maximum attention to what is said, done and experienced by the dyad (material).	I1;P3;L97 I3;P2;L67 I5;P5;L152
Dyad communicates in a way which maximises their communication abilities. This is usually verbal but may be through drama, art, play, touch	I1;P2;L54 I2;P25;L832 I3;P7;L230 I6;P4;L133
Therapist invites the person to communicate whatever is on their mind. This may be explicit (question/prompt) or implicit (not directing/taking charge)	I1;P2;L58 I2;P5;L154
Focus of interaction is the person and their relationships (past & present), particularly focussing on acknowledgment of disability, sexuality, loss, dependency and annihilation/death.	I2;P7;L215 I4;P5;L139 I5;P3;L88 I7;P9;L300
Therapist relates what is said and done to its potential meaning for the person.	I1;P4;L121 I2;P5;L204 I6;P17;L563
Therapist develops thoughts about person based on: <ul style="list-style-type: none"> <li>▪ Transference (&amp; Counter-transference/Projective Identification)</li> <li>▪ Links within material</li> <li>▪ Links between material and other information</li> <li>▪ Known history of the person</li> <li>▪ Psychoanalytic theories</li> <li>▪ Attachment theories</li> <li>▪ Notions of Containment and Holding</li> <li>▪ Systemic theories</li> <li>▪ Developmental theories</li> </ul>	I1;P16;L510 I2;P9;L298 I3;P10;L317 I4;P15;L475 I5;P8;L265 I6;

Therapist reflects on the potential meaning of thoughts & behaviour, takes in projections, considers the content and transforms them into something which may be helpful to the person (interpretation)	I1;P11;L311 I2;P9;L287 I3;P22;L724 I6;P20;L644 I8;P4;L111
Therapist initially notices behaviour and thoughts shown by the person. Noticing becomes progressively more reflective, thoughtful and interpretive when the person is deemed ready to tolerate increased challenge	I2;P5;204 I6;P16;403 I7;P11;L355
Interpretations are communicated using simple language which validates and opens topics for consideration rather than confronting or challenging. Interpretations are communicated in a way which does not demand anything from the person.	I1;P3;L69 I3;P5;L154
Impact of interpretations are measured through changes in: <ul style="list-style-type: none"> <li>▪ Rapport</li> <li>▪ Openness</li> <li>▪ Transference</li> <li>▪ Secondary Handicap</li> <li>▪ Tension/Anxiety</li> <li>▪ Eye-contact</li> <li>▪ Facial expression</li> <li>▪ Explicit response</li> <li>▪ Material raised</li> <li>▪ Thinking Capacity</li> <li>▪ Commitment to therapy</li> <li>▪ Attachment to therapist</li> <li>▪ 3<sup>rd</sup> Party report</li> <li>▪ Behaviour change</li> <li>▪ Connectedness of thoughts &amp; emotions</li> </ul>	I1;P14;L440 I2;P26;L854 I3;P19;L570 I4;P14;L414 I5;P22;L643 I6;P12;L390 I7;P9;L293 I8;P23;L733
Dyad thinks about meaning and consequences of thoughts and behaviour	I2;P29;L952 I4;P5;L144
Therapist remembers and repeats previous links and thoughts when appropriate	I1;P12;L370 I3;P6;L192 I7;P15;L504
Therapeutic change is measured in terms of: <ul style="list-style-type: none"> <li>▪ The person's relationship with the therapist - ability to attach to the therapist realistically as a mixture of good &amp; bad, not idolised or denigrated. Changes in transference/counter-transference</li> <li>▪ The person's ability to acknowledge &amp; communicate both positive and negative feelings.</li> <li>▪ The person's ability to show intimacy</li> <li>▪ The person's level of self awareness/insight</li> <li>▪ Changes in behaviour – level of challenging behaviour and pain (maybe from 3<sup>rd</sup> Party report)</li> <li>▪ The person's ability to manage situations in a more helpful/positive way than previously.</li> </ul>	I2;P28;L926 I3;P26;L812 I5;P30;L1006 I6;P23;L933 I7;P21;L798 I8;P25;L861
End of therapy typically occurs after a fixed, pre-determined period of therapy/number of sessions, but may be based on therapeutic change and the needs and wants of the person, therapist and referrer.	I3;P29;L963; I5;P26;L870 I6;P29;L968

Note Regarding Data & Analysis:

The data generated through interviews with participants, consisted of a combination of clear, uncomplicated, unambiguous descriptions of the practical aspects of delivering psychotherapy to people with learning disabilities, alongside more complex, rationales for practice and philosophies underpinning psychotherapeutic work with this group.

The more straightforward descriptions of psychotherapy practice required little elaboration or development in order to understand the meaning of the data:

e.g. *"... we meet in a room, once a week, for 50 minutes"*  
Interview7;P1;L9

This compares with less clear, more ambiguous descriptions of the practice and philosophies behind the work, which required greater consideration in order to fully understand the meanings attributed to them:

e.g. *"...the more, umm, disabled we are, the more the nature of the society we're attached to imprints itself on us, and stamps us in it's name, and, umm, has the largest vote over our internal non-democracy."*  
Interview2;P20;L301

Subsequently, greater analysis was required to develop an understanding of the more ambiguous data in the early stages of the analysis. The sequential process identified (See p51) was linked to a wider model following its development in the latter stages of analysis.

## Secondary Analysis:

### a. Development of Core Concepts:

From the 78 recurrent categories identified in the initial analysis, 24 core concepts were delineated (See page 54 for details). These were split into two distinct areas: those that related to the *practice* of psychotherapy with people with learning disabilities, and those that referred to the *philosophies* underpinning the work:

#### Philosophies:

- i Inability & Disability
- ii Difference, Impairment, Damage & Value
- iii Reliance & Dependency
- iv Power & Control
- v Trauma & Vulnerability
- vi Attachment
- vii Pain & Loss
- viii Unconscious Defences
- ix Behaviour & Secondary Handicap
- x Containment & Holding
- xi Transference
- xii Insight

#### Practice:

- i Privacy
- ii Consistency
- iii Communication
- iv Gentle, warm, caring & genuine
- v Respect, equality, empowerment
- vi Attentive, Observant & Interested
- vii Interpretive
- viii Tolerant, Accepting, Understanding
- ix Experiential
- x Intimate
- xi Different
- xii Flexible & Integrative

Each of the core-concepts is outlined below with supporting evidence from the interview data:

Philosophies:

Participants described 12 core philosophical concepts which informed their work with people with learning disabilities:

i Inability & Disability:

Participants described a philosophy that all people have inabilities, but that people become labelled as disabled when the more able members of society perceive their inabilities as unacceptable.

*Participant: "I have a bad back, so there are some things that I can't do, so I...I get someone else to do it for me. But it doesn't quite feel like that [with people labelled as learning disabled, where] somebody, umm... knows they have their own money but isn't allowed to have it because actually if they have it they'll spend it all"*

*Interviewer: "So that's where someone else is saying that what you do with your ability is... is wrong."*

*Participant: "Mmm, Yeah"*

*Interview8;P19;L617-627*

ii Difference, Impairment, Damage & Value:

Participants described perceptions of people with learning disabilities being different from other people were held by multiple parties, society, therapists, network and the person with a learning disability.

*"...the life's journey that a learning disabled person brings to therapy is very different, and we can't possibly know what it's like"*

*Interview3;P20;L662-664*

*Interviewer: "So the experience of, of being a person with a learning disability is very different fundamentally from a person who grows up without having a... a label of learning disability?"*

*Participant: "It is definitely."*

*Interview3;P20;L650-654*

They asserted that this sense of difference lead to a belief by people with learning disabilities that they were impaired compared to other people leading to feelings of being damaged and of having low value.

*"...I should never have been born, I should have been aborted, I'm disabled"*

Interview2;P7;L220

*"...[people with learning disabilities have]... a profound, deep template [of] "you're a piece of shit" ..."* Interview2;P31;L1021

Participants also described a negative sense of value and damage developing through interactions with others; particularly maternal care givers in childhood, whom they described as unable to hide their own sense of disappointment at having a disabled child.

*"...mother's eyes...aren't saying "Oh you beautiful baby aren't you lovely"*

Interview2;P16;L517

*"...there may be kind of a negative gaze"* Interview4;P4;L118

*"...I think shame, born from a sense of feeling different, an outsider, not...not like other people, and damaged, possibly the shame brought onto families, the terrible shame of just not being, umm, attractive or valued."* Interview5;P26;L869

*"...historically [people with learning disabilities] have been hated and, umm, been put out of, into institutions, out, away, cos they arose, aroused anxiety in people"* Interview6;P21;L702

iii Reliance & Dependency: Participants described that people with learning disabilities are reliant on others to help compensate for their inabilities.

*"It's rare for people to come independently."*

Interview5;P7;L221

*"...people with learning disabilities have so many people in their lives, you know social workers, support workers, day-care workers, therapists, psychiatrists... the list goes on and everyone has a stake in that person. Everyone's trying to do what*

*they think is best to help them... ”*

Interview5;P16;L517

*“...the people we work with are in some sort of supported living, they have some sort of support around them. There are certain individuals who may live alone, but even then they'll get maybe homehelp or social worker or nursing input.”*

Interview6;P15;L493

iv Power & Control: Philosophically, participants described the experience of being reliant and dependent on others as being disempowering, people with learning disabilities being unavoidably controlled by society, and the people in it.

*“...lack of empowerment, the lack of choice, umm... in everyday life even to what to drink and when to drink it, umm... even in the community... where lunch is at this time and its tea at that time, not a choice.”*

Interview2;P30;L995-997

*“...people with learning disabilities have always got to give somebody something. They've either got to behave better or come when they're called, or do what they're told or whatever. They've always got to do something for somebody else.”*

Interview3;P2;L51-54

*“...people with learning disabilities often, very often have decisions made that they don't agree with, and they feel out of control.”*

Interview5;P3;L87

v Trauma & Vulnerability: Participants described people with learning disabilities experiencing trauma in a number of guises. A consistent assertion was that all people with learning disabilities had experienced trauma in some form and were affected by this trauma.

*“... everyone I see is traumatised... ”*

Interview2;P16;L536

*“...the level of trauma in learning disabled clients is so huge... ”*

Interview2;P5;L167

*“...everybody with a learning disability is potentially a vulnerable adult.”*

Interview3;P26;L866

Perceptions of the trauma experienced varied, some participants asserting that the experience of having a learning disability was traumatic in itself, whilst others



described cumulative traumas resulting from dependency, disempowerment and vulnerability.

*"I actually think that...having a disability constitutes a trauma."* Interview2,P18;L582

*"I see, umm... learning disability as a trauma that makes someone more vulnerable to cumulative traumas... ..in addition to the disability and their feelings around that, are their parents feelings about it; and if they're visibly disabled, the shaming when they're in public on a daily level, which is horrendous, umm...there is sexual abuse, physical abuse, racist comments, housing problems, relationship problems, abusive workers, umm...loads of other things, umm...so that it becomes compound trauma."* Interview2,P18;L595-601

*"...the amount of extra trauma you're likely to have in your life if you've got learning disabilities...there's gonna be a lot more.... Umm, a common feature is...is just having more horrible things happening in their lives."*

Interview8,P24;L794-802

*"part of their trauma can be just having a learning disability themselves, and then going about their normal life is a, can be a traumatic experience..."*

Interview6,P24;L806

vi Attachment to others: The concept of attachment was central to participants' reports of the experience of being learning disabled and consequently to psychotherapy practice with this group. Participants described people with learning disabilities typically having disordered/disorganised attachments with others as a consequence of having extreme attachments with caregivers, be this over or under-attached.

*"difficulties around primary attachment may be to do with over attachment from a very protective parental stance, or may be the absolute extreme other end of that"* Interview4,P4;L115-117

*"It's part of my therapeutic, umm, understanding, that what happens when you're little is incredibly*

*important to what happens when you're older."*

Interview5;P4;L105-107

*"the relationship between a mother and a child is different, because of the learning disability, because the mother's had to work so hard, you know, is so affected by the disability, or they've had to work so hard to, umm...to love the child because it's not clear that anyone else will,... and you get stuck with this thing where there's this sort of enmeshed relationship between the mother and the child, which is incredibly significant for their psyche, and how they are with you, and how they experience the rest of the world"*

Interview5;P24;L788-800

Disordered attachments were also described as the result of being dependent on other people, whilst at the same time experiencing them as harmful, dangerous and rejecting. This perceived harm was attributed to the vulnerability arising from dependency and experiences of loss.

*"...there's usually that feeling of, umm, "I'm not gonna get attached to you because you're gonna go anyway."..."*

Interview8;P21;L688

*"...somebody coming, feeling a piece of shit and that no one would possibly want to give them anything"*

Interview2;P6;L197

Generally people with learning disabilities were described as having very few if any intimate relationships with other people.

*"[People with learning disabilities] are less likely to have intimate, umm, relationships"*

Interview6;P21;L695

Attachment was also described as a goal of therapy, and the degree of attachment through therapy asserted as a guide to the impact of interpretations and a clinical measure of therapeutic change.

*"...therapy would be, umm, about changing...changing their ways of...of...of relating"*

Interview8;P3;L75

vii Pain & Loss: Participants described a belief that all people with learning disabilities bring with them a sense of pain and loss when they come to therapy. This was described in terms of awareness of the abilities they don't have, or from the cumulative experiences of lost relationships and opportunities for the future (e.g. driving a car, having a job, having a family)

*"...people that I, I do tend to see people who are very very low, very unhappy, very sad, very damaged."*  
Interview3;P6;L184

viii Unconscious Defences: Participants described an underlying philosophy behind psychoanalytic/psychodynamic therapy being that people protect themselves from difficult thoughts and feelings through unconscious defensive strategies. They asserted that people with learning disabilities tend to use primitive defences such as splitting and projection.

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*"[People with learning disabilities] have some very hefty defences really"* Interview4;P5;L166  
*"...that part which is scary or painful... becomes split off... disowned..."* Interview5;P5;L189  
*"...you know when they're relating to you as though you are... their mother.."* Interview4;P9;L511

ix Behaviour & Secondary Handicap: Participants described a rationale for some of the behaviours commonly displayed by people with learning disabilities.

*"I think that challenging behaviour in practically everybody I've seen, has got a traumatic route... Everyone (sic) that's ever been referred with echolalia, the echolalia has held the trauma in it"*  
Interview2;P18;L601-605

The notion of secondary handicap was discussed by multiple participants, and conceptualised in terms of an exaggeration of a person's difficulties and difference

as a defence against the shame of being different. It was proposed that this exaggeration was because it was easier for both the person with a disability and the rest of society, for them to be perceived as something entirely different to someone than to be seen as an impaired version of them.

*"Somebody, say, with a mild speech defect is so shamed at their voice being made different that they'll exaggerate it, "I gooooo to..." umm, instead of showing just a little speech defect."*

Interview2;P26;L857-860

*"... better to be hanged for a sheep than a lamb. If someone's gonna look at you 'cos your voice is a bit funny, then better to have a voice you've created that's so huge and they think "poor thing they're really handicapped"*

Interview2;P26;L867-870

On a general level, participants asserted that people with learning disabilities were more likely to communicate behaviourally rather than verbally, and attributed this to the cognitive sophistication required to understand and verbalise ones own emotional state. In addition, it was proposed that a lack of containment of emotions by a maternal figure would mean that an ability to bear one's own emotions might not have developed.

*"[Because a person with a learning disability] hasn't got a thinking process that's working like other people, then a thought is more likely to be, umm, an object, a physical entity. Umm, and I think some, the small bit of head banging that's not to do with actually physical abuse, is where there is a sense of uncomfortable thoughts in the head as sensations, and the attempt to kick the television set and make it work."*

Interview2;P24;L793

Changes in behaviour and degree of secondary handicap were also cited as measures of therapeutic change.

Interviewer: *"How do you gauge responses to interpretation?"*

Participant: *"...a decrease in sort of secondary handicaps..."*

Interview7;P14;L458

x Containment & Holding: Containment was described by a number of the participants as the bearing of difficult thoughts and feelings by another person. It was proposed that the experience of being with a person with a learning disability and experiencing the pain and trauma of their lives was incredibly difficult to manage. For this reason it was commonly felt that people with learning disabilities had not typically had experience of their emotions being manageable. This linked very closely with attachment theories about early interactions between maternal figures and children. Participants described that people who have not had experience of their emotions being contained found it very difficult to control their emotions and found them overwhelming and frightening.

*"I'm interested in how learning disability may affect attachments, and umm, and also just kind of ordinary child development through to increasing individuation and independence, and the parent, and umm, you know, being safe to stand on your own two feet, with the sort of internal sense of being loved, wanted, held, contained, so you don't have to actually have it there all the time. Umm, so I suppose I do have a sense of what it should be like ordinarily, umm, and it often hasn't been like that for the people that are referred here."* Interview5;P23;L758

xi Transference: Participants described transference (and counter-transference) as the affective experience resulting from being with another person. Linking very much with psychoanalytic theory, it was described as a central tool in making sense of material and communicating with a person in psychotherapy. Counter-transference – the affective experience of the therapist from being with the person, was described as very powerful when working with people with learning disabilities.

*"I would be interested in how the person viewed me, how he experienced me, what did he, umm, how did he feel about me, what sort of ideas he had about me. The technical term is transference, and I'll be trying to work within that, within the relationship."*

Interview6;P1;L27

*"... it's my, how do I feel as well. I mean sort of the technical term is counter transference, how do I feel in what they're saying, you know, am I feeling that they are, this has been understood, we are having a moment, they are understanding you, or is it falling a bit flat..."*

Interview6;P6;L194

xii Insight: Insight was proposed as the key goal of therapy, and described as the ability to experience reality and truth.

*"as a psychotherapist I would be looking for insight in people"*

Interview8;P4;L109

Practice: For an in depth account of the sequential process of therapy see p51.

i Private:

Participants described that they typically met people privately in a quiet room where they would interact one-to-one with each other as a dyad. An important concept emerging from the data was the importance of managing the privacy and confidentiality of the therapy whilst also respecting the role of the person's third party network in their lives. Therapy would take place away from the person's home or work environment to prevent contamination of the therapy with outside factors, and to protect the person's home and work environments from being contaminated by the therapeutic process.

Participant: *"...there's a lot of reasons we don't go out to peoples homes to see people. One of which is, it is intrusive, it's, you know, again could be going into this dynamic again."*

Interviewer: *"So those boundaries that you spoke about right at the very start, have perhaps implications and importance in not just setting a... a frame...but also in protecting the...the home environment..."*

Participant: *Yeah, absolutely.* Interview6;P17;L556

ii Consistent:

Participants described that the process and interaction of therapy aimed to be consistent, therapy typically occurring at the same time and place, in the same room, and for the same duration (usually 50minutes) each week.

*"...I sit in a regular room, with a person ... and we sit, we meet at the same time, same day, same place each week, for the same amount of time"*

Interview6;P1;L17-19

### iii Communication:

Participants described that the dyad would communicate in a way which maximised the communicative abilities of both parties. This was typically verbal/language based, but in some cases also incorporated drama (role play), art (pictorial communication) and play.

*"... it's always for me, a talking therapy... which will be about me and what I'm comfortable with."*

Interview7;P1;L12-14

*" [Communication]... depends on whether they're able to cope with very verbal communication or not"*

Interview4;P1;L29-29

*"...a lot of people with learning disabilities, well they wouldn't be blinding you with their narrative powers, they really wouldn't. Umm, so it is what they do that's what you've got."*

Interview5;P15;L489

*"with the clients here, the less verbal ones, it... it is what they do that is... is... is helping you understand them. (Pause) Just, you know, how they'll, what it's like for them to leave their escort in the waiting room and come through to you. How they clutch the drink that they get from the drink machine, or not get one, or spill their drink or.... All these things. You know, I'm always always thinking 'what's the meaning of...of that, what's...what's going on unconsciously there?'"*

Interview5;P15;L499

The participants described that they would invite the person to communicate whatever was on their mind through either an explicit question/prompt, or through implicit non-direction.

Therapists aimed to communicate in a way which the person could understand (simple language, grounded concepts, repetition), and which opened topics for consideration rather than confronting, challenging or demanding something of the person.

*"I tend to break them up a bit rather than giving a whole interpretation at once."*

Interview7;P1;L24



*“that I’m probably more repetitive than I would be with someone without learning disabilities, in that I would be inclined to pick something up more often, rather than assuming that that is something that we now have a shared knowledge of and doesn’t need discussing”*

Interview7;P1;L34

*“I am probably more explanatory when working with people with learning disabilities. So I suppose slightly, there’s a slightly more educative element to it”*

Interview7;P3;L68

#### iv Gentle, Warm, Caring & Genuine:

Participants described the importance of being warm and caring towards people with learning disabilities. This was described as particularly important when working with this group, due to a perceived high risk of people feeling persecuted. It was asserted that a neutral, emotionally flat therapist would likely be perceived as having negative feelings about the person and would not be reflecting a different type of experience to that typically experienced (i.e. emotionless).

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*“...to be neutral, to not be their old template, which means actually being a face that’s pleased to see them. Not in a Polly Anna-ish, umm...kind of umm...”Oh we’re going on a lovely walk and then we’re doing a lovely...” but as some real human to human pleasure of “you’re here, how nice to see you, this is your time and I’ve been looking forward to seeing you” ... ”*

Interview2;P16;L519

*“...I would be cognisant of the possibility of them feeling persecuted...I think persecution is a serious issue with people with learning disabilities. So my interpretations would always be gentle.”*

Interview3;P5;L154-157

Participants also described the importance of being genuine in all their interactions with people and having a human demeanour.

*Interviewer: “What was in my head was, you were describing being human, in a way that perhaps this cold, apparently neutral therapist, might be trying to deny something. And you...you spoke about, it seemed as though having an interaction*

*with another human being, any opportunity to build on that, and to notice that, and to... to draw that out, was to be supported and... and encouraged. Where as perhaps, to be colder, or more neutral, more closed, might be more familiar, more... more normal for someone with a disability who feels excluded (quiet laugh) anyway, a lot of the time."*

Participant: "Yep, yeah" Interview2;P15;L499-513

v Respect, Equality & Empowerment:

Participants described that therapists attempt to treat the person as their equal, and treat their thoughts, feelings and beliefs with respect. Giving the person power in therapy was also a recurrent theme. For example therapists would encourage the person to decide aspects of the therapy for themselves and would respect their decisions, e.g. choosing whether to attend therapy or where they want to sit in the room.

*"So the client is free to choose, if they're phobic, if they're frightened of doors opening, if they don't want their back, if they want to see out of the window, if they want to see the door but not the window...you don't know...umm, where as if you come in and the chairs are all pretty equal sized ones, and you just say 'please choose a seat,' rather than the old 'here is the directors chair, and that's that height, and then you're disempowered on walking in."*

Interview2;P4;L113

vi Attentive Observant & Interested:

A key feature of psychotherapy asserted by a number of participants was of the therapist giving maximum attention to what is said, done and experienced by the dyad (material). Participants described the value of showing interest in the person and maintaining curiosity.

*"... what I would be doing is providing, umm, one hundred per cent attention on what the individual is both saying and doing."* Interview3;P2;L67

vii Interpretive:

Participants described therapists developing thoughts about the person based on their feelings in the session (transference & counter-transference), links within the material, links between the material and other information (e.g. third party report, referral information, history), and relevant theories (particularly psychoanalytic, attachment, systems, and developmental theories). These thoughts would be communicated to the person (see communication above) in the form an interpretation which could be accepted or rebuffed without fear of the consequences.

*"... an interpretation would be based on... on... on a lot of information, usually, umm, which would include anything that the person says, as well as anything that the person does. Umm, and also what I might know about the history of... of the relationship that I've had with the individual that I'm seeing."* Interview3;P5;L143

*"...the interpretation, umm, would serve to enable the individual to make their own links. So your interpretation could be wrong, but if it enables the person to realise that there could be an interpretation, then they'll make their own links with their own experiences."* Interview3;P4;L121

viii Tolerant, Accepting & Understanding:

Participants asserted the importance of tolerating the experience of being with someone with a disability, in terms of bearing their distress, their cognitive

difficulties and sense of hopelessness, and the parallel emotions stirred up in them as therapists. This linked with assertions of accepting people's beliefs and not trying to correct perceived cognitive distortions, but trying to understand their development

*"sometimes you might have an extraordinary wave of exhaustion, weight, come over you, that is not umm, not, wasn't there before...and won't be there afterwards. But umm... So I was talking to someone and I was really trying to talk with him about how he felt about being in a wheelchair. And it's, you know, it's difficult for him to talk about it, and umm, at the point we kind of got there, I suddenly thought 'oh my god I'm gonna fall asleep, I'm gonna fall asleep, I'm gonna fall asleep.' And umm, and he umm, he started talking about, in a sort of obsessive way, about something else, and the sleepiness passed. Now that is, I would say that was, you know, something very big and heavy and serious was there, and it nearly knocked me out."*

Interview5;P17;L554-565

*"... and it's so painful to hear the story of their lives, that you can't bear it..."*

Interview8;P9;L298

*"... it's about trying to say 'ok what sense do you make of all this?' ... and working with that."*

Interview7;P13;L413

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Participants also asserted the importance of working within and accepting the reality of people's abilities and inabilities.

*"... the client has to have some sense of what you're talking about... you've got to find their level."*

Interview6;P21;L682-685

#### ix Experiential:

Therapy was described as an experiential process of engaging and disengaging with another person over a period of time, thinking about the impact of these attachments and meanings. Through experience of a safe, predictable and consistent relationship,

insight about the person's relating behaviour and emotional responses can be developed and linked to the world outside of therapy.

*"I think I provided a kind of experience of containment for her...I do think that for her has been a really new experience. So I understood her disturbance in terms of the lack of containment, and it was only really by her coming week after week, and me being here week after week, that she could actually experience something different."*

Interview5;P12;L381-391

x Intimate:

The dyadic relationship was described as intimate, with a closeness developing between therapist and person. This enables previous experiences of intimate relationships to be re-enacted and considered within the therapy, and also enables new experience of intimacy, which enables consideration of key anxieties and fears around relationships.

*"[people with learning disabilities] may not be used to having such an intimate relationship with another individual, you know, in this intense way...and that can cause all sorts of anxieties and feelings"*

Interview6;P14;L442

xi Different:

Therapy with people with learning disabilities was described as different to therapy with people without learning disabilities. The key differences identified were: greater open-mindedness; fewer intellectual defences; involvement of third party network,

greater use of counter-transference, greater physical communication, less verbal communication, fewer dreams and Freudian slips.

*“...people with learning disabilities come with a much more open mind [than people without learning disabilities]”*

Interview3;P1;L10

*“I think in working with learning disability, there is more emphasis on counter transference. What is it that the therapist is feeling that wasn't from their own personal reaction, umm, to that patient, but something that has been transferred by the patient to the therapist to be held there by means of a projection.”*

Interview2;P8;L255-259

Participants asserted that therapy also needed to be a different experience for the person than previous experiences and offer an alternative way of relating to that already available in which the person could develop alternative ways of thinking about themselves, others, society and their place within it.

Participant: *“the aim would be...for the person to, go through the relationship, to be enabled to change the sorts of relationships they have with other people.”*

Interviewer: *“So would...would that be about a different experience to...to one that they'd had before?”*

Participant: *“Well yeah”*

Interview8;P2;L51-58

## xii. Flexible & Integrative:

Participants asserted that flexibility was important when working with people with learning disabilities who are enmeshed in a complex system with little control. They asserted that work may have to be done in less than optimal situations – e.g. noisy room, and that this must be tolerated to enable therapy to continue.

*"...the circumstances in which you're providing therapy are real life, and the person who's having therapy has got to live with that. You can't make it go away, you can't make it change. And our ability to tolerate what can't be changed, is important if we're going to help clients to tolerate what can't be changed"*

Interview3;P18;L595-600

Participants also described the importance of integrating therapy with the person's life and involving the third party network and other stakeholders.

*"I also have a more loose... looser connection with the external networks surrounding a learning disabled client....at the beginning perhaps, in terms of gathering a history and information.... but also...in terms of what is shared and what isn't shared, and how that's negotiated between me, the client and the network."*

Interview4;P3;L86-100

### Development of Abstract Themes:

In developing abstract themes the previously separate practice and philosophies groupings were drawn together under four headings, which reflected the essence of the concepts in both groupings.

- i. Relationships      ii. Person      iii. Reality      iv. Theory

#### i. Relationships:

The centrality of relationships to the therapy described was clear from participants' descriptions. Many participants described the relationship between person and therapist as the basis of therapy with some participants describing that relationship *as* the therapy, the dyadic relationship forming the vehicle of the psychotherapy process. Relationships were also identified as fundamental to the content of psychotherapy with people with learning disabilities, practitioners asserting that people coming to therapy have relationship difficulties which manifest through challenging behaviours, depression, anxiety, self-harm and other clinical presentations. Relationships with society, support networks, family (particularly parents), and peers, were all considered important in understanding the experience of having a learning disability, and discussed in terms of their impact on therapy.

Society was perceived as having a negative impact on people with learning disabilities, imposing its will and causing pain/damage. The resulting vulnerability to feeling persecuted was acknowledged, and the existence of unconscious coping strategies (e.g. splitting, secondary handicap, projection) was described. Another strategy described as protecting against the trauma of living in society was the adoption of alternative labels, which over-shadow that of "learning disabled".

*"I've worked with a number of people who have preferred to be drunk or a drug addict... rather than be [labelled as] learning disabled"*

Interview3;P15;L473-494



Looking at more specific relationships in the life of a person with learning disabilities, participants noted the existence of a collection of people (network) who provided care and support (care/support workers, social workers, family, health professionals). *Reliance and dependence* issues were described, and the emotional and sociological consequences were discussed with particular reference to the loss of *power and control*. Disempowerment and dependence were described as precursors of difficult to manage feelings (neediness, anxiety, and sense of being a burden) alongside feelings of disappointment, resentment and anger (for what the network can't provide and when it fails to meet the person's needs and wants). Participants asserted the importance of trying to have an experience where this power dynamic was not re-enacted in therapy, and where the feelings of hostility, resentment and sadness could be considered. Acquiescence and attempts to please others were linked to a complex relationship of needing others whilst equally resenting one's care/support network. The presence of third parties in therapy was emergent in the data, acknowledging that they are often necessary in the therapeutic dynamic in some way (travel, organisation, escort) and have a stake in the therapy.

“there is a kind of constant dynamic between the  
other carers and yourself as the therapist”

Interview5;P4;L134

Relationships with parents were identified as particularly important in understanding later relating behaviours. Participants described that parents were often over or under attached to a child with learning disabilities, and asserted that this often led to disorganised attachments with others. The primal, mother-child relationship was described as important. Introducing theoretical concepts of the initial maternal gaze, it was suggested that in many cases maternal figures were unable to mask their disappointment at having a child with a disability, leading to feelings of rejection,

repulsion, damage and trauma from a very young age. The resulting anxiety around close relationships, was described as likely to be acted out in therapy.

Participants also described the experience of being learning disabled as a solitary one in terms of peer relationships. Few intimate relationships leading to low expectations around being wanted, valued or equal to others, and anxiety around closeness due to unfamiliarity and risk of rejection.

*“...you know...cos people with disabilities don't really have that closeness, you know they're thrown together with people they don't know and expected to get on with it...they don't have companions in that sense...”*

Interview7;P12;L381

## Person:

Participants described aspects of the individual person with a learning disability, which informed their practice. A central idea described by a number of participants was that a person with a learning disability had experienced *trauma* (core-concept). This was in addition to that already described with respect to society, and was based on the idea that just having a learning disability is traumatic without any of the cumulative traumas, which occur due to being cognitively impaired, and the vulnerability of being *dependent* on others (core-concept).

Participants also proposed that an internal response to trauma is for a person to protect themselves from the difficult feelings evoked becoming conscious through the action of unconscious defences (core-concept). This idea was heavily influenced by psychoanalytic theory (abstract theme), but within the theme of the person, it reflects the individual nature of defensive strategies employed.

Participants described therapy addressing 5-mutative themes relating to the person's internal models:

- Acknowledgement and mourning of disability
- Pain & Loss
- Sexuality Issues
- Dependency Issues
- Feelings of Annihilation

In many respects all of the content of sessions (as opposed to process) relates to the person and the sense they make of the world consciously and unconsciously. Development and insight reflecting changes in the person's understanding of themselves and their place in the world.

### iii. Reality:

This abstract theme reflects the participants' assertions that reality plays a real part in a person's life and that for therapy to be meaningful it must integrate with the real world.

This was demonstrated by accounts acknowledging that if someone's life is abusive and damaging then responding to this may be more important than therapy, and reports of "reality-testing" in sessions. Equally, the reality that people with learning disabilities exist in sometimes chaotic systems where they have little control means that there is a need for flexibility in delivering therapy (e.g. changing times of sessions, therapy room). The importance of balancing this with protecting the therapeutic space was discussed along with the need to negotiate with people outside of therapy about their influence (e.g. referrers, third party network). Recognition and acknowledgement of the reality of a person's situation, (e.g. noisy house, little money, few opportunities, cumulative traumas) was also asserted as an important and difficult aspect of the work.

Participants also discussed the importance of working within the capacities of the person in delivering psychotherapy to people with learning disabilities. It was proposed that therapists would need to be acutely aware of the abilities and inabilities of the people they were working with (particularly cognitive abilities) and to work within the reality of that boundary. This would typically require clarification of ideas, repetition of material and meanings, simplifying language, and taking responsibility for remembering links between material and sessions. In addition there was an assertion that consideration of a person's other needs (emotional and physical) would need to be taken. The reality that people with learning disabilities are often dependent on third parties was also noted, with an acknowledgement that a person's network has a stake in the person's well being, and may want to exert their own influence on the therapy either in terms of directing the content of sessions, or in other cases having a stake in seeing therapy cease or be unsuccessful.

iv. Theory:

In describing the philosophies and practice of psychoanalytic/psychodynamic psychotherapy with people with learning disabilities, participants identified with a number of core theoretical concepts. In the main, these were drawn from:

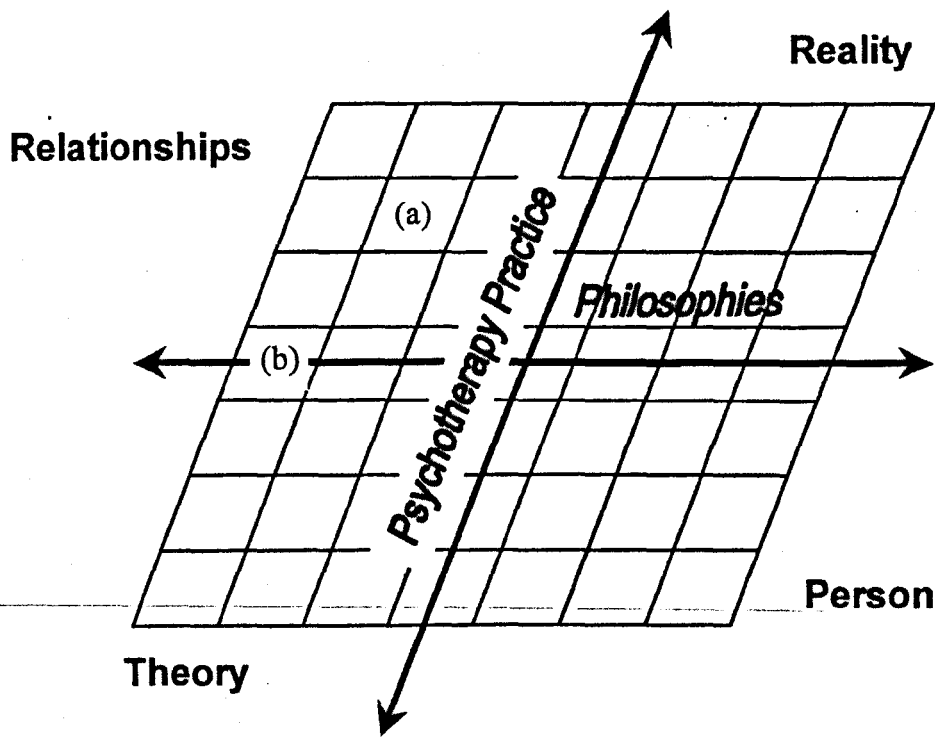
- Traditional psychoanalytic theories – particularly Freudian and Kleinian theories, specific reference to ideas around object relations and projective identification. Concepts around transference (core-concept) and unconscious defences (core-concept) also linked closely to psychoanalytic theories.
- Attachment theories particularly those relating to the primal, mother-child relationship. Participants described ideas around issues of containment & holding (core-concept) linking to theoretical ideas put forward by Winnicott and Bowlby.
- Systemic theories around how a person links to society and is influenced by the system they are in. Participants drew on general systemic ideas to help formulate people's difficulties with respect to relationships and self-image, but the *practice* of therapy did not draw on systemic therapy models.
- Developmental theories relating to the formulation of a person's abilities with respect to typical developmental stages in a person's life. Participants drew comparisons between learning disabled adults cognitive capacities and those of developing children in order to formulate understandings of capacities and understanding.

### Development of a Model Grounded in the Data:

The final stage of the grounded theory procedure was the proposal of links between core-concepts and abstract themes to develop a model of psychotherapy with people with learning disabilities.

The data generated through the interviews were notable for their consistent deviation from the practice of psychotherapy into more philosophical areas. In trying to make sense of the data it seemed important to explore this interaction between practice and philosophy further. Using a modified axial mapping procedure (Strauss & Corbin, 1998) it was possible to generate a diagrammatical map of the interaction between the practice of psychotherapy with people with learning disabilities and the philosophical underpinnings of the work.

Placing each of the four abstract themes along the four sides of a parallelogram, and overlaying two crossed axes representing psychotherapy practice (y-axis) and philosophies (x-axis), enabled the development of a 2-dimensional map. This provided a framework within which links between concepts and categories could be constructed forming the basis of a model of psychotherapy encompassing both philosophies and practice (See Fig.1 below). Psychotherapy Practice can be conceptualised as the manifestation in reality of a theoretical model of helping. As such it can be positioned along the y-axis of the map. Philosophies underpinning the work are drawn more from beliefs about the impact of relationships and internal processes within a person, and as such can be positioned along the x-axis of the map. Both axes reflecting increasing influence towards the poles.



**Fig1: Axial Map**  
 Showing interaction between abstract themes, philosophies & practice of psychotherapy.  
 Based on Strauss & Corbin (1998)

Using the axial map as a template, core-concepts were positioned onto the map based on their relation to each of the abstract themes. Below are two examples to demonstrate this process:

**i. Core-Concept: Difference & Disability:**

This core-concept (See p15) manifests within all four themes: Relationships, Person, Reality and Theory. Its position on the axial map is therefore determined by the degree to which it relates to each theme. On consideration, it was placed in position (a) (See Fig.1). Its position to the left of the centre reflects that it relates more strongly to the Relationships theme than the Person theme. The rationale behind this was that feelings of difference resulted from comparison with others, disability being a societal label for a person's inabilities relative to a perceived norm, and whilst also reflecting a personal experience it was the existence of others and the relationship with them which defined someone as different and disabled.

The concept's position between the 2 themes of reality and theory was towards the top of the map, as the concept was perceived as reflecting more of reality than a theoretical notion. In order to consider how this core-concept was influenced by practice and philosophies of psychotherapy, its position on the map was considered with respect to its distance between the centre and each of the poles. In position (a), the concept was equally distanced from each of the poles of the x and y axes, reflecting an equal influence of philosophy and practice.

**ii. Core-Concept: Intimacy:**

This core concept (See p19) was placed in position (b) (See Fig.1) based on its relationship to the 4 abstract themes. It was felt that the perception that people with learning disabilities had limited experience of intimate attachments with others, related much more strongly to their relationships with others than to them as an individual person. Intimacy was therefore mapped to the extreme far left of the map. Its position along the y-axis was more complicated due to its association with both theory and reality. A lack of intimacy was perceived to be a very real experience for a person with a learning disability, but was also perceived to be a theoretical notion based on assumptions and subjective ideas of intimacy and early infantile experience. The concept was therefore positioned centrally along the y-axis to reflect its equal association with both reality and theory.

Looking at how the core-concept of intimacy relates to the philosophies and practice of psychotherapy, it is clear that the concept reflects a much more philosophical than practical aspect of delivering therapy, it's position being to the far pole of the x-axis and centrally placed along the y-axis.



Following the axial mapping process, greater understanding of the data, their core-concepts and their interrelatedness was developed. From this it was possible to propose links between core-concepts and develop a general model of psychotherapy with people with learning disabilities.

In attempting to draw together a model, links were made between the underlying philosophies and the practice of therapy (core-concept groupings). Often multiple philosophies informed a single practical concept. The links typically developed as rationales for practice, based on the underlying philosophies. Some of these links were explicit in the data, whilst others required interpretation. Many links between core-concepts and themes have been identified and described in the description of the abstract themes, but some of the more concrete links proposed between core-concepts are considered below, and summarised in Table 1 within the framework of an overall model.

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#### Links between practical and philosophical concepts and rationales:

- The concept of Privacy links to the philosophies that people with learning disabilities have disordered attachments with other people, do not have experience of Containment & Holding and are Reliant & Dependent on others. The rationale is that in order to develop a relationship in which an alternative experience can develop, the boundaries of therapy need to be controlled to minimise outside influences, and to enable an intimate relationship to develop. Within a private 1:1 relationship the person can feel more able to discuss their thoughts and feelings without fear of consequences from people outside of therapy. Therapists are also more able to attend to what is said and done by the person in sessions, and are more able to contain the

material and emotions arising. It also enables the person to feel separate from the network on which they are usually dependent and enmeshed with.

- The concept of being Consistent links to the concepts of people with learning disabilities having disordered attachments with other people and of experiencing Trauma & Vulnerability. The rationale for this was that a consistent environment enables the person to predict what will occur in sessions and subsequently have a greater sense of safety and be more able to relax and attach to the therapist without fear of harm.
  
- The concept of Communication links to the philosophies of attachments with other people, Difference, Impairment, Damage & Value and Inability & Disability. The rationale for these links was that by actively trying to communicate with a person, and showing interest in them, they can begin to feel that they have some worth. By removing the responsibility for any communication difficulties from the person and making it the responsibility of the dyad, the person can also begin to develop alternative ideas about inability and disability and subsequently how they perceive themselves and their disabilities.
  
- The concept of Gentle, Warm, Caring & Genuine links to the philosophies of Trauma & Vulnerability; Pain & Loss; and Reliance & Dependency. The rationale for these links is that people with learning disabilities are vulnerable and have had experiences of being persecuted, hated and rejected, and are often treated in a cold and non-emotional way. Subsequently, in order not to be perceived as persecutory, hating or rejecting, therapists must offer an affective experience which takes account

of the person's history of trauma and subsequent expectation of harm in future interactions with people.

- Respect, Equality & Empowerment links to the philosophies of Difference, Impairment, Damage & Value, and Power & Control. The rationale for linking these core-concepts is that in attempting to offer an alternative experience within therapy, which enables changes in beliefs a person holds about themselves and their place within society, therapy must relate to the person in a way which shows that they have worth and merit. This challenges notions of low-value by respecting the person and the choices they make and empowering them to make choices, and by offering an alternative experience to one in which the person is always the least powerful person.
- Attentive, Observant & Interested links to the philosophies of Transference and Behaviour & Secondary Handicap. The rationale behind linking these concepts together, is that it is through giving maximum attention and being interested in the person, observing aspects of their behaviour and thinking about the meaning of the available material that the therapist can make links and develop thoughts about the person through use of transference feelings. This is the therapists' action in the therapy, and also informs the therapist about the dyadic relationship and impact of interpretations.
- The practice of being Interpretive links to the philosophies of Unconscious Defences, power & control and attachment to others. The therapist *interpreting* potential meanings from within the material. Interpretations are attempts to bring into consciousness aspects of the person, which were previously unconscious/un-thought.

The interpretation is an attempt to share an understanding and in doing that connect with the person in a safe way which is not domineering or controlling, and which is not telling the person how they are but is offering a potential meaning which can be agreed with or disagreed with.

- Tolerant, Accepting, Understanding links to the philosophies of Containment & Holding and Inability & Disability. The rationale for linking these concepts was that therapists would be aiming to tolerate the experience of being with a person with a learning disability in a way which previously people had found difficult. This process of tolerating the difficulties, inabilities and painful experiences which a person with a learning disability brings to their interactions, and accepting them with all these difficulties is based on a desire to contain that person's experience and in doing so make the emotions and subsequently the person feel bearable and able to engage in society without fearing that they will harm others.
- The Experiential concept links to the philosophy of people with learning disabilities having disordered/disorganised attachments to others. A key aim of therapy is to offer an experience of an intimate relationship in which people can develop alternative understandings of themselves, others, society, and their role in it. The whole therapy is based on a philosophy that an alternative experience of a relationship can be helpful in enabling the person to connect with the world and develop insight through consideration of themselves from within a relationship.
- Intimate links to the philosophies of people with learning disabilities having and Disordered attachments with other people. The rationale for this link is that people with learning disabilities have relationships with people in their lives which are not

intimate and which limit that person's ability to experience themselves as truly connected to someone else. Intimacy within therapy reflects the need to have a close, connected relationship with the person in order that they can experience themselves as attached to others and subsequently experience themselves as part of a wider whole.

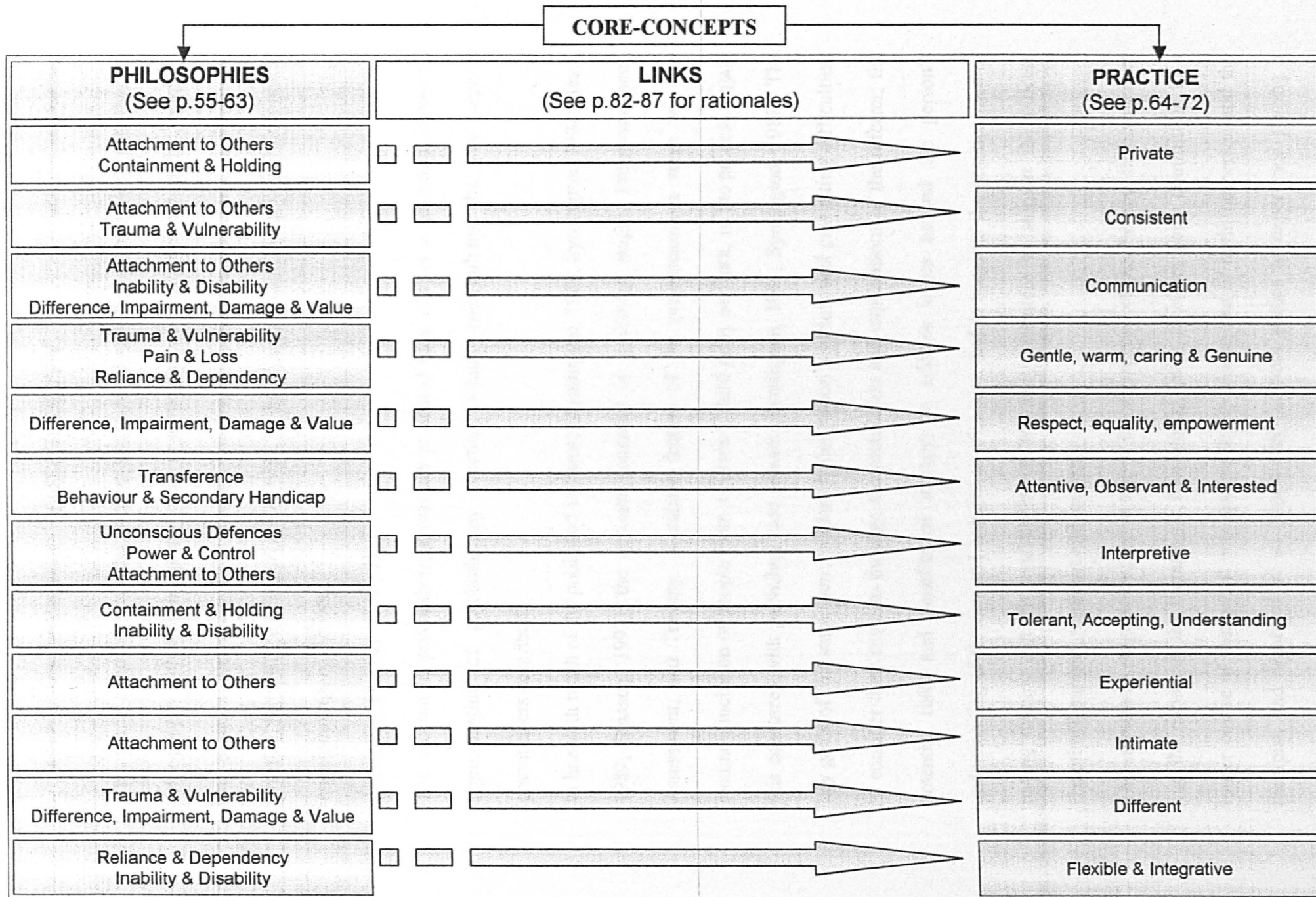
- Different was linked to philosophies of Inability & Disability; trauma & vulnerability and Difference, Impairment, Damage & Value. The rationale for these links was that therapy with people with learning disabilities aims to offer a different experience of being with another person than previous experiences. It needs to take account of, and acknowledge the differences in ability between the therapist and the person with a learning disability, and to offer an experience where this does not infer a value judgement. This link also reflects that the experience of a person with a learning disability is fundamentally different to that of someone without a learning disability. As such being different and being able to tolerate that difference is central to accepting that person and having a genuine relationship with them.

Difference also exists between therapy with this group and more traditional therapy, which are based on philosophies of trauma and vulnerability, and the realities of people's abilities, and the constraints of the systems in which they exist.

- Flexible & Integrative links to philosophies of Reliance, Dependency & Vulnerability and Inability & Disability. The rationale behind these links is based on the idea that people with learning disabilities are very different and are not all the same. They are at least as disparate as people without learning disabilities in terms of their personalities and abilities (cognitive, physical, emotional). Therapy therefore needs to reflect this diversity and not presume that "one size fits all". Flexibility in

terms of accommodating peoples needs (physical and emotional (e.g. phobias) needs to be a central part of the work. Linked to this is the need to be integrative, and accept the reality that people with learning disabilities bring with them a network of people who provide support and care and who have a stake and investment I the person. Negotiating the degree to which a person's network is involved in therapy and integrates with the process is a core consideration of providing psychotherapy to this group.

Table 1 – Model of psychotherapy with people with learning disabilities – from Philosophy to Practice



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## *DISCUSSION*

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This study contributes to the limited literature around psychoanalytic psychotherapy with people with learning disabilities. In particular it identifies some of the technical and practical elements of the therapy, identifying a consistent account of therapists' practice, proposing a wider model of work in the area, and identifying key philosophical underpinnings of the work.

Account of Practice: (See p51)

The account of psychotherapy practice presented (See p51) is a generally sequential representation of psychotherapy practice, which encapsulates the key aspects practitioners described.

In line with much of the published literature (Symington, 1981; Symington, 1988; Beail, 1989; Sinason, 1992), the account consisted of 3 distinct stages: Pre-Assessment, Assessment, and Therapy. A salient feature of the pre-assessment stage was the common inclusion of people from a person's third party network, in the process. Again this concurred with published case reports (Symington, 1981; Symington, 1988). The key goals of this stage were to identify the person's history and presenting difficulties; to consider their route to therapy; the motivation and expectations of the referrer; the potential risks and benefits of therapy; to address issues around the person's understanding of therapy and consent to take part; and to consider the practicalities of having therapy and the availability of necessary resources to support the process (emotional support, transport and escorts).

The assessment stage attempted to mirror the experience of the therapy, its boundaries and the nature of the therapeutic relationship, prior to either party committing to a longer course of therapy. It was notable for its assessment of both the person and the therapist, and described as an opportunity for both parties to experience sharing a



therapeutic space together, gauging their ability to tolerate this experience and determine if they felt there was beneficence in engaging in a therapeutic experience together.

If both members of the dyad were deemed able to tolerate the therapeutic experience, then the therapeutic stage of the process would begin (See p51). A salient feature of the therapeutic stage, was the communication between the therapist and person, which was not limited to verbal communication, but which aimed to maximise the total communication within the dyad and commonly incorporated role-play, art, visual aids, play, physical action or touch. This was similar to case-reports, which described the use of play, toys and expressive materials (Symington, 1988; Simpson, 2002; Hodges, 2003). Subsequently, communication varied dependent on therapists' communicative strengths and weaknesses (verbal, dramatic etc.) and clients' strengths and weaknesses (verbal, visual etc.). Typically communication from the therapist to the person was simplified to various degrees through the use of language appropriate to the person's developmental abilities; use of short statements reflecting the person's working memory capacity; being repetitious appropriate to the person's short-term memory capabilities; and concrete with respect to the person's ability to understand abstract themes, principles also asserted in key texts in the area (Brandon, 1989; Sinason, 1992; Hodges 2003; Beail & Newman, 2004). Another key feature of the communication within the dyad was that the therapist would be cognisant of the person's vulnerability to feeling persecuted and pressurised to do something for the therapist, and would therefore be gentle in their communications and avoidant of demanding responses. In terms of communication from the person to the therapist, participants asserted that people with learning disabilities were more likely to represent abstract and unconscious desires literally and physically rather than verbally. An example of this was when head banging

was described as representing a desire of a person to get thoughts out of their head. This was described in terms of high levels of “acting-out” and “acting-in” behaviours.

A notable feature of the therapy was the assumption of five key issues, which were felt to cause difficulties for all people with learning disabilities who present to psychotherapy services.

1. Disability: Participants described a key issue in therapy being the difficulty people with learning disabilities have acknowledging their disabilities. Enabling acknowledgement of their disability was seen as an important part of all therapeutic work with this group
2. Dependency needs: Very much linked to the acknowledgement of disability, was the extrapolation of this to acknowledging one’s own dependency on other people, and the consequences of this.
3. Loss: Linked to the themes of disability and dependency was the assertion that therapy should address the feelings and realities of loss for a person with learning disabilities (abilities, control, choice, relationships, opportunities).
4. Sexuality: The notion of sexuality was described as important in developing a person’s sense of being a living, affective, feeling entity. Identifying sexual needs and the barriers to intimacy present in the lives of people with learning disabilities was described as an important aspect of the therapy process.
5. Annihilation: The issue of annihilation reflects participants’ perceptions of a feeling amongst people with learning disabilities that they are so impaired, damaged and burdening on others that it would be better if they didn’t exist. This theme was central to participants’ formulations of many presenting difficulties.

Another salient feature of the therapy was the use therapists made of third party reports of behaviour and between session affect in order to inform their understanding of the person and measure the impact of the therapy.

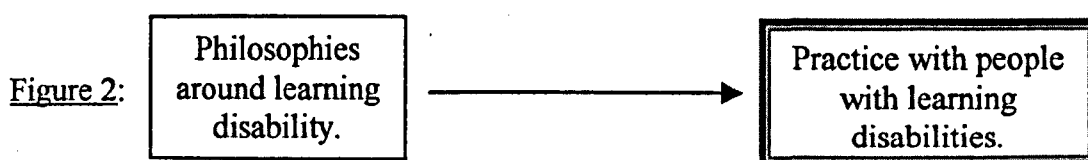
### Model of Psychotherapy:

An important issue relating to this study is that the model proposed was emergent rather than theoretical. That is to say that the model proposed was one which was identified from practitioners accounts of their practice, and as such may not reflect what practitioners intended to do or what they would proclaim as their ideal.

### - Philosophies & Practice:

A key feature of the proposed model was the role of philosophical notions of disability; attachments with other people; the impact of society on a learning disabled person's life; implicit and cumulative traumas; and the action of a person's unconscious. Philosophies relating to the experience of living with a learning disability were linked to descriptions of psychotherapy practice such that the emergent model was one where practice and philosophies combined. The complimentary nature of the philosophies and practice was such that it prompted consideration of their origins.

Potentially, the association is a simple one in which philosophies inform practices. This rationale assumes that practice develops from earlier philosophies (i.e. the philosophies exist before the practice) (See Fig.2).



However, alternative explanations are possible. Consideration of the history of the psychoanalytic involvement with people with learning disabilities reveals that the practice is relatively new - earliest accounts of work dating back to the early 1980's, with a case report by Symington, 1981 (Beail, 1989; Frankish, 1989; Sinason, 1992). Practitioners at this time predominantly had histories providing generic psychoanalytic



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between two adults rather than an adult and a minor. As such issues of respect, power, equality, sexuality and the age-appropriateness of interventions are fundamentally different. In addition the experiences of trauma, pain and loss described by participants would distinguish the proposed model from that used with children. It is prudent to note however that these considerations may parallel aspects of therapy with other non learning-disabled clinical populations who have experienced traumas (e.g. victims of abuse, people with physical disabilities). Taken as a whole therefore, the proposed model represents a unique amalgam of practices, which individually are not specific to psychotherapy with people with learning disabilities.

- Theory:

The proposed model of psychotherapy was partly based on participants' explicit descriptions of theories informing their practice (psychoanalytic theories - transference & counter-transference (Freud, 1904); attachment theories - holding (Winnicott, 1962), maternal containment (Bion, 1959); and developmental theories - infantile projections (Bion, 1959)). However, consideration of the data revealed that many aspects of the proposed model had links with theories, which were not stated explicitly by the participants. The concept of secondary handicap could be conceptualised as a behavioural manifestation within people with learning disabilities, of Freud's (1901) notion of secondary gain. In addition, the acknowledgement of disability and loss, and experience of pain described within the five mutative themes which are considered in therapy, could be described in terms of Melanie Klein's (1923) theories of paranoid-schizoid and depressive positions – healthy insight developing from acknowledging and experiencing the pain of reality. Similarly, the mutative theme of annihilation, in which a learning disabled person feels so damaged and disgusting that they have unconscious

desires not to exist, could be described as the manifestation within a person with a learning disability of Freud's (1920) death instinct.

In considering the findings in these terms, it could be argued that the proposed model offers little to understanding the field of psychotherapy with people with learning disabilities that was not previously present in the literature. The counter argument to that is that the study has clarified the practice rather than developing it or adding to the theoretical understanding of the work. In quantifying what the study has achieved, it is important to note what was missing in the literature previously. The literature was not bare with respect to theoretical representation, rationale or efficacious evidence, but was notably missing a description of practice. It is this gap in the literature, which this study aimed to address, and it is hoped that the model proposed can sit comfortably alongside the existing literature in the field.

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## CRITIQUE

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### Methodological Limitations:

Grounded Theory (Glaser & Strauss (1967); Strauss & Corbin (1998)) was selected as the method of data analysis, because it was a recognised and robust qualitative method of data analysis (Morse & Richards, 2002), which aimed to “*understand the action on a substantive area from the point of view of the actors involved*” (Glaser, 1998). It contrasts with many other qualitative methodologies such as IPA, which are more focussed on identifying the essence of an experience (Denzin & Lincoln, 1998).

The methodological limitations of Grounded Theory in the present study were largely related to the nature of the data. The descriptive qualities of participants’ reports meant that an emergent account was identified early in the analysis prior to developing abstract themes. Following true Grounded Theory methodology, models should emerge following abstraction of data, which conflicted somewhat with this study. Subsequently the proposed model was developed from concrete concepts, then conceptualised within abstract terms, before being re-grounded again within a concrete model. This was not a wholly paper exercise however as the process of developing abstract themes facilitated greater understanding of data and consequently informed the final model proposed.

The other key methodological issue arising from the study was the data. During the analysis it became clear that the quantity of data collected (which exceeded 135,000 words) was in excess of what was optimal for a study of this scale. The conflicts around this were partly methodological and partly arose due to the context of the study. Methodologically, the quantity of data could have been reduced through greater specificity of the interview schedule, although this needed to be balanced against being non-directive, a central philosophy of qualitative analysis. The other pressure with regards to the quantity of data collected was the context of the study, which formed part

of a doctoral qualification in clinical psychology. As such there were academic demands in terms of the number of participants included in the study, which conflicted with the methodology of Grounded Theory, which asserted that data collection should cease following saturation of emergent themes. In the present study saturation of themes occurred after 5 interviews, but data collection (and analysis of that data) continued until 8 interviews had been carried out in order to meet course requirements. The consequence of this was that data was repetitious, arduous to analyse and the study became more voluminous than was necessary. Reporting this within the word limits of the study required simplification of themes and under-representation of evidence from the data.

#### Validity, Reliability & Generalisability:

Validity of the study was strengthened through the homogeneity of the sample. Participants were all full members of the Institute of Psychotherapy & Disability, and met the criteria for that membership (See Appendix 8).

Internal validity is measured through assessment of both the descriptive and interpretative validity of the study. Descriptive validity considers the degree to which the account represents the data collected. In this respect the methodology was robust, as the account was wholly emergent from the data. Descriptive validity was further safeguarded through triangulation of emergent themes with a 3<sup>rd</sup> party through supervision. This involved comparison of raw data with emergent categories and concepts at different stages of analysis. Interpretive validity considers the degree to which emergent themes represent participants' viewpoints, thoughts, intentions and experiences. To ensure interpretive validity, clarification of the researcher's understanding of the data was made during data collection. The findings appeared to have interpretive validity as they typically triangulated with participants' views expressed in existing literature. Interpretive validity could have been increased through relaying findings back to participants and seeking feedback. Unfortunately this was not achievable within the timeframe of the study. An



additional consideration was the impact of the researcher's subjective influence on the emergent data. The researcher's perspective was influenced by being a post-graduate clinical psychologist completing the study as part of the academic requirements for conferment of a doctoral qualification in clinical psychology. Subsequently there were influences on the researcher's perspective other than that of curious investigator. In addition the researcher had professional interests in psychoanalytic psychotherapy and learning disabilities, both independently and in relation to each other. These interests meant that the emergent data was subject to interpretation based on prior knowledge of psychoanalytic concepts and common ideas relating to psychological thinking around learning disability. There was an additional influence due to the researcher's knowledge of some of the participants, from literature they had published in the field of psychotherapy in relation to people with learning disabilities. The potential influence of this was that all interview data was not treated equally and that data which reflected the researchers existing understanding or came from participant's who the researcher felt were highly eminent may be more likely to be identified with in the analysis process.

External validity considers the theoretical validity and generalisability of findings. Theoretical validity considers the degree to which findings support previous theory. As previously described the findings broadly compliment existing psychoanalytic and learning disability psychotherapy literature. Generalisability considers the degree to which findings apply to wider audiences than the participants in the study. In this respect, application of findings may be limited because of the specificity of the area investigated, and the small numbers of practitioners in the field. However, there were high levels of concordance between participants' reports, which is likely to reflect common understandings between practitioners. In addition, the model proposed shares much with other psychotherapy models (adult and child) and may have application with these groups or with other specific clinical populations (e.g. physical disability or psychoses).

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## *CONCLUSIONS*

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The aims of the present study were:

1. To establish whether practitioners could identify a clear and consistent account of psychoanalytic/psychodynamic psychotherapy practice with people with learning disabilities.
2. To generate a working model which adequately described the practice of psychoanalytic/ psychodynamic psychotherapists working with people with learning disabilities.

From the results, it is clear that the first of these aims was achieved, participants reporting a consistent account of their practice with people with learning disabilities (See p51).

The second aim of developing a model of psychotherapy with people with learning disabilities was achieved through the proposal of links between core-concepts arising from the data, and consideration of abstract themes (See p46).

24 core-concepts were delineated from recurrent categories in the data and from these 4 abstract themes developed. A key feature of the proposed model was that psychotherapy with people with a learning disability was not a purely practical, technical activity, but one which drew heavily on philosophical notions of disability, society, trauma and unconscious protective processes. Development of the model involved consideration of underlying philosophies and their association with practice. The model proposed was perceived as similar to traditional psychoanalytic psychotherapy, whilst having significant differences. The scope of the present study did not enable comparison of the proposed model with other psychoanalytic therapy models, but did provide a concise account of practitioners' practice, which may enable this to be taken up at a later time.

The central principle of the model impressed by participants through the data was that therapy was an attempt to connect people to the world, to help them identify themselves as a part of a wider society, and to help them to understand their place in it.

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## ————— *CRITICAL APPRAISAL* —————

In carrying out this study, a number of key learning points emerged for me, which I will discuss below charting a roughly chronological route through the research process.

The process began with the selection of a research topic for which the broad criterion from the course of “... *any topic area from clinical psychology...*” was a double-edged sword. On the one hand there were seemingly infinite options of potential areas to research into – with few constraints; whilst on the other there were seemingly infinite options of potential areas to research into – with few means for deciding which. As the study would entail considerable time, thought and effort, I decided to research an area that was of interest to me clinically and could link to my development and learning as a clinician as well as my development and learning with regards to research skills. At the time (June 2002) I had recently finished a core placement in learning disabilities during which, I had become very interested in the provision of psychoanalytic and psychodynamic psychotherapy to learning-disabled adults. Through discussions with my placement supervisor and examination of some of the published literature, a question emerged around what the practice of providing this particular therapy to this particular clinical population entailed. This formed the basis of an initial research proposal, which I submitted to the university (October 1002). I easily identified my learning-disabilities placement supervisor an ideal research supervisor for the study as he was well versed in both the topic area, supervision of doctoral theses and publishing research generally, and was keen to be involved in the study, seeing it as a relevant piece of work in the area. As a member of the course team, he could also fulfil both the

NHS supervisory role and the university supervisory role, a matter discussed in more detail later in this appraisal.

Submission of Research Proposal (February 2003):

Submission of a more in-depth proposal detailing the literature around the selected topic and methodology proposed for the study, required greater consideration of the nature and process of investigation and focus of the research. Due to the vast quantity of literature around the provision of psychoanalytic and psychodynamic literature to non learning-disabled adults and children, a comparative study was not deemed to be within the resource capabilities of this piece of work. In addition, the focus was more towards the practice rather than the theoretical ideal of providing therapy to this group. In terms of the methodology, it seemed clear that the study was more suited to a qualitative approach, in that the aim was to explore what was happening rather than to evaluate or measure (quantify) what was happening in any way. Following the limited teaching and experience I had around qualitative methodology, I initially submitted a proposal which aimed to analyse the data using IPA. This was based purely on the fact that I was relatively ignorant of other qualitative methodologies. Following a review of the proposal by the department's research sub-committee, it was suggested that further investigation and familiarisation around different qualitative methodologies took place. This was to be the start of a long learning process for me around the nature and philosophies underpinning qualitative research. Following some exploration into different methodologies, the proposal was resubmitted with a Grounded Theory (Glaser & Strauss, 1967) methodology at its core. This was chosen because its aim was to "*understand the action on a substantive area from the point of view of the actors involved*" (Glaser, 1998).

At this stage of the research process, there was also a concern about the nature of the study, being descriptive rather than evaluative or comparative. This was anxiety provoking for me as someone inexperienced in qualitative research, who had been educated largely as a scientist, measuring phenomena and using statistical analyses to support or oppose hypotheses. In this study, there were no hypotheses to address, and the reassuring boundaries I was used to when carrying out experimental studies were subsequently absent. I was particularly concerned that the study be scientifically valid and rigorous, and that it would be acceptable for conferment of the doctorate I was pursuing. From reading the literature, I was reassured by assertions of the validity of qualitative research. My supervisor also assured me that identifying a model of practice in the area was not something which could be addressed by a simpler means (i.e. asking practitioners collectively what they did in their work) as the field was very small and practitioners were disparate and unable to easily convene. In addition, the present study enabled greater expression of practice by affording anonymity to the participants. Interestingly, my fears around the study's suitability for a doctoral thesis were shared by one member of the research sub-committee and aired in the review meeting of the submitted proposal. Following a discussion between the members of the research sub-committee, my supervisor and myself however, it was agreed that the present study was appropriate for a doctoral research project and approval to continue granted.

The key learning points for me at this stage were around educating myself about the nature and value of qualitative research, and of the different applications of various qualitative methods (e.g. describing a substantive area/practice from the perspective of those involved [Grounded Theory], or capturing the essence of what an experience feels like [IPA]). In progressing through this process, I also developed a greater sense of what



I was aiming to achieve through the research, and focussed more specifically on the nature of the investigation.

Ethical Approval, Governance & Indemnity:

Following approval of the research proposal by the research sub-committee, I applied for ethical approval, research governance and indemnity. This was to prove a more arduous and prolonged process than I had envisaged, extending over six months. The proposed study recruited participants nationally, employed in multiple settings, by differing employers. I was originally advised therefore that I seek ethical approval from the national multi-site ethics board for research conducted within the NHS, the Central Office of Research and Ethics Councils (COREC). At that time (June/July 2003), COREC were implementing a standardised form, which covered all research studies carried out in the NHS. They were clearly in a stage of transition, developing from multiple, disparate councils with individual processes and administrative procedures, into a centralised office with a standardised process. Not only were COREC in transition, (which led to three changes in the application form I had to fill out) but the study I was applying approval in respect of, also seemed incongruous to their process. Following submission of an application, I was repeatedly (three times) contacted to provide more details of the nature of the participants and materials I would be using which were detailed in the form under headings such as “...*use of live tissue samples...*”; “...*health status of living participants...*”; “...*risks of contamination/infection...*”. The form whilst standardised was clearly not particularly

suiting to an application for a qualitative study interviewing healthy psychotherapists about their work. During one of a number of telephone exchanges with the COREC office (November 2003) relating to my now second application, I was told that as the participants I would be interviewing worked predominantly in the private sector and not typically for the NHS, COREC was probably not the most appropriate ethics panel to apply to as they could not approve on behalf of non-NHS bodies. Following this enlightening and somewhat frustrating exchange, I discussed my options with my supervisor and the chair of the research sub-committee, who advised that I did not require COREC approval for the study so long as I ensured that participants were interviewed in their capacity as private practitioners and not in respect to their NHS work, and interviews did not take place on or make use of NHS resources. After making the necessary changes in the proposed methodology, I applied for ethical approval from the University of Sheffield, Psychology Department's Ethics Board, and approval was quickly granted (December 2003). Governance registration and Indemnity insurance were also applied for from my employer and these were obtained without difficulty.

Working through the minefield of getting ethical approval for the study, forced me to consider in more detail the parties on which the study may impact, and the potential influence of the research. Although not welcomed at the time, my struggle with the application to COREC and my dealings with them, also educated me a great deal around the process of gaining ethical approval for research in the NHS and research involving multiple sites.

#### Selection of Participants & Data Collection:

Following ethical approval of the study, I could begin to proceed with the research project proper. This involved the recruitment of participants and collection of data.

Central to the recruitment of participants, was my supervisor's position as a director of the Institute of Psychotherapy and Disability (IPD). IPD members had previously stated a desire for a research project of this type to be carried out, and agreed in principle to act as participants. My supervisor contacted the other directors of the institute and asked if we could have permission to approach members to invite them to volunteer for inclusion in the study. This permission was granted and members were approached via an open letter or email. 14 members volunteered to be interviewed as part of the study, and eleven interviews were arranged. Saturation of themes occurred after five interviews, but data collection continued due to course requirements of a minimum 8-12 participants. The ethics of this was difficult to endorse. Interviewing participants with the knowledge that their time and effort would not in truth add to the evidence, purely to meet the guidelines of the training course rather than that of scientific or methodological rigour was not a comfortable position to be forced into. In hindsight, the power issues in carrying out this research were something I had not been explicitly aware of prior to carrying out the study, I did not want to jeopardise my doctorate by not meeting course requirements but this compromised the ethical integrity of the study. I subsequently considered that in most cases of research there are likely to be outside influences, which may prevent the process from being a purely scientific pursuit (commissioning bodies, financiers, university deadlines, publication requirements etc.) It should be noted that I do not feel that my interviewing of additional participants caused them any harm or influenced the validity or reliability of the findings. Consideration of this matter deviates somewhat from the process of data collection I was describing, in which ten participants were interviewed. Of the eleven interviews arranged, one participant cancelled, one participant identified themselves as not being homologous with the rest of the sample during the interview and was excluded from the study (they were a CBT

therapist), and one interview was not captured adequately on tape and was not able to be transcribed. This left eight sets of interview data for analysis. All the interviews took place between February and April 2004.

A key point of interest for me around this stage was the ease with which participants were recruited to the study. I was struck by their readiness to be involved and wondered about the role of my supervisor in getting access to such a motivated and available sample. I considered what a different experience it would have been if I had not had access to this sample and if recruitment had been more arduous and taken longer. Certainly my delay in getting ethical approval would have proved more significant. Ironically, it was the ease of recruitment which led me to note the potential consequences of poor time keeping (not meeting deadlines, getting sufficient data to complete the study) and to be thankful for my relatively painless data collection process. Seeing peers struggling in this respect with their own projects made this all the more notable, and assured me of the importance of managing time more carefully in any future research I may carry out.

#### Transcription & Analysis:

Following data collection, I sent the tapes of interview data to a third party to be transcribed. The quality of the transcripts was high, and certainly saved me a great deal of time, but there was a considerable period between sending tapes off and receiving the transcripts back, which was not without anxiety. In my dealings with the transcriber, I typically asserted that there was no rush to get them back to me as I had other work to do. This in part I think was due to my discomfort in employing someone else and the position of power this put me in, and I struggled with this throughout this process. I am sure that it would have been more helpful had I been more assertive in requesting a

quick turnover of the tapes, as peers on the course using the same transcriber would receive transcripts back much more quickly than I did. The learning for me was around the use of third parties and contractors whilst also keeping control of the process, an area where I feel there remains room for improvement. Transcripts were returned in batches of two, during May and June 2004, which meant there was quite a time pressure in order to get the data analysed and written up for the deadline at the end of July.

A degree of self-awareness and recognition for my own working methods meant that I had elected to take an extended research block four weeks prior to the deadline rather than taking one day each week throughout the year. This period was enormously useful for me given the delays in data collection and receipt of transcripts, and enabled me to focus all my attentions on the study with limited distractions from clinical placement commitments. The most striking thing I realised on receipt of the transcripts was the volume of data I had collected. Each of the eight interviews had lasted around one and a half hours, which yielded around 400 sides of A4 type and in excess of 150,000 words. The size of my task began to dawn on me. I had a real sense at this time that I had bitten off more than I could chew and that I had gathered so much data that it was crippling me. I resented the course guidelines for "making" me collect more than I needed, and masochistically sat up all night, locked away vowing that this mass of data would not beat me. Eventually a sense of order and form emerged, and after weathering the storm I was able to reflect that if I had my time over, I would probably be more boundaried with respect to the interviews, control the content and focus a little bit more, certainly go into it with my eyes open. I have to admit to having a certain sense of pride for having worked through that mass of raw data though and I know that should I be confronted with a similar experience, I will have a little more self-belief that I can make sense from the chaos. With respect to the process of analysis, I had been conducting

very general analyses of data following each interview based on notes made during the interviews and transcripts as they were received, but in-depth analysis did not really begin until the full data set was compiled. This in itself was a flaw in the study and went against the true methodology of Grounded Theory (Glaser & Strauss, 1967), which cited that analysis of each interview should occur prior to commencing with the next. Because of the delay in receiving transcripts this was not possible, although tentative analyses based on field notes were made. The process of analysis was a steep learning curve riddled with mistakes and reanalysis. Familiarity of the methodology was cited as important for a successful analysis in all the key texts I was reading, (Glaser & Strauss, 1967; Strauss & Corbin, 1992; Denzin & Lincoln, 1998) but the catch-22 I found myself in was that familiarity was described as gained through experience of doing analyses. The consequence was that I had to do many analyses badly and with error before feeling that I had analysed the data to a “good-enough” degree. As a learning exercise I think this process was enormous for me, interpreting the methodology, trying it out, going back to the literature, and making sense of where I’d gone wrong. A major issue was that my supervisor’s expertise in qualitative research lay in IPA, not Grounded Theory. An error on my part had been to assume that it was a benefit to have only one supervisor who fulfilled both the NHS and university supervisory roles, having a second supervisor would have provided an extra brain with which to make sense of the methodology and they may even have had some experience of using the technique. As it was, the analysis and learning was a pretty solitary journey, my supervisor’s availability was limited, and as I’ve said, his expertise was elsewhere. Subsequently, there was an anxiety around whether my “good-enough” analysis was “good-enough” by anyone else’s standards. I remember the day I took a draft to my supervisor for comments. It felt like I was introducing a baby to the rest of the world for the first time.

Was it ok? Was it healthy? The sense of relief I felt when my supervisor shrugged his shoulders and told me that it seemed okay - a bit repetitious perhaps and some typographical errors dotted around but it seemed alright. I could have jumped for joy. It was only on consideration of my relief that I realised how isolated I had made myself and subsequently how anxious I'd been. In any future research, I would certainly ensure that I had better links with supervisors or co-researchers, and made use of them along the way.

Writing up the study (July 2004):

In terms of writing up the research project, I think the key themes for me have been around time-management and isolation. With respect of time management, I recall sitting for hours on end forbidding myself to get up or do anything else. My life stopped, I didn't go out socially, I didn't do anything to relax - hobbies and sporting activities were ousted in favour of staying in and staring at a computer monitor for hours, to the neglect of my family. But the time spent was not efficiently used. I would have been more effective if I had allowed myself breaks and worked efficiently for a few hours at a time instead of attempting to work solidly all day every day. It would have been healthier as well. Perhaps this links to my feelings of isolation as well. A big learning experience for me has been that a large piece of work can be managed more effectively by implementing a structure to it, not by applying the same "cramming" approach that is used on smaller pieces of work but on a larger scale. This really reflects the whole research process starting back in June 2002, I think that if I had been able to implement the timetable proposed by the course team, and made use of a similar structure during the write-up, I could have saved myself some considerable stress and anxiety.

The experience has certainly not put me off doing research in the future, far from it. Whilst I may have had an idealised notion of producing the best piece of work possible for my thesis, I have to satisfy myself that it was like all the other pieces of work I have done during my training, a learning exercise. I got it done in time for the submission deadline, and hopefully it is “good-enough”, but I take from it experience and knowledge which can make the next piece better and maybe that’s what it was all about.



## APPENDICES

### **i) Formats:**

- 1- *Editorial Policy for Contributors to "Mental Retardation"*
- 2- *Letter of approval of selected journal for literature review & format of research report from research sub-committee*

### **ii) Ethical Approvals:**

- 3- *Research-Committee Approval Letter*
- 4- *Ethics Committee Approval Letter*
- 5- *Certificate of Non-Clinical Trial Insurance*

### **iii) Measures:**

- 6- *Details of categories (150)*
- 7- *Details of recurrent categories (78)*

### **iv) Other:**

- 8- *Criteria for full membership of IPD*
- 9- *Copy of participant invitation letter*
- 10- *Copy of information sheet*
- 11- *Copy of participant consent form*
- 12- *Copy of interview schedule*
- 13- *Copy of transcriber confidentiality form*

## **APPENDIX 1**

### **Editorial Policy for Contributors to “Mental Retardation”**

# Editorial Policy

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*Mental Retardation (MR)* is a journal of policy, practices, and perspectives in the field of mental retardation. As a journal with an applied focus, MR publishes essays, qualitative and quantitative research articles, conceptual papers, comprehensive reviews, case studies, policy analyses, and innovative practice descriptions and evaluations. The style, methodology, or focus of an article is less important than its quality and contribution to our knowledge. MR publishes journal-length articles, which are subject to peer-review, and commentaries, which appear in a feature called *Perspectives*.

## INFORMATION FOR CONTRIBUTORS: JOURNAL ARTICLES

### Review Process and Editorial Decision:

Articles submitted to MR are subject to review by at least two and usually three anonymous reviewers selected by the Editor or Associate Editor. The review process is usually completed within 3 months of receipt of the manuscript. MR strives toward fairness and courteousness in the review process.

### Criteria for Acceptance:

Articles are judged on relevance to policy or practice, potential reader interest, originality, and clarity of writing. Research articles are reviewed based on standards appropriate to the methodology used in the study. Other articles are reviewed according to scholarly or literary standards. Authors should address the implications of their articles for policy and practice, if not apparent.

### Style:

MR adheres to the 2001 *Publication Manual of the American Psychological Association (APA)*. Manuscripts should be double-spaced on 8½" × 11" paper, with at least 1-inch margins on all sides. An abstract of no more than 120 words should be included. References should be typed double-spaced on a separate page. Articles should not exceed 20 pages in length, including references. Authors are encouraged to submit shorter manuscripts. Highly specialized or technical articles should be 5 pages in length. Because articles are reviewed anonymously, the author's name and other identifying information should appear only on the cover page.

### Submission:

Five copies of manuscripts, including abstracts, and a letter of submission stating that the manuscript is not under review by any other journal should be submitted to Steven J. Taylor, Editor.

## INFORMATION FOR CONTRIBUTORS: PERSPECTIVES

### Editorial Decision:

Commentaries are published in *Perspectives*. MR welcomes thoughtful, well-reasoned, interesting, clearly written contributions. Submissions are reviewed by the Editor and *Perspectives* Editor, who will make editorial decisions usually within a month after receipt of the manuscript. Detailed comments are not provided for manuscripts not accepted for publication in *Perspectives*.

### Style:

Commentaries should not exceed 5 pages. An abstract is not necessary.

**Submission:** Three copies should be submitted to Steven J. Taylor, Editor. A cover letter should clearly state that the manuscript is being submitted to *Perspectives*. Authors should advise the editor if the submission is under review or has been published by any other journal. Include E-mail address, if available.

## GENERAL INFORMATION FOR CONTRIBUTORS

### Language:

MR adheres to AAMR policy regarding the use of "people first language." Authors should use language that emphasizes the humanity of people with mental retardation. Generic descriptive terms such as *people*, *participants*, *students*, *children*, and *adults* are preferred over *subjects* or *informants*. Language should be free of gender bias. He should not be used generically to refer to persons of both genders.

### Copyright Assignment:

In view of the Copyright Revision Act of 1976, if a manuscript is accepted for publication, the author(s) must sign a Copyright Assignment and Agreement conveying all copyright ownership, including electronic rights, to AAMR. Permission to reproduce copyrighted materials for classroom uses is granted.

### Revisions and Corrections:

The editor reserves the right to reject manuscripts that fall significantly short of the standards contained in this editorial policy and to make editorial changes in accepted articles that do not alter the meaning of the text.

### Accepted Manuscripts:

After acceptance, send an electronic copy in WordPerfect or Word on a 3.5" IBM compatible disk to the editor. Authors do not receive galleys. Any changes must be made on the copyedited manuscript, which will be received from the Senior Editor before the paper goes to the printer. For technical questions, contact Yvette Taylor (561) 462-0341. E-mail: ytaamr@aol.com.

### Data-Sharing:

After research results are published, authors do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release.

### Submissions:

Articles should be sent to Steven J. Taylor, Editor, *Mental Retardation*, Center on Human Policy, 805 S. Crouse Ave., Syracuse University, Syracuse, NY 13244-2340.

## **APPENDIX 2**

**Letter of approval of journal of selected  
journal for literature review and format of  
research report from research sub-committee**



**THE UNIVERSITY OF SHEFFIELD**  
**Clinical Psychology Unit**  
**Department of Psychology**

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)  
Clinical supervision training and NHS research training and consultancy

**Clinical Psychology Unit**  
**Department of Psychology**  
**University of Sheffield**  
**Western Bank**  
**Sheffield S10 2TP UK**

Unit Director: Prof Graham Turpin  
Assistant Director : Prof Pauline Slade  
Prof Gillian Hardy

Telephone: 0114 2226570  
Fax: 0114 2226610  
Email: dclinpsy@sheffield.ac.uk

Clinical Practice Director: Ms Joyce Scaife  
Course Administrator: Carole Gillespie  
Prof Nigel Beail

---

21<sup>st</sup> October 2004

Tom Jackson  
Third year trainee  
Clinical Psychology Unit  
University of Sheffield

Dear Tom

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

**Literature Review:** Mental Retardation

**Research Report:** Option A

Please remember to bind in this letter and copies of the relevant instructions to Authors with your thesis.

Yours sincerely

  
Andrew Thompson  
Chair, Research Sub-Committee

## **APPENDIX 3**

### **Research-Committee Approval Letter**



**THE UNIVERSITY OF SHEFFIELD**  
**Clinical Psychology Unit**  
**Department of Psychology**

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)  
 Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit  
 Department of Psychology  
 University of Sheffield  
 Western Bank  
 Sheffield S10 2TP UK

Telephone: ++44 (0)114 22 26632  
 Fax: ++44 (0)114 22 26610  
 Email: dclinsky@sheffield.ac.uk

Unit Director: Prof Graham Turpin (26569)  
 Clinical Practice Director: Ms Joyce Scaife (26574)

Assistant Director : Professor Pauline Slade (26568)  
 Course Administrator: Carole Gillespie (26570)

To: Research Office  
 Sheffield Health & Social Research Consortium  
 Fulwood House  
 Old Fulwood Road  
 Sheffield S10 3TH

**RESEARCH THESIS**

**Approval of Research Project**

Trainee name T. Jackson

University Research Supervisor Nigel Beal

**Title of Research Project**

TOWARDS A MODEL OF PSYCHOANALYTIC PSYCHOTHERAPY WITH  
PEOPLE WITH LEARNING DISABILITIES

I confirm that this research project has been reviewed by the Research Sub-Committee and all necessary amendments have been made. The project therefore receives full approval from the Course.

Signed .....

Date .....

(University Research Supervisor)

Signed [Signature]

Date 9/6/03

(Course Research Tutor)

## **APPENDIX 4**

### **Ethics Committee Approval Letter**





THE UNIVERSITY OF SHEFFIELD

DEPARTMENT OF PSYCHOLOGY

Head of Department

Professor Rod I Nicolson

Psychology Building  
Western Bank  
Sheffield S10 2TP  
Tel: 0114 2226546

Email [r.nicolson@sheffield.ac.uk](mailto:r.nicolson@sheffield.ac.uk)

From: Dr Mark Blades +44 114 222 6549 <http://www.shef.ac.uk/psychology/> [m.blades@sheffield.ac.uk](mailto:m.blades@sheffield.ac.uk)

16th December 2003

To whom it may concern,

Dear Sir/madam,

Tom Jackson

This is to confirm that ethical approval has been obtained by Tom Jackson from our Departmental Ethics Sub-Committee for his project entitled "Towards a model of psychoanalytic psychotherapy with people with Learning Disabilities".

Yours faithfully,

Dr Mark Blades  
Chair of the Departmental Ethics Sub-Committee (Semester 1, 2003-04)



THE QUEEN'S  
ANNIVERSARY PRIZES  
FOR HIGHER AND FURTHER EDUCATION  
1998 2000

## **APPENDIX 5**

### **Certificate of Non-Clinical-Trial Insurance**

UNIVERSITY OF SHEFFIELD

DEPARTMENT OF FINANCE

To Tom Jackson Date 04-Dec-03

Department Clinical Psychology Unit

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**Certificate of Insurances (non clinical trial)**

Trial Number NCT03/Z18  
Department Clinical Psychology Unit  
Title of Trial Towards a model of Psychoanalytic Psychotherapy with People with Learning Disabilities

Name of Investigators T Jackson, N Beail

Commencement Date Jan-04

The University has in place insurance against liabilities for which it may be legally liable and this cover includes any such liabilities arising out of the above research project/study

  
.....  
C.F. Jackson , Financial Accountant (Insurances)

- Please Note**
1. If not already provided please forward a copy of the Ethics Committee Approval as soon as possible
  2. A record of the names of all participants, copies of signed Consent Forms and G.P.'s approvals should be retained by the Department.

NCT

## **APPENDIX 6**

### **Details of categories (150)**

## INTERVIEW 1

### Over Arching Themes

Awareness of reliance on other people and propensity to be subsequently let down and rejected – leading to insecure or disorganised attachments  
 Consideration of the impact on people with learning disabilities of living in a society which cannot bear to see or accept disability  
 All people are linked to society: more affluent, intelligent and lucky, the more able to control the impact society has on us. Less affluent, intelligent and lucky, the more society imprints itself on us and positions us according to its rules.  
 Experience of living with a LD is different to living without a LD – solitary, traumatic, rejecting, disappointing, shaming.  
 Trauma is initially from having a disability, but also makes people more vulnerable to cumulative/consequential traumas (shaming in public, sexual abuse, physical abuse, housing problems, relationship problems, abusive workers, losses of key relationships)  
 Secondary handicap behaviours are often exaggerated in order to make the difference between LD and non-LD greater. Better to be something different than you than an impaired version of you. Evokes pity rather than ridicule in others and promotes mocking hostility in people with LD, that others are unable to see the exaggeration.

Prior to Meeting	Initial Contact	Assessment	Therapy
What is the history and motivation behind this referral? What has happened? Why now? <p style="text-align: right;">Joan Bicknell</p>	Think about the cost to the person of coming? (other activities)	1:1 in a room (someone known may attend for a few minutes to put person at ease if they want). Same boundaries as therapy.	Therapist and person meet alone
3 <sup>rd</sup> Party motivation or volitional decision?	Think about the emotional impact of coming. (travel experience)	Acknowledge anxiety and try to make person feel safe. Take responsibility for labelling self as threatening	In a private room
Power and choice?	Don't make assumptions re: ability/disability	Assume person has experienced trauma	Meet weekly
Consent?	Check out how person would like to be addressed/address you	Describe referral details and check out accuracy explicitly	Same place each week

	Check out communication, don't assume to know intentions	Be transparent in role and communication within system	Same time each week
		Check person's understanding of therapy and referral	Same room each week
		Give choice to person where possible to decrease power differential (seating,	Rationale that consistency in the relationship between Therapist and person is containing for the person's anxiety, enabling safer communication
		Sit face to face, not from behind a desk	Therapeutic Rationale: People attach to another person in a genuine way leading to improvements
		Describe the framework and boundaries of therapy	Therapist and person interact face to face.
		Assessment not about measuring persons ability to manage an interpretation, but about their ability to bear coming, stay in room and show interest in trying something like therapy in future	Dyad communicates in a way which maximises the communicative abilities of both parties. (verbally, dramatically, drawing, playing)
		Assessment is not focussed on needs of referrer or other health professionals	Insight develops from the interplay between therapist and client. Therapist communicating an interpretation of their understanding of the person and

			gauging their response.
		Assessment is attempt to include not exclude people in therapy	Therapist formulates interpretations about the person based on their experiences of Transference, Counter-transference and projective identification
		Gives opportunity to accept or reject therapy and serves to enable this choice without anxiety about consequences	Therapist takes in projections, considers their content, transforms them and communicates something to the person in response to them which is intended to make a difference to the twosome

		Assessment forms a template for themes arising in later therapy	Interpretations are informed by: Psychoanalytic Theory (Klienian) Developmental theory Attachment theory Assumptions of trauma
		Focus is on: Abuse, Trauma and secondary handicap	Impact of interpretations measured through changes in transference/rapport, and in impact on secondary handicap
		<p>Assessment is about:</p> <ul style="list-style-type: none"> <li>▪ Making someone feel comfortable</li> <li>▪ Raising what therapy is about</li> <li>▪ Discovering what the person is worried about</li> <li>▪ Telling the person that a therapist will be found to meet with them if that is what they want.</li> </ul>	<p>Psychotherapy with people with LD different to generic therapy, more human and warm:</p> <ul style="list-style-type: none"> <li>▪ Less rigid/constrained by history</li> <li>▪ More open to adaptations</li> <li>▪ Therapist welcomes curiosity &amp; questioning</li> <li>▪ Support negative feelings &amp; aggression</li> <li>▪ Therapist's affect – affective mirror needs to be warm and welcoming in order to counteract the negativity of other experiences people with</li> </ul>



			<p>LD are used to. Neutral would be perceived as indifferent and cold</p> <ul style="list-style-type: none"> <li>▪ Counter-transference is greater when working with people with LD</li> </ul>
			Therapy aims to remove as many power obstacles as possible
			Don't assume to know. People with LD have very different perceptions of the world
			<p>Traditional therapy can be dissociative – creating a barrier between therapist and person having a genuine interaction. Balance between open self up to counter-transference feelings and bearing the pain of the client. Sometimes level of trauma is so great that we need protection from it</p>
			Perspective that people with LD have all been traumatised.
			Rationale that CB is caused by trauma and that understanding and

			acknowledging the trauma in a genuine and compassionate way is helpful leading to reduction in CB
			<p>People with LD have reduced ability to filter conscious and unconscious data and differentiate their own and other's thoughts (theory of mind)</p> <ul style="list-style-type: none"> <li>▪ Damage discussed in the content of sessions often reflects real damage to the person</li> <li>▪ More acting in and acting out</li> <li>▪ Literal translation of thoughts into actions e.g. head-banging (get thoughts out of head)</li> <li>▪ Thoughts linked to objects and physical entities</li> <li>▪ Less verbal leakage of unconscious material (dreams Freudian slips etc) more non-verbal leakage (physical body movement)</li> </ul>
			Impact of therapy is measured

			informally: <ul style="list-style-type: none"> <li>▪ Ability to attach to therapist realistically as a mixture of good and bad, not idolised or denigrated.</li> <li>▪ Ability to communicate both +ive and -ive feelings</li> <li>▪ Ability to show intimacy</li> <li>▪ Reduction in unwanted behaviours and pain.</li> </ul>
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**INTERVIEW 2**  
**Over Arching Themes**

Having a LD is traumatic. Trauma and traumatic relationships with other impact on the unconscious  
 People with LD are not viewed well within society (Bottom of the Ladder) and are very disempowered, infantilised, prejudiced against, hated (aroused by anxiety and other uncomfortable feelings), bullied. They are often unwell or perceived as sick/ill all of which leads to very few intimate relationships being formed.  
 Power dynamic is lived out in therapy and needs to be considered.  
 Sometimes justice is important (e.g. following abuse) but effecting this may cut across therapeutic boundaries – other person needs to be available for this role in order to protect therapeutic relationship  
 Other people (e.g. professionals) often make decisions on behalf of people with LD.  
 People with LD are supported by other people who control aspects of their lives – infantilise, pressurise, coerce – “I know what’s best for you”

<b>Assessment</b>	<b>Therapy</b>
Referred by 3 <sup>rd</sup> party (professional or parent/carer) (v.occasionally self	Meet with person in a room

referral) – usually because of anxiety/concern about the person’s behaviour. (change)

Pre therapy work: to build up picture of the person  
 Meet with professionals, family/carers  
 Gain idea about: communication abilities, comprehension, relationships with other people.  
 Discuss risks of therapy – network needs to support the person and not sabotage, stop therapy.  
 Consent is absolutely essential –person needs to want to be in therapy.  
 Issues of power and coercion.

Same time, day, place each week for the same amount of time 30/50minutes
The boundaries are to protect the therapy sessions fro outside influences and also to protect the person’s world from being influenced unduly by the therapy (e.g. going into somebody’s home)
The person comes to the therapist.
Converse with a focus on the emotional experiences of the person particularly loss and abuse.
Think about how the person relates to the therapist – how perceived, experienced, feelings about – Transference
Work within the context of the relationship between the person and the therapist
Therapist tries to explore the hidden meaning behind what person says
Therapists thoughts are informed by: <ul style="list-style-type: none"> <li>▪ Information about the person’s history</li> <li>▪ Transference how the person is experienced by the therapist)</li> <li>▪ Psychodynamic/PA ideas</li> <li>▪ Object relations</li> <li>▪ Kleinian ideas</li> <li>▪ Attachment theory</li> <li>▪ Relationship with therapist – development of.</li> </ul>
Thoughts are checked outside of therapy through: <ul style="list-style-type: none"> <li>▪ Supervision</li> <li>▪ Literature</li> <li>▪ Discussion with Colleagues</li> </ul>

	<p>Thoughts are shared with the person as an interpretation when the therapist feels that the person is ready and available to think about the topic. Therapist may hold onto ideas until they think the person is ready.</p>
	<p>Readiness/availability is assessed through slow step-by-step introduction of topics. With growing trust and belief in the safety of the setting comes increased readiness. Also counter-transference. Mistakes are made and need to be worked through.</p>
	<p>Interpretations are communicated using appropriate language.</p>
	<p>Sometimes interpretation are not understood which requires further formulation by the therapist</p>
	<p>Impact of interpretations is measured through counter-transference. Often people will say they understand when they don't to avoid conflict or shame. Also through changes in way of relating to therapist, changes in reports about life and behaviour and 3<sup>rd</sup> party reports about behaviour change.</p>
	<p>Risks of therapy – making behaviour problems worse – intimate relationships can lead to anxieties and feelings which need supporting</p>
	<p>Impact of therapy measured through clinical feelings (Counter-transference), feedback from wider network, changes in behaviour.</p>
	<p>Fixed term of therapy contracted but can vary from client to client depending on needs assessed at assessment.</p>
	<p>Ending opens up loss for people and enables links with other losses – feelings of anger, sadness about what wasn't done what might have been.</p>



**INTERVIEW 3**  
**Over Arching Themes**

Awareness of the impact on a person with LD of society and their surroundings

People with LD are vulnerable

People with LD who come to therapy are fragile: very low in mood, very unhappy/sad, very damaged

People with LD are anxious and uncomfortable with who they are, where they are and what they are.

People with LD have always got to give somebody something: Behave better, do what they're told. They are disempowered and controlled

People with LD have a fundamentally different experience of life than people without LD (institutionalised), which cannot easily be understood.

People with LD are not all the same and have individual experiences.

<b>Assessment</b>	<b>Therapy</b>
Assessment is important	Therapy aims to enable the development of insight in the person. Enabling a realistic sense of self, acknowledging their place in history as someone with a past a present and a future. It helps people move from feeling to thinking from unconscious to conscious responses, and to a position of more control in society. Enabling person to interact with the world as a human being rather than as an object (the result of institutionalisation), and be more attached/less separate from the world. Linking with the world is empowering.
Occurs before the start of therapy	Therapy provides the person an environment in which to look at himself. The therapist is an enabler of this process and gives pointers.
Assesses ability of person and therapist to communicate with each other <ul style="list-style-type: none"> <li>▪ Non-verbal people: communicate Yes, No &amp; Don't Know?</li> <li>▪ Verbal people: require prompts/questions due to anxiety about being wrong</li> </ul>	Therapy with people with LD different to therapy with non-LD people: <ul style="list-style-type: none"> <li>▪ People with LD more open, with fewer intellectual defences</li> <li>▪ Communication is less cognitive and explicit, and shared experience tends to be unspoken.</li> </ul>
Assess nature of difficulties	Takes place in a safe, quiet place
Informs duration of therapy offered to person	Power and control are shared as much as possible person treated with

	respect as an equal if they are able to bear this responsibility.
	Therapist makes appointment and keeps appointments in order to provide a secure base from which to conduct therapy (Bowlby)
	3 <sup>rd</sup> parties (carers and other health professionals) are involved in giving information about client and provide feedback about therapeutic impact, but also influence therapy and can sabotage it (space, time, confidentiality). Also impact of society and person's reality needs to be acknowledged and tolerated.



	<p>Therapy is part of a wider system for the person and is not an isolated experience. Need to work with what is there and compromise. This is part of living with a disability (problems of privacy, reliance on others, inability to travel) and needs to be tolerated. Working with the person's reality (Bowlby). People with LD are often used to this and less affected by this than non LD people.</p>
	<p>Central core of therapy is the person's self-concept. Behaviour and other problems are linked to this. Acceptance of self as a person with LD is very difficult and defended against</p>
	<p>Defences: Avoidance</p> <ul style="list-style-type: none"> <li>▪ Exaggeration (secondary handicap)</li> <li>▪ Alternative Label (e.g. drunk)</li> <li>▪ Adoption of false self</li> </ul> <p>Existence illustrates unconscious awareness of self as impaired. Therapy makes unconscious conscious which can result in depression</p>
	<p>Anything the person wants to talk about is ok.</p>
	<p>Therapy focuses on the person, and involves reflecting on the self not on others. Therapist draws focus continually back to the person.</p>
	<p>Therapy begins with noticing aspects of the person, then reflecting on them, then thinking about their meaning and consequences.</p>
	<p>Person with LD does not need to understand psychic defences. Therapist can do that work. Person needs to experience themselves through the transference and survive it in the context of reality. Some core PA concepts too abstract and difficult to bear (murderousness, masturbation) for fear of persecution, difficulty separating literal and</p>

	abstract concepts. Experience is shared non-verbally. “ They know that I know that they know” Doesn’t need to be explicit for change to occur.
	Sessions often begin by linking to the outside world, describing what has occurred between sessions. Therapist may use prompts and questions in order to explicitly give permission to the person that their views are valid
	Therapist gives 100% attention to what person says and does
	Therapist makes links between: <ul style="list-style-type: none"> <li>▪ What is spoken about in the session</li> <li>▪ Content of previous discussions</li> <li>▪ Knowledge of history</li> </ul> Based on what is said and done in the room Cognitive links enables a sense of self in time and place rather than existing just in a moment – then and now. More of a continuum
	Where something comes into mind which does not have cognitive links – unconscious communication (transference) it is noted and communicated when therapist feels person is ready for it to come into consciousness.
	Some people with LD are unable to hold a stream of conscious thoughts and require the therapist to maintain links. This is done by: <ul style="list-style-type: none"> <li>▪ Making things explicit and concrete (drawing)</li> <li>▪ Repetition</li> </ul>
	Links may be communicated to person as a “gentle interpretation” when therapist feels person is receptive to it and able to cope with it and which is considerate of the risk of the person feeling persecuted
	Interpretation is given in simple language, which validates and opens

	up topic for discussion in a safe non-judgemental way rather than confronting or challenging. Hopes to lead to deeper understanding
	Interpretations given in a way which avoids the person feeling that they have to give something/do something, as this is a dynamic which therapy aims to offer an alternative to.
	Interpretation opens person up to the possibility of linkages between things, which enables them to create their own links.
	Some interpretations are not communicated explicitly, but a shared awareness develops which is helpful: I know that you know that I know
	Impact of an interpretation is gauged largely by non-verbal changes in rapport: person becomes more relaxed, eye-contact changes, facial expression changes. There is sometimes verbal confirmation/rebuffal
	With accurate interpretations, there is a shift in dynamic between person and therapist from one of mistrust to one of trust.
	With trust and experience of safe/containing therapy, person can begin to see therapist as a good enough person and from that see themselves in the same way
	A counter-transference feeling of being disabled, stupid and unable to understand the other is typical and needs to be tolerated in order for the person to have their own inability to know contained. It is a shared experience of not knowing/understanding the other.
	Risks of therapy are: depression & inability to cope following insight. Therapist has a responsibility to provide a long enough course of therapy to support the person through this. Evidence that depression typical after 1yr of therapy; therefore offer either 9months or 18months.
	.Flexibility is important with wide variability in the work:

	<ul style="list-style-type: none"> <li>▪ Frequency of therapy -</li> <li>▪ Duration of therapy – Brief therapy (eg 6-wks) possible but rare</li> <li>▪ Abilities of clients</li> <li>▪ Settings – care homes, secure settings</li> </ul>
	Therapy is measured by degree to which person becomes more aware of self and more able to bear the pain of who they are. Move from physical manifestations of pain (eg head-banging) to ability to acknowledge it (I need to talk about something that's upsetting me”

**INTERVIEW 5**  
**Over Arching Themes**

People with LD have experienced trauma, disappointment and rejection - Parental Gaze. This leads to fragmentation of thoughts.  
 Having a LD is traumatic: society's negative response, parental disappointment  
 People with LD are massively influenced by the system they live in and the societal influences/pressures imposed on them. Persecution  
 Emotional well-being and cognitive abilities are linked. Thinking is dangerous/painful. It's easier not to think  
 People with LD are disempowered

Referral	Assessment	Therapy
From 3 <sup>rd</sup> Party: Health professional usually in response to a problem posed by the person to someone-else. (Reactive) Some but little work is proactive.	Gathering history and information about person, needs, abilities and difficulties	In a room
Assessment takes longer with people with LD		Private interaction between person and therapist

<p>Assess readiness to bear pain          Ability to think          Ability to distinguish between abstract and literal</p>			<p>Communicating with each other through the most appropriate means for the dyad:</p> <ul style="list-style-type: none"> <li>▪ paper and art</li> <li>▪ drama (role-play)</li> <li>▪ play</li> <li>▪ verbal</li> </ul> <p>Inability to communicate is not the responsibility of the person but the dyad.</p>
			<p>Therapy needs to be client led, empowering and try to develop a growing ability to think.</p>
			<p>Understanding develops based on ideas of attachment theory, systemic theory, PA theory, developmental theories</p>
			<p>Consider the primal relationship with the parents – informs how person relates to the rest of the world, sense of self, sexuality and “here &amp; now” behaviour</p>
			<p>Also attachment to person’s immediate network, and wider society</p>
			<p>Informed by emotional responses to each other in the room: transference and counter-transference.</p>

			<p>Therapy is different with people with LD:</p> <ul style="list-style-type: none"> <li>▪ More external influence (3<sup>rd</sup> party involvement)</li> <li>▪ Material is less explicit more behaviourally based and experiential</li> <li>▪ Less ability to think or distinguish between abstract and literal</li> </ul>
			<p>Negotiation about what is shared/unshared between person, therapist and wider network and what needs are.</p>
			<p>Assume that the person has difficulties with attachments (often due to over/under attached parent). Extreme attachment styles</p>
			<p>Therapy varies with each individual based on their level of:</p> <ul style="list-style-type: none"> <li>▪ Communication (verbal/non-verbal)</li> <li>▪ Cognitive ability</li> <li>▪ Trauma</li> </ul>
			<p>People with LD often very compliant and try to please. Will spend time trying to find out what you want from them and give it to you. Therapy needs to grant permission to the person to have an experience with another person without consequences or being controlled</p>
			<p>Limited range of behaviours: repetitious</p>

			Risks: 3 <sup>rd</sup> party involvement, contracting rules, boundaries
			Communicating interpretations: Simple reflection and dialogue
			Some clients unable to hold onto links between now and previously. Therapist needs to do this
			With interpretation comes reciprocal learning through the interaction. Therapist feeds person's thinking who helps to build therapist's thinking and understanding.
			Impact of interpretations: <ul style="list-style-type: none"> <li>▪ More open</li> <li>▪ Different material</li> <li>▪ More thought</li> <li>▪ More commitment</li> <li>▪ More attachment (emotional)</li> <li>▪ 3<sup>rd</sup> party report</li> <li>▪ Behaviour change</li> <li>▪ Greater connectedness, linkage of thoughts – less fragmented</li> </ul>
			Therapy aims to enable more fluid thinking and empower the person and change person's relating behaviour

			Work is slow. NEEDS to be slow and respectful of the pain of the trauma defended against. Trauma is heavily defended. Takes a long time to uncover latent meaning
			Impact of therapy is measured informally through changes in behaviour, development of insight, changes in thinking (style and content). Potential for new experiences Absence of feedback does not necessarily equate to absence of thinking or change Ability of person to manage similar situations differently to before – more helpful/positive
			Therapy can enable experience of a more attached object, offering experience of something new opportunity to behave in a new way
			Ending usually motivated by therapist (sometimes person) when reason for referral has been worked through and associated difficulties worked through or contained. After therapy person should be more able to manage life and appreciate their part in the world. There should be greater connectedness, ability to cope and less isolation/disconnectedness



			Therapy may need to be conducted at the appropriate infantile/developmental level for the person, or regress to an earlier stage to work through some important stage which was missed out (reparation)

**INTERVIEW 6**  
**Over Arching Themes**

People with LD have little control over their lives, or decision-making power.

Person usually brought to therapy by escort – dependence

Early infantile experiences are very important in making sense of later life (parent-child interaction)

Parents of children with LD are often disappointed when they first see their child. This disappointment is communicated to the child (1<sup>st</sup> maternal gaze) and affects the psyche of the person leading to disturbed relationships/attachments with carers and people in authority. This will be enacted in therapy/

Leaving people with LD to represent themselves is difficult for carers, particularly when carers receive little support themselves

People with LD are affected by: organic factors, developmental disorders (e.g. autism) emotional responses – Therapy has to consider the impact of all these factors carefully

Experience of being a person with a LD is of being enmeshed with others but separate and isolated from them.

Core relationships are the key to happiness and satisfaction.

People with LD feel shamed by the experience of being different, damaged unattractive and unvalued.

**Assessment**

Therapy is not for everyone. Assessment is important

**Therapy**

Firm boundaries borrow heavily from PA

Same place once/week

50minutes

Same time, room, place

Private 1:1 interaction in a room sitting facing each other

Therapist makes links between content and reality and gauges the person's response

Work with what the person brings into the room (actions and words)

Focus on the emotional quality of the material

Awareness that reality has a big impact on the person but that therapy is not about finding out the truth.

Therapy focuses on the nature of relationships: staff, family, peer group, and how the person relates to the therapist in the room. How does the person relate to the world, what is their perception of the world.

Draws on object relations theory, how are others perceived and links to past experiences particularly parent-child experiences

Therapist notices behaviour and patterns within content, and opens up for reflection/thinking. Notices out of the ordinary responses to therapy.

Lack of power and control will be enacted within therapy

	Therapist makes links between past, present and transference (here & now)
	Often person can't recall memories spontaneously or link between points in time – therapist must help with this
	3 <sup>rd</sup> party influence is important. Referrer has power and stake in therapy (jealousy, possessiveness about knowing person's mind) Constant dynamic between other carers and therapist. Important to have a positive collaborative relationship with referrers and negotiate the influence of outside network. Liaison is required, but can contaminate the therapy. Protect therapy as a precious bounded space, but be pragmatic with 3 <sup>rd</sup> parties. Managing the boundary is difficult
	Interpretations are informed by: <ul style="list-style-type: none"> <li>▪ Childhood experience</li> <li>▪ Attachment theory</li> <li>▪ Object relations</li> <li>▪ Containment/Holding (Bion Winnicott)</li> </ul>
	Therapy is experiential and active – working to help the person think within his or her own capacities.
	Therapy attends to what is being done and said and interprets the communicative function of the behaviour
	Therapist receives feelings (counter transference) and from this gains an insight into what is going on for the person. (e.g. tiredness/exhaustion.
	Balance between pragmatism and analysis.

<p>Interpretations are communicated in a non-confrontational way using simple language pitched at the level of the persons understanding, ability, and awareness. The person has to have some sense of what you are saying.</p>
<p>Therapy is about joining and separating from someone and thinking about the impact of this</p>
<p>Often narrative power for person with LD is limited, so therapist must attend to actions and transference. Considering the potential meaning of everything.</p>
<p>Noticing things in an interested way about a person with LD is a new experience for them</p>
<p>It is important to talk openly and honestly about difficult reality: shame, disappointment, disability, loss, unmet wishes</p>
<p>Impact of interpretations are measured informally through:</p> <ul style="list-style-type: none"> <li>▪ Changes in behaviour/interaction</li> <li>▪ Changes in how person relates to therapist</li> <li>▪ 3<sup>rd</sup> party feedback</li> </ul>
<p>Therapy is slow and takes a long time and can be on-going for some people when it is about coping with extreme trauma.</p>
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**INTERVIEW 8**  
**Over Arching Themes**

Having a LD is traumatic. Trauma and traumatic relationships with other impact on the unconscious  
 People with LD are not viewed well within society (Bottom of the Ladder) and are very disempowered, infantilised, prejudiced against, hated (aroused by anxiety and other uncomfortable feelings), bullied. They are often unwell or perceived as sick/ill all of which leads to very few intimate relationships being formed.  
 Power dynamic is lived out in therapy and needs to be considered.  
 Sometimes justice is important (e.g. following abuse) but effecting this may cut across therapeutic boundaries – other person needs to be available for this role in order to protect therapeutic relationship  
 Other people (e.g. professionals) often make decisions on behalf of people with LD.  
 People with LD are supported by other people who control aspects of their lives – infantilise, pressurise, coerce – “I know what’s best for you”

Assessment	Therapy
Referred by 3 <sup>rd</sup> party (professional or parent/carer) (v.occasionally self referral) – usually because of anxiety/concern about the person’s behaviour. (change)	Meet with person in a room
	Same time, day, place each week for the same amount of time 30/50minutes
	The boundaries are to protect the therapy sessions fro outside influences and also to protect the person’s world from being influenced unduly by the therapy (e.g. going into somebody’s home)
	The person comes to the therapist.
	Converse with a focus on the emotional experiences of the person particularly loss and abuse.
	Think about how the person relates to the therapist – how perceived, experienced, feelings about – Transference
	Work within the context of the relationship between the person and the therapist
	Therapist tries to explore the hidden meaning behind what person says
Pre therapy work: to build up picture of the person Meet with professionals, family/carers Gain idea about: communication abilities, comprehension, relationships with other people. Discuss risks of therapy – network needs to support the person and not sabotage, stop therapy. Consent is absolutely essential –person needs to want to be in therapy. Issues of power and coercion.	

Therapists thoughts are informed by:

- Information about the person's history
- Transference how the person is experienced by the therapist)
- Psychodynamic/PA ideas
- Object relations
- Kleinian ideas
- Attachment theory
- Relationship with therapist – development of.

Thoughts are checked outside of therapy through:

- Supervision
- Literature
- Discussion with Colleagues

Thoughts are shared with the person as an interpretation when the therapist feels that the person is ready and available to think about the topic. Therapist may hold onto ideas until they think the person is ready.

Readiness/availability is assessed through slow step-by-step introduction of topics. With growing trust and belief in the safety of the setting comes increased readiness. Also counter-transference. Mistakes are made and need to be worked through.

Interpretations are communicated using appropriate language.

Sometimes interpretation are not understood which requires further formulation by the therapist

<p>Impact of interpretations is measured through counter-transference. Often people will say they understand when they don't to avoid conflict or shame. Also through changes in way of relating to therapist, changes in reports about life and behaviour and 3<sup>rd</sup> party reports about behaviour change.</p>
<p>Risks of therapy – making behaviour problems worse – intimate relationships can lead to anxieties and feelings which need supporting</p>
<p>Impact of therapy measured through clinical feelings (Counter-transference), feedback from wider network, changes in behaviour.</p>
<p>Fixed term of therapy contracted but can vary from client to client depending on needs assessed at assessment.</p>
<p>Ending opens up loss for people and enables links with other losses – feelings of anger, sadness about what wasn't done what might have been.</p>
<p></p>
<p></p>
<p></p>
<p></p>

## **APPENDIX 7**

### **Details of recurrent categories (78)**



Influence of society – disempowered, bullied, hatred, hostility fear (historically marginalized)
Consent and power dynamic – where to sit in the room understanding of therapy. Have they been told about what it is- not a cup of tea/chance to talk to someone nice
Exclusion of escorts
Reliance & Dependency
Power dynamics
1:1, Quiet room Face to face
Same time, place, each week (once weekly)
Consistency
Containment & Safety – new experience (maternal gaze)
Maternal Gaze/Relationship with family particularly mother-child interactions
Relationships with carers – paradox in but excluded (solitary)
Meet with 3 <sup>rd</sup> parties for information – 3 <sup>rd</sup> parties much more involved
Pre-assessment meetings – consent etc. understanding and background history, family and carers involved – other professionals
Assessment – V IMP*** - not about assessing ability to make use of interpretation – can person bear to attend stay in room be with another person
Few intimate relationships
Assessment of therapists ability to bear counter-transference feelings – very painful and difficult to tolerate – sleepiness – shared experience of being disabled
Communication difficulties – toys and drawing materials, play , sand etc
Physical disabilities/needs
Escorts and 3 <sup>rd</sup> party network
Tolerant, awareness of needs .
Gentle, warm, caring.
Abuse Trauma – cumulative or from LD
Different life experience

5x mutative themes – loss, dependency, disability, sexuality, annihilation
Theories – attachment, systemic, psychoanalytic
Interpretations, Malan's triangles, Hidden unconscious meaning
Pacing, holding onto links
Memory, cognitive abilities
IQ – emotional handicap
Containment Bion Alpha to Beta
Noticing, mirroring, reflecting, interpretation, challenge
Few intimate relationships – sexuality
Experience of a different way of being with a person
Observe behaviour in sessions, as well as verbal
Body tension, eye contact, body language, facial expression
Transference & Counter-transference (Core clinical tool)
Hostility – Defences (splitting, avoidance, introjection, projection)
Pain & Loss – Acknowledgement of pain/disability/dependency
Links between material
Person themselves – wide variability/difference
Attachment to therapist
Meaning about behaviour/ability to think
Process of joining and separation
Cognitive difficulties – what is organic and what is emotional/defensive (secondary handicap).
Therapists affect – shared experience of not understanding/knowing the other
Vulnerability – adult abuse, society shaming, stigmatising
Impact measured by changes in behaviour
Secondary handicap (as clinical tool)
Change in behaviour
3 <sup>rd</sup> party report – liaison with care network and referrers
Reality testing – v important
Insight***
Reality is important- abuse common, more important than therapy (?justice)
Klein paranoid schizoid and depressive positions

Ability to show intimacy
To attach to another person
Contain emotions
Physical acting out of behaviours
Recognition of own needs – realistic perception of others not denigrated or idolised
Support staff often very neglected and poorly paid, supported – envy and resentment about what people get in therapy.
Negotiation with referrers – they have a stake in therapy.
Sabotage of therapy
Negotiated and planned not just abrupt end. Even if person doesn't want to come anymore
The end of therapy – end of contract/funding, referrers wishes, core goals achieved

## **APPENDIX 8**

### **Criteria for full membership of IPD**

The **Institute of Psychotherapy and Disability** exists as an organisation to develop, accredit and regulate psychotherapists who work with people with disabilities. Established in May 2000 our initial focus will be on the needs of people with learning disabilities, as this reflects the expertise of founder members. However, the objects are written broadly to enable other forms of disability to be included. The initial model of therapy to be developed for accreditation is psychoanalytic. Again this reflects the interests and expertise of the founders. Other models are both acceptable and welcomed.

The founder members have spent the last twenty years acquiring knowledge, applying expertise and evaluating outcomes, prior to taking the step of forming the Institute. Their motivation has come from the needs of individuals with learning disabilities to have an opportunity to benefit from therapies that are readily available for non-disabled people.

#### **OUR AIMS**

Through the work of its Trustees, the Institute plans over the next 2 years to:

- ◊ Sign up at least 50 founder members who meet the criteria for grandparent membership. *(These are, briefly: to hold a qualification to master's level or above in psychotherapy or a discipline relevant to learning disabilities; and to have provided therapy, with supervision, to 10 people with a learning disability. Additional details on the exact criteria are available.)*  
50 founder members will permit an application to UKCP for recognition of the qualification.
- ◊ Promote best practice in the training of professionals working in the field:
  1. By devising or approving a range of courses to develop and increase the availability and quality of psychotherapy to people with learning disabilities;
  2. By supporting providers of existing psychotherapy courses to meet the specialist needs of therapists wishing to work in the field of disability.

To date the Institute has set up two separate committees (Training and Membership) to pursue the above aims.

#### **RESEARCH AND EVALUATION**

The Institute has a further aim: to promote research. To this end members will be expected to evaluate the efficacy and effectiveness of psychotherapeutic approaches and to disseminate their results and findings.

#### **GRADES OF MEMBERSHIP**

3 grades of membership have been agreed.

**Full members** will meet the standards described above. **Associate members** will have met some of the standards and be working towards full membership. Those whose training and experience is with other forms of disability are also welcome as Associate members. **Friends** will be supporters who are interested but not planning to become full members.

#### **APPLICATION**

We look forward to receiving applications for all grades of membership.

(Details of how to obtain application forms can be found over.) For informal discussion at any point during the process of application, you may wish to contact one of the Trustees. We hope to be able to answer your questions.

The grandparenting arrangements will stay in force until there are graduates of training courses. After that, it is expected that most applicants for membership will be via accredited courses.

## **APPENDIX 9**

### **Copy of participant invitation letter**

Clinical Psychology Unit  
Department of Psychology  
University of Sheffield  
Psychology Building  
Western Bank  
Sheffield  
S10 2TP

REF: ID 01

25 July 2004

Dear IPD member

I am currently undertaking a research study exploring the nature and process of dynamic psychotherapy with people with learning disabilities. The research is being carried out as part of a D.Clin.Psy qualification I am undertaking at the University of Sheffield. The research is supervised by Professor Nigel Beail, and is supported by the directors of the institute of psychotherapy and disability.

The study involves interviewing psychoanalysts, psychoanalytic psychotherapists and psychodynamic psychotherapists who work with people with learning disabilities. The focus of interviews will be interviewees' practice in providing therapy to people with learning disabilities. Following analysis of transcripts, findings will be circulated to interviewees and other professionals working in the area for feedback.

---

Interviews will last between 1 and 1.5 hours and will take place at a time and place convenient to the interviewee. All interview data and feedback will be anonymised and tapes and transcripts will be destroyed on completion of the study.

If you are available for interview between now and April 2004, and would like to be approached for inclusion in the study, and/or would be willing to provide brief feedback from a written summary of findings, please complete the enclosed response form and return in the envelope provided.

If you would like any further information, please contact me by telephone: 07815 735 434, via email: [tommyj110@hotmail.com](mailto:tommyj110@hotmail.com) or write to the above address.

Many thanks for your time

Yours sincerely

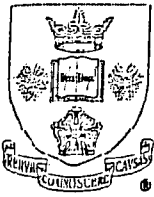
Tom Jackson  
Trainee Clinical Psychologist

Professor N. Beail  
Consultant Clinical Psychologist

**APPENDIX 10**

**Copy of information sheet**





**THE UNIVERSITY OF SHEFFIELD**  
**Clinical Psychology Unit**  
**Department of Psychology**

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)  
Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit  
Department of Psychology  
University of Sheffield  
Western Bank  
Sheffield S10 2TP UK

Telephone: ++44 (0)114 22 26570  
Fax: ++44 (0)114 22 26610  
Email: dclinpsy@sheffield.ac.uk

Unit Director: Prof Graham Turpin (26569)

Assistant Director: Prof Pauline Slade (26568)

Clinical Practice Director: Ms Joyce Scaife (26574)

Course Administrator: Carole Gillespie (26649)

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**INFORMATION SHEET**

Research Title: Towards a model of Psychoanalytic Psychotherapy with People with Learning Disabilities

Name of Researcher: Tom Jackson, Trainee Clinical Psychologist, University of Sheffield

*Who is doing the research?*

The research is being carried out by Tom Jackson, a Clinical Psychologist in Training, as part of his doctoral qualification at Sheffield University.

*What is the research about?*

The research is investigating the nature of psychoanalysis, psychoanalytic psychotherapy, and psychodynamic therapy with people with learning disabilities.

*What will be involved?*

If you would like to be involved in the research, the researcher will ask to interview you for about 1 hour. The focus of the interview will be the nature, process and theory behind your therapeutic interactions with people with learning disabilities, and will take place at a time and place convenient to you. The interviews will be taped and from this, transcripts confidentially prepared.

*Do I have to take part in the study?*

No. If you do not want to take part in the study there is no obligation to do so. Involvement is strictly voluntary and you may withdraw from the study at any time, without giving a reason and without consequence.

*Will all information be kept confidential?*

Yes. If you decide to take part in the study, you will be allocated an identification number and your name will not be linked in any way to the data or the final thesis. All tapes and transcripts will be anonymised using the ID number, and will be destroyed when the research is complete.

*I have some more questions. How can I find out more?*

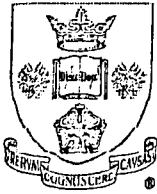
If you have any further questions, then please contact the researcher:

Tom Jackson c/o Clinical Psychology Unit, Department of Psychology, University of Sheffield,  
Western Bank, Sheffield S10 2TP UK.

Telephone: 0114 22 26570 Fax: 0114 22 26610 Email: tommyj110@hotmail.com

## **APPENDIX 11**

### **Copy of participant consent form**



**THE UNIVERSITY OF SHEFFIELD**  
**Clinical Psychology Unit**  
**Department of Psychology**

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)  
 Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit  
 Department of Psychology  
 University of Sheffield  
 Western Bank  
 Sheffield S10 2TP UK

Telephone: ++44 (0)114 22 26570  
 Fax: ++44 (0)114 22 26610  
 Email: dclinpsy@sheffield.ac.uk

Unit Director: Prof Graham Turpin (26569)

Assistant Director: Prof Pauline Slade (26568)

Clinical Practice Director: Ms Joyce Scaife (26574)

Course Administrator: Carole Gillespie (26649)

**CONSENT FORM**

Research Title: Towards a model of Psychoanalytic Psychotherapy with People with Learning Disabilities

Name of Researcher: Tom Jackson, Trainee Clinical Psychologist, University of Sheffield

Please initial box

- 1. I have read and understood the information sheet
- 2. I have had the opportunity to ask questions and these have been answered
- 3. I understand that the interview will be tape-recorded
- 4. I understand that I can chose whether or not to take part in the study, and that I am free to withdraw at any time (without giving any reason) without consequence
- 5. I agree to take part in this study

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

Date \_\_\_\_\_

Signature \_\_\_\_\_

Researcher \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

## **APPENDIX 12**

### **Copy of interview schedule**

## INTERVIEW SCHEDULE:

- *What do you do in your clinical work with people with learning disabilities?*
  - *PROMPT – What does your clinical practice look like*

## FOLLOW UP QUESTIONS:

- *How do you gather information?*
  - *How do you understand the latent unconscious meaning?*
    - *Transference, Developmentally, Dynamic, Economic (Smith, 1987)*
  - *How do you formulate interpretations?*
  - *How do you communicate interpretations?*
  - *How do you assess/measure change/outcomes?*
-

**APPENDIX 13**

**Copy of transcriber confidentiality  
form**

# Doctorate in Clinical Psychology

University of Sheffield

## Confidentiality Form

Type of project: Clinical Skills Assessment Research thesis

Project title \_\_\_\_\_

Researcher's name \_\_\_\_\_

The tape you are transcribing has been collected as part of a research project. Tapes may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree not to disclose any information you may hear on the tape to others, to keep the tape in a secure place where it can not be heard by other people, and to show your transcription only to the relevant individual who is involved in the research project. If you find that anyone speaking on a tape is known to you, we would like you to stop transcription work on that tape immediately.

### Declaration

I understand that:

1. I will discuss the content of the tape only with the individual involved in the research project
2. I will keep the tape in a secure place where it cannot be heard by others
3. I will treat the transcription of the tape as confidential information
4. If the person being interviewed on the tapes is known to me I will undertake no further transcription work on the tape

*I agree to act according to the above constraints*

Your name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Occasionally, the conversations on tapes can be distressing to hear. If you should find it upsetting, please speak to the researcher.