The effectiveness of psychological therapies and therapists when working with adults with intellectual disabilities.

By Charlotte Clarke

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology.

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Submission date: November 2020

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Declaration

I declare that this thesis has been submitted to the University of Sheffield for the Doctorate in Clinical Psychology. It has not been submitted for any other qualification or to any other institution.

Structure and Word Counts

Summary: 475

Section I: Systematic review

Excluding references and tables: 7,988

Including references and tables: 13,895

Section II: Research report

Excluding references and tables: 7,920

Including references and tables: 11,223

Total

Excluding references and tables: 15,908

Including references and tables: 25,118

Acknowledgements

Firstly, I would like to thank my thesis supervisors Professor Nigel Beail and Dr Stephen Kellett, for their support, expertise and wonderful stories which have made the process of thesis more enjoyable. Secondly, I would like to thank all of the clinical psychologists who gave their time to participate in the study. You have provided me with a greater understanding of what it means to be an effective therapist and I hope that I will take this knowledge into my first qualified role.

I would also like to thank my fellow trainees, who have continued to support me with thesis despite now working as qualified clinical psychologists. It has been a wonderful experience to learn alongside you throughout training.

Finally, I would like to thank my beautiful family for their encouragement, support, and the endless baby-sitting for my son who was born during training. Last but certainly not least, thank you to my husband Jamie. You have been so patient, supportive, and selfless throughout this entire process. Edward and I are so lucky to have you in our lives.

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Summary

Psychological therapy has not always been readily available for individuals with intellectual disabilities (ID) due to the belief that therapy was ineffective for this population group. This resulted in an avoidance of offering psychological therapy to clients with ID, often referred to as the ‘unoffered chair’ (Bender, 1993). Over time it has become evident that individuals with ID experience a wide range of emotions and often higher rates of mental health difficulties in comparison to non-disabled individuals. Psychological therapy is now increasingly offered to clients with ID and an abundance of psychological approaches are utilised in clinical practice.

The first part of this thesis will systematically review existing systematic reviews on the effectiveness of psychological therapy for adults with ID and mental health difficulties. The intention was to bring the literature together and provide a useful document for clinical decision makers to easily compare and contrast the evidence. Twelve systematic reviews were identified which focused primarily on cognitive behavioural therapy, psychodynamic therapy, and third-wave therapies. This review tentatively suggested that psychological therapy can be effective for improving a variety of mental health difficulties in adults with ID, including reducing depression and anxiety. However, the review highlighted that the existing systematic reviews are of critically low quality. No conclusions could be made regarding which therapeutic approach works best for adults with ID, however, cognitive behavioural therapy reviews dominated the evidence base and were the only reviews to include comparison groups.

The second part of this thesis explored the feasibility of an innovative Q-methodological design, with the hope that this would shed further light on what makes an effective therapist for adults with ID. Outside of the field of ID, a number of core qualities have been associated with increased therapist effectiveness. This has included

the therapist's interpersonal skills, ability to be flexible and adaptive, and the ability to develop a therapeutic relationship with a broad range of clients. Twenty-seven clinical psychologists completed an online study and three distinct view points on what makes an effective therapist for this population were identified**.** However, delivering the Q-sorting task online did not meet the feasibility criteria set out and resulted in a low participant sample size. Consequently, further statistical analysis was deemed inappropriate and recommendations are provided for future studies utilising this methodology.

Together, the systematic review and research study provide further insights into psychological therapy for adults with ID and highlight the need for more research. The two studies indicate a lack of consensus regarding what works for clients with ID and also that there is not enough high-quality research regarding particular therapeutic modalities for clinicians to base their decisions on. If clinical psychologists vary considerably on what they believe is clinically effective in their work, then it is likely that their practice and possibly client outcomes, will subsequently vary also.

Contents

Section I: Systematic review

Section II: Research report

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Section I: Literature review

Exploring the effectiveness of psychological therapy for adults with intellectual disabilities and mental health difficulties: A systematic review of systematic reviews

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Abstract

Objectives

This systematic review had four main aims: (1) assess the quality of systematic reviews on the effectiveness of psychological therapy for adults with intellectual disabilities (ID) and mental health difficulties; (2) explore whether psychological therapy is effective for treating mental health difficulties in adults with ID; (3) determine whether a particular therapeutic modality is more effective than others; and (4) highlight the strengths and limitations of the current evidence.

Methods

The following four electronic databases were utilised: Cochrane, PsycINFO, PubMed and Scopus. Studies were included if they were a systematic review focused primarily on psychological therapy for adults with ID and mental health difficulties. Systematic reviews focused on anger were also considered for inclusion.

Results

Twelve relevant systematic reviews were identified, which included seven reviews focused primarily on cognitive behavioural therapy, two on psychodynamic therapy, and three on third-wave therapies. The findings indicated a bias in the evidence base towards males with mild ID, aged below 50. Forty-eight different outcome measures were reported across the studies, highlighting the breadth of psychological problems treated across the reviews. The AMSTAR-2 indicated that all twelve reviews were of ‘critically low’ quality.

Conclusion

These findings suggest that psychological therapy can have benefits for adults with ID, including reducing depression and anxiety. However, findings are mixed and some studies indicated no improvement following psychological therapy. There are significant problems with the evidence base and as such no strong conclusions can be made regarding which psychological approach works best for particular presenting difficulties.

Practitioner Points

- When making intervention decisions practitioners need to be aware of the limitations of the evidence base with people who have ID and need to continue to also refer, as NICE recommend, to the evidence available for the general population.
- It is recommended that practitioners routinely monitor the outcomes of psychological therapy in order to contribute to practice based evidence.
- Practitioners should consider using mindfulness to support clients who are experiencing anger or aggression.
- To support future research, practitioners should attempt to make a clearer distinction between mental health difficulties, aggression, or challenging behaviour when working with clients.
- When drawing upon the evidence base, practitioners should be mindful of the possible bias towards males under the age of 50 with mild ID, and consider whether the intervention would be suitable for their particular client.

Key words

Intellectual disabilities; mental health; psychotherapy; systematic review.

Introduction

It is becoming more widely accepted that individuals with intellectual disabilities (ID) experience higher rates of mental health difficulties in comparison to the general population and these difficulties often persist over time (Cooper et al., 2015; Horovitz et al., 2011). A recent study by Perera et al. (2019) found that 8.1% of individuals with ID in England had a diagnosed mental illness in comparison to 0.9% of individuals without ID. When focusing on depression alone, 13.2% of individuals with ID were found to have depression in comparison to 12.2% of individuals without ID. Despite studies consistently highlighting this disparity, mental health difficulties in individuals with ID have gone largely unrecognised due to societal beliefs and diagnostic overshadowing. Moreover, there is a lack of training for professionals which results in a failure to understand that individuals with ID also experience a wide range of emotions (Beail, 2016). Razza et al. (2014) suggested the combination of limited training for professionals and lack of research within the field of ID could result in psychologists and psychotherapists being insufficiently prepared to work with clients with ID and co-morbid mental health difficulties.

Psychological Therapy for Clients with ID

The National Institute for Health and Care Excellence (NICE, 2016) provides guidelines for treating mental health difficulties in individuals with ID and recommends that cognitive behavioural therapy (CBT) should be offered for depression, and relaxation or graded exposure should be offered for anxiety or phobias. However this guidance is bounded by a limited evidence base. There are few studies of psychotherapy outcomes for individuals with ID which meet the high standards of NICE reviews; notably there is a lack of randomised controlled trials within this field. In clinical practice a wide range of therapeutic approaches are now offered to clients with ID. This includes psychodynamic therapy, cognitive analytic therapy (CAT), dialectical behaviour therapy (DBT), mindfulness and acceptance-based therapies, solution-focused therapies, and systemic therapy (Beail, 2016). Where there was once ‘therapeutic disdain’ and an avoidance of offering psychological therapies to clients with ID (Bender, 1993), there is now an abundance of approaches offered but with little research into their utility and efficacy (Beail, 2016). The majority of research on psychological therapy with people with ID has been conducted within everyday clinical practice and as such the existing literature typically includes small sample sizes, a lack of control groups, and minimal or low-quality randomised control trials (Bhaumik et al., 2011; Shepherd & Beail, 2017; Willner, 2005).

Systematic Reviews on Psychological Effectiveness for Clients with ID

There has been an increase in the number of published reviews exploring the effectiveness of psychological therapy for clients with ID. Initially reviews of psychological therapy outcomes have been narrative rather than systematic, however, this has changed in the last decade. Nevertheless, the variety of systematic reviews on therapy outcomes for people with ID make it difficult to easily establish what works and for whom. Some systematic reviews have focused on a particular therapeutic modality, such as psychodynamic therapy, but have included clients with a wide variety of presenting difficulties (Shepherd & Beail, 2017). Other reviews have focused on both a particular model and presenting difficulty, such as CBT for anger (Nicol, Beail & Saxon, 2013). Further reviews have taken a broader stance and explored a wide variety of therapeutic approaches. For example, Patterson, Williams and Jones (2019) investigated the impact of different third-wave therapies for a variety of presenting problems including anxiety, depression, over-eating, post-traumatic stress disorder and psychosis. Additionally, Brown et al. (2011) reviewed studies focusing on psychodynamic therapy, CBT, counselling and systemic family therapy, but excluded studies focusing on DBT, CAT, interpersonal psychotherapy and eye movement desensitisation reprogramming.

Similarly to individual studies, systematic reviews are often of variable quality and the plethora of systematic reviews emerging makes it difficult to establish which psychological therapy is most effective for clients with ID. A logical next step is to conduct a systematic review of systematic reviews, which will bring the literature together and provide a useful document for clinical decision makers to easily compare and contrast the current available evidence (Bellón et al., 2014; Smith et al., 2011). Gustafsson et al. (2009) had a similar aim and conducted a survey of systematic reviews exploring the effectiveness of psychosocial interventions for adults with ID and co-morbid mental health difficulties. The authors identified fifty-five systematic reviews on such interventions between 1969 - 2005, however, only two psychological studies met their inclusion criteria which required them to clearly report on their search strategy and inclusion and exclusion criteria. These two included studies focused on behavioural interventions and CBT for aggression and sexual offending, and as such shed little light on the effectiveness of psychotherapy for mental health difficulties in this population. Consequently, this systematic review of systematic reviews aims to build on the work of Gustafsson et al. (2009) by extending the inclusion criteria and focusing more specifically on psychological therapy for mental health difficulties.

Aims

This review has four main aims:

1. Assess the quality of systematic reviews which focus on the effectiveness of psychological therapy with adults with ID and co-morbid mental health difficulties.

2. Explore whether psychological therapy is effective for treating mental health difficulties in adults with ID.
3. Determine whether any particular therapeutic modality provides better outcomes for adults with ID and co-morbid mental health difficulties than other modalities.
4. Highlight the strengths and limitations of the current evidence base and provide suggestions for future research.

Method

A systematic search of systematic reviews focused on psychological therapy for adults with ID and co-existing mental health difficulties was conducted and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. A protocol for this review was published with PROSPERO (CRD42019157200).

Definitions

Intellectual Disability

The World Health Organisation defines ‘intellectual disability’ as an impairment in intelligence and social functioning which existed prior to adulthood and has a lasting impact on development (WHO, 2020). Typically, impairment in intelligence is considered as an IQ score of 70 or below (Papazoglou et al., 2014). Other terminology may be used to describe the same population group, such as ‘learning disability’ which is commonly used within the UK or ‘mental retardation’ which was previously used within the U.S (Cluley, 2017). For the purpose of this study, the term intellectual disability (ID) will be used.

Mental Health Disorders

The International Classification of Diseases, 11th revision (ICD-11) groups mental health disorders alongside behavioural and neurodevelopmental disorders (Reed et al., 2019). A total of 21 disorders are classified, however, for the purpose of this study the following were regarded as mental health disorders and commonly seen presentations within mental health services: schizophrenia or other primary psychotic disorders; mood disorders; anxiety or fear-related disorders; obsessive-compulsive or related disorders; stress related disorders; dissociative disorders; feeding or eating disorders; impulse control disorders; disruptive behaviour or dissocial disorders; personality disorders; factitious disorders; and disorders associated with pregnancy, childbirth or puerperium. The following disorders were excluded, unless secondary to one of the disorders above: neurodevelopmental disorders; neurocognitive disorders; catatonia; disorders of bodily distress; elimination disorders; disorders due to substance abuse and other addictive behaviours; paraphilic disorders; secondary mental health syndromes; and psychological factors impacting disorders elsewhere classified.

Psychological therapy

The National Health Service (NHS) refers to psychological therapy as ‘talking therapy’ and describes it as a treatment for mental and emotional problems. Psychological therapy should be delivered by trained therapists and can be delivered in various formats such as one-to-one, group, with family, via the phone or online (NHS, 2018). The aim of therapy is to discuss the client’s feelings, thoughts and the impact on the client’s behaviour and wellbeing (NICE, 2014). This broad definition of psychological therapy was utilised as it captures a wide range of therapeutic models and the format that they can be delivered in. Whilst the NHS suggests that therapy should be delivered by trained therapists, this was not an inclusion criterion for this review.

Search Strategy

The lead reviewer conducted an electronic search in May 2019 and again in November 2019 using the following databases: Cochrane, PsycINFO, PubMed and Scopus. Search terms were selected to account for the diversity in terminology and included: (“learning” OR “intellect*” OR “mental*”) AND (“disab*” OR “impair*” OR “handicap*” OR “retard*”) AND (“psycholog*) AND (“therap*” OR “intervention” OR “treatment”). Search terms were applied to the keywords, titles and abstracts of studies and no restrictions on publication date were set. Other members of the research team also identified further known studies which they thought may meet inclusion criteria.

The initial search resulted in 1176 studies. After the removal of duplicates a total of 885 studies remained. Duplicates were initially removed using EndNote and then a hand search was conducted to remove any remaining duplicates. The lead reviewer screened the titles and removed non-reviews, those not clearly related to ID, mental health or psychological therapy. If a title was ambiguous, the abstract was read for further clarification. A further 863 studies were removed at this stage. Twenty studies were read in full and independently by the lead and second reviewer, Cohen’s $\kappa = 0.89$ (95% CI, 0.692 to 1.096). Disagreements were resolved through discussion and it was agreed that thirteen studies met inclusion criteria. Table 1 provides the details of the excluded studies. Reference lists of each included study were investigated, however no further relevant papers were identified. Authors of the included studies and experts in the field were also contacted and asked whether they were aware of any other relevant systematic reviews, either published or unpublished. No further relevant studies were identified and one author felt their study was not a systematic review and was subsequently removed, resulting in 12 included studies (see Figure 1).

Inclusion Criteria

Systematic reviews focusing predominantly on psychological therapy for adults with ID and mental health difficulties were included. Anger was also considered for inclusion due to the large proportion of adults with ID who present with difficulties in managing anger (Beail, 2017). Anger is not a diagnosed mental health condition but research indicates that anger and mental health difficulties are closely related in the general population and in individuals with ID (Rose et al., 2013). It is possible that due to diagnostic overshadowing in individuals with ID, anger and aggression are more readily highlighted by family and carers and appropriate mental health diagnoses go undetected (Langlois & Martin, 2008; Manohar et al., 2016). Systematic reviews of interventions based within a variety of settings such as inpatient, community or residential settings, were included in this review. Systematic reviews which included studies which took place in forensic settings were considered for inclusion if these were the minority of studies. Due to the reviewers' language limitations, only studies published in the English language were included; however, systematic reviews could report on psychological interventions delivered in any country.

Exclusion Criteria

Studies were excluded if they: (1) were not published in English; (2) not clearly a systematic review; (3) if the majority of the studies within the review did not focus on adults with ID and co-existing mental health difficulties; and (4) when the main focus was on other presenting difficulties or on therapy within forensic settings.

Table 1

Excluded studies and reasons why

Author(s)/ Year	Reason for exclusion
Ali, Hall, Blickwedel & Hassiotis (2015)	Focused mainly on challenging behaviour.
Evans & Randle-Phillips (2018)	Focused on experience of therapy rather than effectiveness.
Flynn (2012)	Unable to gain access and not clearly a systematic review.
Hassiotis & Hall (2008)	Review includes same sample as review by Ali et al. (2015). Focus on challenging behaviour.
Jowett, Karatzias, Brown, Grieve, Paterson & Walley (2016)	Author felt that their review did not sufficiently meet the criteria for a systematic review.
McNair, Woodrow & Hare (2017)	Focused mainly on forensic settings and therapy for forensic risk.
Nelson & Harwood (2011)	Not focused on psychological therapy.
Vereenooghe et al. (2018).	Not a significant focus on adults and psychological therapy. Also focuses on children and pharmacological interventions.

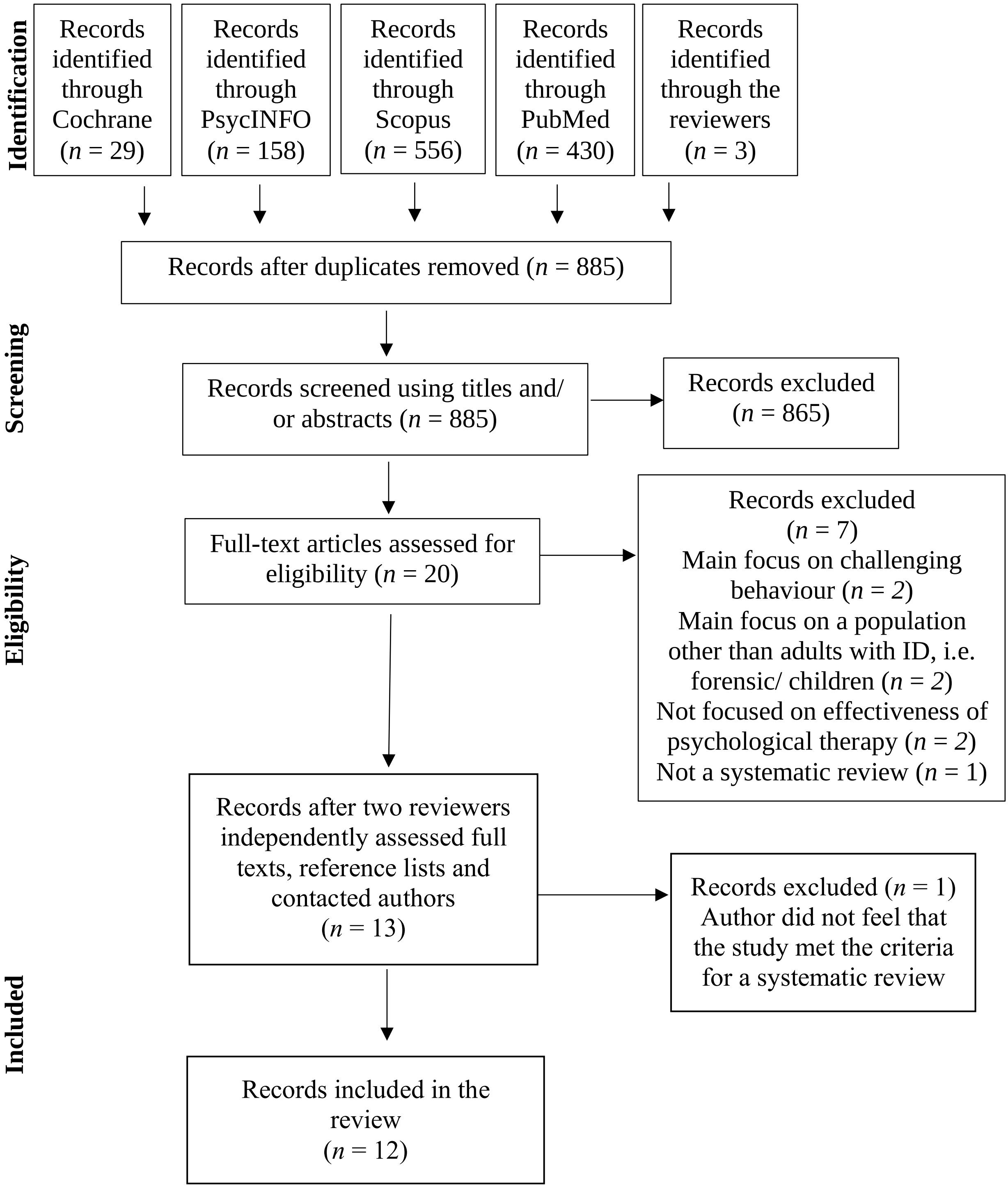

Figure 1. PRISMA diagram showing search and inclusion process

Quality Assessment

The first and second reviewers independently assessed the 12 systematic reviews using the AMSTAR-2 (Shea et al., 2017). The reviewers had almost perfect agreement and scoring disagreements were resolved through discussion (Cohen's κ = 0.95, 95% CI, 0.896 to 0.998). The AMSTAR-2 is a 16-item critical appraisal tool designed specifically for systematic reviews which include both randomised and non-randomised studies (see Appendix A). Three items are aimed at meta-analyses. The intention of the AMSTAR-2 is not to generate an overall score, but to instead provide a confidence rating using the descriptions 'high', 'moderate', 'low' or 'critically low', based on how many weaknesses the systematic review is assessed as having. However, a total score is provided for each of the studies to aid comparison. These scores and the comparison thereof, should be interpreted with caution.

Study Characteristics

Only studies within each systematic review which met the inclusion criteria, i.e. focused on psychological therapy for adults with ID and mental health difficulties, were included in data extraction. Table 2 shows the study details of each systematic review, including the original number of studies within the review and how many were included in data extraction. The majority of the systematic reviews were conducted in the UK (*n* = 10), however, one was conducted in the USA and one in Australia. Seven of the reviews examined cognitive behavioural therapy (CBT) or cognitive or behavioural approaches; two focused on psychodynamic therapy; and three focused on third-wave approaches such as mindfulness, compassion focused therapy (CFT), dialectical behaviour therapy (DBT) and acceptance and commitment therapy (ACT). The original total number of studies included within each systematic review ranged from five to 22. After excluding studies, the total number of relevant studies within each review ranged from five to 19. The systematic reviews focused on a wide variety of presenting problems. Five of the reviews focused predominately on anger or aggression. Other frequently reported presenting problems included depression, anxiety, post-traumatic stress disorder and obsessive-compulsive disorder.

A total of 78 relevant studies were reported across the 12 systematic reviews. Fourteen of the studies appeared in two of the systematic reviews, ten studies were included in three reviews, two studies appeared in four reviews, and one study was reported in five of the systematic reviews. The majority of the studies were conducted in the UK (*n* = 43) or the USA (*n* = 16). Other included studies were conducted in Australia (*n* = 4), New Zealand (*n* = 1), Sweden (*n* = 1) and Ireland (*n* = 1). For 12 studies, the country in which they were conducted was unclear. The 78 studies included 1,056 participants with ID, including 607 males and 380 females. For 69 participants their gender was not clearly reported. Age was reported in various ways, including individual ages, mean, median and age range. The largest age range reported was 17 to 73 (Marwood & Hewitt, 2013). Where authors reported on individual ages or provided age ranges, participants were often below age 50 (*n* = 25 studies). A large number of studies did not report on participant age (*n* = 32 studies). The majority of studies reported on participant’s level of ID using descriptive categories such as ‘mild’ or ‘moderate’ (*n* = 58 studies). The majority of participants were described as having a ‘mild’ ID (*n* = 363 participants) or ‘mild to moderate’ ID (*n* = 128 participants). Five participants were classed as having a ‘moderate’ ID and only six participants were described as having a ‘moderate to severe’ or ‘severe’ ID. Twelve studies did not report on ID level, which accounted for 188 participants.

Table 2

Overview of included systematic reviews

Author(s)/ year/ location	Total studies/ relevant studies	Countries of studies	Population characteristics *Treatment only population in relevant studies* (number of participants)	PRISMA flow diagram	Quality assessment tool used in the review	AMSTAR-2 confidence rating
Chapman, Hare, Caton, Donalds, McInnis & Mitchell (2013), UK	11 (6)	Not reported	Total 31 (14 male; 17 female). Age range 18 – 47. ID: Mild (13); moderate (3); mild to moderate (15).	Yes	Yes – The Evaluative Method for Determining Evidence Based Practice. All rated as 'weak'.	Critically low
Dagnan, Jackson & Eastlake (2018), UK	19 (19)	Ireland - 1 NZ - 1 UK - 13 USA – 4	Total 107 (45 male; 62 female). Age range 17 – 73. ID: Mild (75); mild to moderate (7); unspecified (25).	Yes	No	Critically low
Hamelin, Travis & Sturmey (2013), USA	8 (8)	Not reported	Total 192 - Age/ gender not reported. ID/ IQ level: not reported (3 studies); mean IQ for treatment groups ranging from 63.9 – 69.3 (4 studies); no ID to severe ID (1 study).	No	No	Critically low
Hwang & Kearney (2013), AUS	12 (6)	Not reported	Total 17 (14 male; 3 female). Age range 18 – 43. ID: Mild (7); moderate (3); moderate to severe (1); unspecified (6) .	No	No	Critically low
James & Stacey (2014), UK	13 (10)	Not reported	Total 32 (6 male; 6 female; 20 unreported). Only two studies reported age: two females aged 25 and 37. ID: Mild (23); mild to moderate (1); moderate (1); moderate to severe (2); severe (3); unspecified (2).	No	No	Critically low

Author(s)/ year/ location	Total studies/ relevant studies	Countries of studies	Population characteristics *Treatment only population in relevant studies* (number of participants)	PRISMA flow diagram	Quality assessment tool used in the review	AMSTAR-2 confidence rating
Jennings & Hewitt (2015), UK	5 (5)	Not reported	Total 154 (82 male; 72 female). Ages reported for four participants: 20, 28, 35, 47. Mean ages reported ranging from 33.7 – 38.4 (3 studies). ID: Mild (104); mild to moderate (50).	Yes	No – authors provided their own quality appraisal for each study.	Critically low
Nicoll, Beail & Saxon (2013), UK	12 (12)	AUS - 2 UK - 10	Total 214 (160 male; 54 female). Age unreported. ID: Borderline (41); borderline to mild (22); mild (79); IQ less than 70 (50); unspecified (22).	No	Yes – Cahill et al. (2010) checklist, adapted from Downs & Black (1998). Quality ratings ranged from 15 – 29 out of 32, mean = 23.75.	Critically low
Osugo & Cooper (2016), UK	16 (7)	Not reported	Total 314 (138 females; 176 males). Age range 18 – 67. ID: Mild (272); mild to moderate (34); moderate (2); unspecified (6).	Yes	No – authors provided their own quality appraisal for each study.	Critically low
Patterson, Williams & Jones (2019), UK	20 (14)	UK – 8 USA - 6	Total 54 (17 male; 37 female). Age range 18 – 61. Age unreported in 1 study. ID: Mild (19); mild to moderate (26); moderate (4); IQ 44 (1); unspecified (4).	Yes	Yes – Reichow, Volkmar & Cicchetti (2008) evaluative method. All studies rated ‘weak’.	Critically low
Shepherd & Beail (2017), UK	13 (8)	Sweden – 1 UK – 7	Total 94 (65 male; 18 female; 11 unreported). Unable to identify age range for only relevant studies. Age range for total studies was 17 – 64. ID: Mild to moderate (20); unspecified (47). IQ ranged from: <30 to 69 (27).	Yes	Yes – Cahill et al. (2010) checklist, adapted from Downs & Black (1998). Quality ratings ranged from 8 – 21, out of 32. None rated ‘high’.	Critically low

Author(s)/ year/ location	Total studies/ relevant studies	Countries of studies	Population characteristics *Treatment only population in relevant studies* (number of participants)	PRISMA flow diagram	Quality assessment tool used in the review	AMSTAR-2 confidence rating
Unwin, Tsimopoulou, Kroese & Azmi (2016), UK	11 (11)	AUS - 3 UK - 5 USA - 3	Total 210 (94 male; 87 female; 29 unreported). Age range 17 – 73. Age unreported in 2 studies. ID: Mild (110); borderline to mild (23); mild to moderate (57); unspecified (20).	Yes	Yes – Kmet, Lee & Cook (2004). Three studies fell below the cut-off score of 55% for the total possible score.	Critically low
Vereenooghe & Langdon (2013), UK	22 (17)	AUS - 3 UK – 11 USA - 3	Total 465 (285 male; 132 female; 48 unreported). Mean ages reported range from 21 – 45 (13 studies); median age 37 (1 study); unspecified/ unclear (3 studies). ID: mild/ moderate/ severe (34); borderline to mild (28); mild (20); mild to moderate (43); unspecified/ unable to separate intervention from comparison (184). IQ level means reported range from 63.9 to 69.3 (65).	Yes	No – authors provided their own quality appraisal for each study.	Critically low

Results

Quality Assessment

All of the systematic reviews received a confidence rating of ‘critically low’ using the AMSTAR-2 (see Table 3). All scored ‘no’ on items four to seven. Item four asked whether the authors had conducted a comprehensive literature search. This item could be scored ‘no’, ‘partial yes’ or ‘yes’. For a partial yes, the authors needed to search two databases, report key words and their search strategy, and justify publication restrictions. Many reviews failed to indicate publication restrictions. This included limiting their searches to only include studies published in the English language but failing to justify this. For a ‘yes’ score, authors needed to meet the above criteria and additionally have searched the reference lists, trial or study registries, grey literature, have consulted experts in the field and conducted the search within 24 months of completion. Only Osugo and Cooper (2016) met these additional criteria, however, they scored ‘no’ due to failing to justify their publication restrictions.

Items five and six asked whether at least two reviewers independently performed the study selection and data extraction. In some of the reviews, the authors made reference to a second reviewer, but were unclear whether they had worked independently. For example, Unwin et al. (2016) stated that two authors extracted the data, however, it was unclear if they had done this together and if not, how consensus was reached. Nicoll, Beail and Saxon (2013) had a second reviewer check a subsample of their studies, however, kappa was 0.63 and the AMSTAR-2 guidelines indicate that the reviewers should achieve a kappa score of >0.80. None of the reviews provided a list of their excluded or stated whether their included studies had received funding (item seven and 10 respectively). Only Unwin et al. (2016) reported on their own sources of funding (item 16).

Item one required the authors to be explicit about the population, intervention, comparator group and outcome (PICO) that they were exploring in the review. Only four studies reported all four PICO components (Hamelin et al., 2013; Jennings & Hewitt, 2015; Osugo & Cooper, 2016; Vereenooghe & Langdon, 2013). All of the studies which received a ‘no’ did not report whether a comparator was present and some studies also failed to be explicit about the outcome they were examining (Chapman et al., 2013; Hwang & Kearney, 2013; Patterson et al., 2019; Shepherd & Beail, 2017).

Item 14 received the highest rating and asked whether the authors had discussed any heterogeneity found within the results. Eight studies provided a satisfactory explanation (Chapman et al., 2013; Dagnan et al., 2018; Hwang & Kearney, 2013; Jennings & Hewitt, 2015; Nicoll et al., 2013; Shepherd & Beail, 2017; Unwin et al., 2016; Vereenooghe & Langdon, 2013). A total AMSTAR-2 score is provided to aid comparison of the studies. Notably, systematic reviews on the effectiveness of CBT (Hamelin et al., 2013; Jennings & Hewitt, 2015; Osugo & Cooper, 2016; Unwin et al., 2016; Vereenooghe & Langdon, 2013) received more ‘yes’ ratings than reviews of other psychotherapeutic modalities.

Table 3.

Quality assessment using the AMSTAR-2

Authors	Item																Total	Confidence
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
Chapman et al. (2013)	N	N	Y	N	N	N	N	N	PY	N	N/A	N/A	N	Y	N/A	N	2.5/ 13	Critically low
Dagnan et al. (2018)	N	N	N	N	N	N	N	N	N	N	N/A	N/A	N	Y	N/A	N	1/ 13	Critically low
Hamelin et al. (2013)	Y	N	Y	N	N	N	N	PY	N	N	N/A	N/A	Y	N	N/A	N	3.5/ 13	Critically low
Hwang et al. (2013)	N	N	N	N	N	N	N	N	N	N	N/A	N/A	N	Y	N/A	N	1/ 13	Critically low
James et al. (2014)	N	N	N	N	N	N	N	N	N	N	N/A	N/A	N	N	N/A	N	0/ 13	Critically low
Jennings et al. (2015)	Y	N	N	N	N	N	N	PY	N	N	N/A	N/A	Y	Y	N/A	N	3.5/ 13	Critically low
Nicoll et al. (2013)	N	N	N	N	N	N	N	N	PY	N	N	N	Y	Y	N	N	2.5/ 16	Critically low
Osugo et al. (2016)	Y	Y	Y	N	N	N	N	PY	N	N	N/A	N/A	N	N	N/A	N	3.5/ 13	Critically low
Patterson et al. (2019)	N	Y	N	N	N	N	N	N	PY	N	N/A	N/A	Y	N	N/A	N	2.5/ 13	Critically low
Shepherd et al. (2017)	N	N	N	N	N	N	N	N	PY	N	N/A	N/A	N	Y	N/A	N	1.5/ 13	Critically low
Unwin et al. (2016)	N	N	N	N	N	Y	N	N	PY	N	N/A	N/A	N	Y	N/A	Y	3.5/ 13	Critically low
Vereenooghe et al. (2013)	Y	N	N	N	N	N	N	PY	N	N	Y	N	N	Y	N	N	3.5/ 16	Critically low

Y = Yes, N = No, PY = Partial Yes, N/A = Not Applicable. Y responses have received 1 point and PY have received half a point
Items 2, 4, 7, 9, 11, 13, 15 are critical domains and are used to determine the confidence rating.

Narrative Synthesis

To aid interpretation of the findings of the twelve systematic reviews, these reviews are grouped below according to the therapeutic modality which they primarily focused on. Table 4 provides further details of the therapeutic treatments included in each systematic review.

CBT

Seven of the systematic reviews had a primary focus on CBT. Two reviews focused specifically on CBT for the management of anger. These two reviews will be discussed later. The remaining five studies focused more specifically on mental health disorders such as anxiety and depression and included a combined total of 44 relevant studies after removing duplicates. The majority of the studies were conducted in the UK (*n* = 25) and the USA (*n* = 9), however, studies were also conducted in Australia (*n* = 3), New Zealand (*n* = 1) and Ireland (*n* = 1). Two of the systematic reviews focused on only one presenting problem. Dagnan, Jackson and Eastlake (2018) reviewed 19 studies which focused on anxiety disorders, including phobia, post-traumatic stress, panic, hoarding, non-specific anxiety and individuals who presented with obsessive-compulsive symptoms. Their included studies involved 45 male and 62 female participants, aged from 17 to 73, and the majority were described as having mild ID (*n* = 75). Five of the studies did not report how long treatment lasted. In the studies which reported treatment duration it varied from one to thirty sessions. Only two studies reported follow-ups and these ranged from six to 12 months. Seven CBT interventions were delivered in group format. It was unclear how these interventions were tailored to suit the needs of all group members and the authors did not provide a clear comparison of individual versus group interventions.

Table 4.

Overview of therapy within each systematic review

Authors	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
			Cognitive behavioural therapy (CBT)				
Dagnan et al. (2018)	CBT Group (7); individual (12). Target: Post-Traumatic Stress Disorder (5); phobia (3); obsessive- compulsive symptoms (2); panic (1); hoarding (1); non-specific anxiety (7).	Relaxation (13); psychoeducation (9); exposure (7); addressing beliefs/ self-statements (12).	Treatment range: 1 – 30 sessions; unreported (5). Follow-up: 6 – 12 months (2); no follow up/ unclear (17).	Not reported.	Treatment as usual (2) – unclear what this involved.	BAI- Youth (1); BDI-Youth (1); BSI (1); CIRS (1); CRIES 8 (1); GDS (4); GAS (6); HoNOS-LD (1); IES-ID (1); Spider Phobia Questionnaire (1); interview (2); self-report (7); observations by others, i.e. researcher, staff, therapist (5).	All except one study reported positive outcomes, including reduction in ruminations, distress, compulsive behaviours, anxiety, depression and clutter. Increased coping strategies and goal achievement.
Hamelin et al. (2013)	CBT for Anger (8). Group (7); group and individual (1).	Cognitive restructuring (6); role play (6); skills training i.e. assertiveness/ problem solving (7); self-monitoring (1); relaxation (5).	Treatment range: 9 weeks – 9 months. Follow-up: 1 – 30 months (7); none (1).	Psychologist (6); carer (5); nurse (2); graduate students (3); therapist (1); not specified (1).	Wait-list control group (8).	AI (4); Dundee Provocation Inventory (1); NAS (1); PI (2).	Majority of effect sizes were medium to large. Unweighted mean Cohen's *d* for the between-group effect size of the: RCT studies = 1.52 (2); Pretest posttest non-equivalent control group studies = 0.89 (6); individual intervention effect size *d* = 1.21. Two studies reported that participants did not make clinically significant change.

Authors	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
Jennings et al. (2015)	CBT. Group (3); individual (2). Target: Anxiety (1); depression (5).	Activity planning (1); assertiveness (1); monitoring/ challenging thoughts (3); role play (1); self-talk (1); psychoeducation (3); problem solving (1); social skills training (1).	Treatment: Studies reporting weeks ranged from 5 – 16; sessions ranged from 7 – 15. Follow-up: 6 weeks – 8 months.	BABCP accredited therapist (1); non-mental health staff trained to deliver group (2); unreported (2).	Treatment as usual (1); waiting list (3).	ATQ-R (3); BDYI (1); BDI-II (3); BAYI (1); CSQ-8 (1); MANSA (1); RSES (1); SCS (2); SRRS (1); ZDS (1); ZAS (1).	Reductions found in self-reported depression, anxiety and automatic thoughts. Reductions maintained at follow-ups at 3 and 8 months. One study reported significantly lower scores on the BDI in comparison to the control group. One study reported no significant difference between intervention and treatment as usual.
Nicoll et al. (2013)	CBT for anger (12). Group (9); individual (3).	Not reported (12).	Treatment range: 18 – 40 hours (11); up to 18 hours (1). Follow-up: 12 weeks – 30 months; none (5).	Not reported (12).	Control (2); comparison (1). No details of what either involved.	Anger diary (1); anger rating (1); AI (9); behaviour checklist (1); coping skills inventory (1); incident reports (1); imaginal provocation test (1); PACS (1); PI (3); qualitative (1).	11 studies suggested improvements in anger and also fewer incidents of physical aggression. Improvements were maintained or improved further at follow-ups. One study indicated mixed evidence of improvement, with one case showing an increase in anger scores.

	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
Osugo et al. (2016)	CBT (4); single components of CBT (3). Group (5); individual (2). Target: Anxiety (2); depression (6); schizophrenia (1); personality disorder (1); adjustment disorder (1); intermittent explosive disorder (1).	Problem solving training (1); CBT manual followed but no details of what this included (1); not reported (5).	Treatment range: 5 – 16 sessions. Two studies reported weekly treatment but provided no length. Follow-up: 2 – 8 months.	Not reported (7).	Treatment as usual – no further details (1); wait list control (3); GP referral only (1); other therapy (1).	ATQ-R (4); BDI-II (4); BSI (1); BDI- Y (1); BAI -Y(1); ABSR (1); GDS-LD (1); HoNOS-LD (1); MANSA (1); SUDS (1); RSES (1); SCS (2); SRRS (1); ID depression scale (1); index of community involvement and participation in domestic life (1).	Decreased self-reports of psychiatric symptoms and distress levels; mean depression (BDI-II) and automatic thoughts (ATQ) scores lower post-intervention. Increased general well-being post-intervention. One study found no significant reduction in post-test automatic thoughts and another found no significant difference between intervention and control.
Unwin et al. (2016)	CBT. Group (6); individual (5). Target: Anxiety (3); depression (4); mixed presentations including anxiety, depression and anger (4).	Therapy components not reported (7). Four studies reported using manualised treatments, however, it is unclear what this involved.	Treatment range: 5 – 47 sessions. Follow-up: 3 – 6 months (8); none (3).	Agency staff with degree in psychology or sociology/ qualification in working with individuals with ID (1); qualified therapist (10).	Treatment as usual (1); waitlist (2); treatment as usual or waitlist (1); CBT compared with cognitive therapy and behavioural therapy (1).	ATQ-R (3); BAI (1); BAI- Youth (1); BDI-II (4); BDI-Youth (1); BSI (1); CSQ-8 (1); Client Service Receipt Inventory adapted for study (1); GAS-LD (3); GDS (1); HoNOS-LD (1); MANSA (1); RSES (1); SCS (2); SRRS (1); SCL-90R (1); QOLS (1); ZAS (1); ZDS (1); carer rating (1); interview (3).	Qualitative feedback: increased coping strategies by participants and their carers; increased confidence and feelings of calmness; improved mental health and cognitive skills. Quantitative findings: one study indicated no significant difference between intervention and control, or reduction in any measures. All other studies reported some significant improvement on a variety of measures including: ATQ-R, BAI, BDI-II, BSI global severity index, ZAS and GAS-ID.

	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
Vereenooghe et al. (2013)	CBT (14); counselling (1); implosive therapy (1); unclear (1). Group (10); individual (6); group and individual (1). Target: Anger (9); aggression (2); anxiety (2); depression (3); bereavement (1); phobia (1).	Behaviour modelling (1); core beliefs/ negative thoughts (2); discussions (1); role play (3); problem solving (1); goal setting (1); imagery (1); relaxation (2); stress inoculation (2); psycho-education (1); manualised treatment (2); not reported (3).	Treatment range: 10 – 18 individual sessions. Group range from 9 – 16 weeks. One study reported treatment lasted for 40 sessions. Follow-up: 4 weeks – 6 months (14); none (3).	Bereavement counsellors (1); family carers/ day centre staff (1); staff – no further details (2); lay therapists (1); not reported (13).	Other intervention (3); treatment as usual (7); no treatment (4); waiting list (10),	Aberrant behaviour checklist (1); AI (4); Anger Provocation Inventory (1); Anger Expression Scale (1); ATQ (2); Brief Psychiatric Rating Scale (1); BDI- Y (1); BDI-II (2); conflict situations test (1); Dundee Provocation Inventory (1); HoNOS (1); PI (4); RSES (1); SCS (2); NAS (2); Nurses’ Observational Scale for Inpatient Evaluation (1); SRRS (1); self/ staff reports of behaviour (2).	Mixed findings reported. Positive findings included reduced aggression/ anger, phobic avoidance and depression. Some studies reported that there were no significant differences when comparing against other therapies. The majority of studies maintained or showed further improvement at follow-up. Meta-analysis showed a moderate effect size (*g* = .682), with individual therapy appearing better than group interventions (*g* = .778 and *g* = .558 respectively). Moderate- large effect sizes were found for anger and depression.

	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
			Psychodynamic therapy				
James et al. (2014)	Psychodynamic (8); CAT (2). Individual and family (1); individual (9). Target: Ambulophobia (1); anger (2); aggression (4); bereavement (2); food refusal (2); hypochondriasis (1); sadness (2); self-injury (1); social withdrawal (1).	Not reported (10).	Treatment: 5 – 48 sessions (6); 40 – 90 hours (1); 8 years (1); unreported (2). Follow-up: 3 months – 1 year (2); unclear/ unreported (8).	Not reported (10).	None.	No formal measure (5); therapist observations (5); APES (1); BSI (1); Incident reports (1); IIP (2); RSES (2); NAS (1); PI (1); questionnaire – no further details (2).	Therapist observations suggested improvements in the therapeutic relationship; independence; happiness; assertiveness and managing interpersonal problems. Decrease found in aggressive behaviour and distress. One client showed minimal improvement. Formal measures showed improvements in self-esteem and anger, but not in interpersonal problems. Two clients showed minimal improvement.
Shepherd et al. (2017)	Psychodynamic. Individual (8). Target: Aggression/ anger (3); ambulophobia (1); anxiety (1); behavioural problems (4); bereavement (1); bulimia (1); depression (3); hypochondriasis (1); personality disorder (1); obsessive compulsive disorder (1); psychosis (2); relationship difficulties (1); self-injury (2); sexually inappropriate behaviour (2); social isolation (1).	Not reported (8).	Treatment range: 5 – 48 sessions (5); 3 – 43 months (3). Follow-up: 1 – 6 months (3); none (5).	Not reported (8).	None.	APES level (1); Behaviour frequency (2); BSI (1); Defense Mechanism Test (1); DMRS (1); Draw-a-Person test (1); experience of service questionnaire (1); Idiographic data (1); IIP (2); NAS (1); Percept-genetic object relations test (1); RSES (2); satisfaction with therapy and therapist scale (1); SCL-90R (1); secondary handicap (1).	Mixed findings, however, positive findings included: Reduction in aggressive and behavioural problems, better ego functioning, less use of defences and secondary handicap, significant decrease in IIP scores and increased self-esteem. One study found an increase in IIP scores, and another reported no change in defence functioning.

Authors	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
			Third-wave therapies				
Chapman et al. (2013)	Mindfulness. Group (1); individual (5). Target: Anger/ aggression (5); unclear (1).	Soles of the feet meditation (5); observing breathing, noises and objects (1); role play and self-practice (5).	Treatment range: 6 months (1); unclear (5). Follow-up: 4 weeks – 2 years. No follow up/ unclear (2).	Therapist (5); peer with ID (1).	None.	Incidents of aggression (6); use of restraint or medication (1); psychological well-being (1).	All studies reported positive findings, including reductions in aggressive behaviour and the use of medication and restraint. Increases in activity participation and psychological well-being scores were found. One study reported a significant reduction in the use of an observation room and physical intervention.
Hwang et al. (2013)	Mindfulness. Individual (6). Target: Aggression (5); anger (1); bipolar (2); depression (1); obsessive thoughts (1); schizophrenia (1).	Body and thought awareness (1); soles of the feet meditation (5); role play (1); imagining past aggression (1); self-practice (4).	Treatment range: 5 days - 27 months. Follow-up: 4 weeks – 2 years (5); unreported (1).	Not reported/ unclear (2); first author (1); therapist (2); peer (1).	None.	AAQ9 (1); activity engagement (1); physical restraints (1); parent reports (1); PRN medications administered (1); staff or self-report (5).	All studies reported positive findings, including reduction in aggressive behaviour, use of restraint and medication, and less avoidance of cognitions and emotions. Increases shown in self-control and activity engagement. Transition to or maintenance of community placement.

	Therapy modality/ format/ target	Components	Length/ follow-up	Delivered by	Comparison	Outcome measures	Results
Patterson et al. (2019)	ACT (2); CFT (3); DBT (4); Mindfulness (5). Group (3); individual (7); group & individual (3); unclear (1). Target: Aggression (4); anger (1); anxiety (4); bipolar (2); conduct disorder (1); depression (3); emotion regulation (3); mental disorder unspecified (2); obsessive compulsive (1); over-eating (1); post-traumatic stress (1); psychosis (2); schizophrenia (1); self-harm (2).	Therapy components not reported (8). Six studies reported using manualised treatments: Soles of the Feet (4) and I Can Feel Good (2).	Treatment range: 5 days – 27 months (11); 4 – 13 sessions (3). Follow-up: 1 week – 2 years (9); none (5).	Not reported (14).	Not reported (14).	AAQ9 – adapted (1); BDI-II (1); CAMS-R (1); CORE-LD (1); CRI (1); CIRCLE (1); ECQ (1); Emotional Problems Scale (1); FSCRS (1); GAS- LD (1); PTOS-ID (2); RBS (1); Self-compassion scale (2); HoNOS-LD (1); STAI (1); SUDS (1); SCS- adapted (1); YBOCS (1); activity engagement (1); PRN medication (1); observations/ behaviour reports (8); physical intervention/ seclusions (2); sleep (1).	The studies report mixed findings. The majority of studies reported reductions in aggression and that less physical interventions were needed as a result. Another reported that the participant was able to move into a community setting following the intervention. Two studies reported no improvements in anxiety and depression, with one of the studies stating that idiosyncratic measures of mood deteriorated throughout. A further study reported mixed findings.

Therapy models: Acceptance and Commitment Therapy (ACT); Cognitive Analytic Therapy (CAT); Cognitive Behavioural Therapy (CBT); Compassion Focused Therapy (CFT); Dialectical Behaviour Therapy (DBT).

British Association for Behavioural and Cognitive Psychotherapies (BABCP).

Outcome measures: Adapted Acceptance and Action Questionnaire-9 (AAQ9 - adapted); Adapted Behaviour Scale Revisited (ABSR); Anger Inventory (AI); Assimilation of Problematic Experiences Scale (APES); Automatic Thoughts Questionnaire Revised (ATQ-R); Beck Anxiety Inventory (BAI); Beck Anxiety Youth Inventory (BAI- Youth); Beck Depression Inventory – II (BDI-II); Beck Depression Youth Inventory (BDI- Youth); Brief symptoms inventory (BSI); Adapted Sex Offender Self-appraisal Scale (SOSAS); Adapted Sexual Violence Risk 20 (SVR-20); Adapted Youth Risk Behaviour Survey (RBS); Assessment of Sexual Knowledge (ASK); Chart of interpersonal reactions in closed living environments (CIRCLE); Clinical Outcomes in Routine Evaluation – Learning Disabilities (CORE-LD); Client Satisfaction Questionnaire (CSQ-8); Clutter Image Rating Scale (CIRS); Cognitive and Affective Mindfulness Scale – Revised (CAMS-R); Coping Response Inventory (CRI); Revised Childs Impact of Events Scale (CRIES 8); Defense mechanism rating scale (DMRS); Emotional Control Questionnaire (ECQ); Forms of self-criticising and self-reassuring scale (FSCRS); Glasgow Depression Scale for people with a learning disability (GDS-LD); Glasgow Anxiety Scale for LD (GAS-LD); Global Severity of Distress Scale of the Brief Symptoms

Inventory (BSI); Health of the Nation Outcome Scales for People with Learning Disabilities (HoNOS-LD); Inventory of interpersonal problems (IIP); Manchester short assessment of Quality of Life (MANSA); Novaco Anger Scale (NAS); Profile of Anger Coping Skills (PACS); Provocation Inventory (PI); Psychological Therapy Outcome Scale- Intellectual Disabilities (PTOS-ID); Questionnaire Attitudes Consistent with Sex Offending (QACSO); Quality of Life Scale (QOLS); Rosenberg Self-esteem Scale (RSES); Short Term Assessment of Risk and Treatability (START); Social Comparison Scale (SCS); The Social Readjustment Rating Scale (SRRS); State Trait Anxiety Index (STAI); Symptom Checklist 90 – Revised (SCL-90R); The revised Impact of Event Scale ID (IES-ID); Victim Empathy Scale (VES); Vineland Adaptive Behaviour Scales – second edition (VABS-II); Yale-Brown Obsessive compulsive scale (YBOCS); Zung Anxiety Scale (ZAS); Zung Depression Scale (ZDS).

The majority of interventions included relaxation (*n* = 13) and addressed core-beliefs (*n* = 12), and approximately half of the studies included psychoeducation as a core component of treatment (*n* = 9). A range of outcome measures were used across the studies. The most commonly used measures were the Glasgow Depression Scale (GDS) and the Glasgow Anxiety Scale (GAS), which were reported in four and six studies respectively.

Jennings and Hewitt (2015) included 154 participants with ID and depression, across five studies. The participant sample included 82 males and 72 females and again the majority were described as having a mild ID (*n* = 104) or mild to moderate ID (*n* = 50). Three of the CBT interventions were delivered in group format. Psychoeducation, thought monitoring and thought challenging were most frequently reported as therapy components. Eleven formal outcome measures were reported across the studies. The Automatic Thoughts Questionnaire Revised (ATQ-R) and the Beck Depression Inventory – II (BDI-II) were used in three studies. The authors reported mixed findings overall. However, they stated that some studies had shown reductions on measures of mood and anxiety both post-intervention and at three and eight months follow-up. Four studies had comparison groups, three of which were a waiting list group and one was treatment as usual. The study which included the treatment as usual group showed no significant between-group differences.

The systematic review by Unwin et al. (2016) included eleven studies which focused on anxiety and depression, both as sole presenting problems and as co-existing presentations. Out of these five systematic reviews on CBT, the review by Unwin et al. (2016) was the only one not to report any therapy components. They did state that some of their included studies had delivered manualised treatments, however, to those unfamiliar with the manuals it was unclear what these treatments involved. The majority of studies reported that the intervention was delivered by a qualified therapist (*n = 10*), however, the authors did not report on therapists’ experience or qualifications. A total of 19 different outcome measures were used across the studies. The ATQ-R, BDI-II and the GAS- Intellectual Disability measures were again the most commonly reported. Unwin et al. (2016) reported the largest treatment range of all the five CBT studies, stating that participants across the studies engaged in 5 to 47 sessions. Qualitative feedback suggested participants gained coping strategies and improved their confidence and calmness.

The systematic reviews by Vereenooghe et al. (2013) and Osugo et al. (2016) focused mainly on CBT. Vereenooghe et al. (2013) also included two studies focused on counselling and implosive therapy, and Osugo et al. (2016) included three studies that offered either cognitive or behavioural therapy. Both reviews included a range of presenting problems such as anger, anxiety, depression, bereavement, schizophrenia and personality disorder. The review by Osugo et al. (2016) provided minimal details on what therapy entailed and it did not report who delivered therapy. Furthermore, they did not use a quality appraisal tool to assess included studies but instead provided their own subjective appraisal. Vereenooghe et al. (2013) provided some details of what each intervention included. Within their review there were no commonly offered therapy components, other than role play which was reported in three of the seventeen studies. With the exception of one study which reported that therapy lasted for 40 sessions, treatment typically lasted from 9 to 18 sessions. Approximately half of the studies focused on anger or aggression and the Anger Inventory was the most frequently reported measure (*n* = 4). No outcome measure was frequently used in the studies focusing on anxiety, depression, bereavement or phobia. Only Vereenooghe et al. (2013) conducted a meta-analysis and explicitly compared group and individual therapy, reporting better effect sizes for individual therapy (individual *g* = .778; group *g* = .558).

CBT for anger

In addition to Vereenooghe and Langdon (2013), Hamelin, Travis and Sturmey (2013) and Nicoll, Beail and Saxon (2013) reviewed the effectiveness of CBT for individuals with ID and anger difficulties exclusively, and included eight and twelve studies in their systematic reviews respectively. Six studies were included in both reviews, and all nine studies on anger and aggression in Vereenooghe and Langdon (2013) were reported in either of these two systematic reviews. Hamelin et al. (2013) did not provide participant characteristics such as age or gender and did not report the level of ID for three of their included studies. As such, despite the authors concluding many positive findings of CBT for anger, it is impossible to determine whether anger treatment may be more suited to particular clients. The majority of studies reported the use of cognitive restructuring, role play, skills training and relaxation. Furthermore, six out of eight studies reported that psychologists delivered the intervention. Despite many similarities, the treatment length reported varied widely, ranging from nine weeks to nine months and follow-ups were conducted between one and 30 months.

The systematic review by Nicoll et al. (2013) included 214 participants, with the majority being male (*n* = 160) and described as having borderline or mild ID (*n* = 142). Only three studies out of nine reported on individual therapy and therapy duration ranged from 18 to 40 hours across 11 studies. The authors did not provide details of what therapy entailed or who delivered it. The length of treatment varied between 18 to 40 hours across 11 studies and seven studies reported follow-ups between 12 weeks and 30 months. Eleven of the studies indicated improvements in anger following the intervention, however, one study showed an increase in scores on anger measures. The authors reported an average effect size of 0.84 in group studies and 1.01 in individual studies.

The most frequently used measure across both systematic reviews was the Anger Inventory, reported four times by Hamelin et al. (2013) and nine times by Nicoll et al. (2013). The second most frequently cited measure was the Provocation Inventory. As neither review reported the age of participants it is not possible to comment on whether CBT for anger will be an effective treatment for all adults with ID across the age range. Furthermore, there are significantly more males included in the review by Nicoll et al. (2013) and it is unclear whether males or females responded differently to treatment.

In terms of meta-analyses for anger treatment, Nicoll et al. (2013) published a fixed-effects analysis of uncontrolled mean differences calculated within the intervention arm (pre–post) for nine studies of anger treatment. Hamelin, Travis, and Sturmey (2013) calculated standardised mean differences of pre–post change in their meta-analysis of eight outcome studies. Vereenooghe and Langdon (2013) conducted a random-effects meta-analysis of standardised mean differences of independent groups for outcomes assessed after treatment for nine CBT studies of anger problems. The results of the three meta-analyses are very similar, with effect sizes of 0.88 (Nicoll et al., 2013), 0.89 (Hamelin et al., 2013), and 0.827 (Vereenooghe & Langdon, 2013).

Psychodynamic therapy

Two systematic reviews explored the effectiveness of psychodynamic therapy for adults with ID. These reviews included 15 relevant studies in total, with three studies reported in both reviews. The systematic review by Shepherd and Beail (2017) included eight relevant studies which focused on individual psychodynamic therapy and the majority of which took place within the UK (*n* = 7). Therapy aimed to target a wide variety of presenting problems including aggression and anger, anxiety, depression, bulimia, obsessive compulsive disorder and psychosis. The majority of participants within the studies were male (*n* = 65, 69.15%) and aged between 17 to 64. For 47 participants (50%) their IQ level was not clearly reported, and one study reported that participants' IQ ranged from <30 to 69 (*n* = 27, 28.72%). The remaining participants were described as having mild to moderate ID (*n* = 20, 21.28%). Studies varied in the way in which they reported treatment length, with some reporting the number of sessions that participants engaged in and other reporting how many months of treatment participants completed. Five studies reported session lengths (ranging from five to 48 sessions), and three studies reported months (ranging from three to 43 months). No study provided details of what therapy entailed and only three studies reported follow-ups (ranging from one to six months post-treatment). The authors rated the quality of the studies using the Cahill et al. (2010) checklist and reported that no study was of high quality.

The systematic review by James and Stacey (2014) included eight studies focused on psychodynamic therapy and two studies focused on cognitive analytic therapy. All studies reported on individual therapy, with the exception of one study which also included work with the client's family. The authors included studies focusing on a variety of presenting problems, such as ambulophobia, food refusal, anger, sadness and social withdrawal. A total of 32 participants were included in the relevant studies and 23 of these presented with mild ID (71.88%). The gender of 20 participants was unclear. The remaining participants included six males and six females. The majority of the studies reported treatment length in number of sessions and this ranged from five to 48 sessions. One study reported that treatment lasted eight years. Two studies did not report on treatment length. The majority of the studies included within the review did not report whether a follow-up had been offered (*n* = 8). The authors reported that five studies did not include formal measures and another study did not include any formal measure of mood. The authors suggest that their review provides some evidence for the use of psychodynamic therapy for adults with ID, however, the authors did not assess the quality of their studies. As such it is unclear whether there are significant methodological limitations in the studies which would inform the conclusions that can be drawn.

In both systematic reviews it is unclear who therapy was delivered by, what therapy involved, and whether comparison groups were included. A variety of formal outcome measures were administered to assess the effectiveness of psychodynamic therapy. These included the Novaco Anger Scale (NAS), Provocation Index (PI), the Rosenberg Self-Esteem Scale (RSES), the Inventory of Interpersonal Problems (IIP), the Brief Symptom Inventory (BSI) and the Symptom Checklist Revised (SCL-90R). Of the studies which reported using formal measures, the majority did report improvements in client's presentations, such as a decrease in anger and improvements in self-esteem. However, one study in James and Stacey (2014) found that interpersonal problems deteriorated throughout therapy despite improvements on other measures. Another study reported that one client made no significant changes on any measure including the BSI, the RSES and the IIP. The majority of studies relied heavily on therapists' observations to determine whether clients had made improvements. The studies in both reviews did not provide adequate data for meta-analyses.

Third-wave therapies

Three systematic reviews explored the effectiveness of third-wave therapies. Four studies were reported in all three reviews and three studies were reported in two reviews. After removing duplicates, a total of 15 studies were found which focused on third-wave therapies for adults with ID and co-existing mental health difficulties.

Chapman et al. (2013) and Hwang et al. (2013) both conducted systematic reviews on the effectiveness of mindfulness. The main presenting problem in both reviews were aggression or anger, however, studies also included participants with bipolar, depression, obsessive thoughts and schizophrenia. The two reviews included five of the same studies and four were by the same author, Singh et al. The age of participants ranged from 18 to 47 across the two reviews and the majority were reported as having mild to moderate ID. As such, it is unknown whether mindfulness would be effective for individuals with more severe ID or the older population. Chapman et al. (2013) only reported treatment length for one study, which lasted six months. Hwang et al. (2013) reported that treatment ranged from five days to 27 months and that follow-up periods ranged from four weeks to two years. Across the two systematic reviews, only one study used a standardised outcome measure (the Acceptance and Action Questionnaire). The majority of studies focused on reports of aggression from staff members. Chapman et al. (2013) reported that all their included studies were of ‘weak’ quality. Hwang et al. (2013) did not conduct a quality assessment.

Patterson, Williams and Jones (2019) reviewed a variety of third-wave therapies including mindfulness, acceptance and commitment therapy (ACT), compassion focused therapy (CFT) and dialectical behaviour therapy (DBT). This systematic review included 14 relevant studies, eight of which were not included in either of the above reviews by Chapman et al. (2013) and Hwang et al. (2013). A total of 54 participants were included in the studies. Participants were aged between 18 and 61 and were predominantly female (*n* = 37). The majority of participants were described as having a mild or moderate ID (*n* = 49). The authors did not describe the therapy components of any of the included studies, however, six studies used manualised treatments including Soles of the Feet (*n* = 4) and I Can Feel Good (*n* = 2). ACT, CFT and DBT treatments focused on a variety of presenting problems such as anxiety, depression, over-eating, obsessive thoughts, psychosis, self-harm, emotional regulation difficulties, and interpersonal difficulties. It is unclear whether therapy was tailored for different presenting problems or whether a transdiagnostic approach was taken. Treatment length varied widely, ranging from five days to 27 months. Nine studies offered a follow-up. Study follow-up periods ranged between one week and two years post-treatment. Eighteen different outcome measures were reported, however, no single outcome measure was used frequently. Eight studies reported using observations or behaviour reports to measure the outcome of therapy. The authors used the Reichow, Volkmar and Cicchetti (2008) evaluative method to assess the quality of studies and found all studies were of weak quality.

Patterson et al. (2019) did not report who treatment was delivered by, however, the majority of studies focusing on mindfulness were conducted by a therapist, as reported by Chapman et al. (2013). Patterson et al. (2019) reported mixed findings with regard to whether third-wave therapies are effective for adults with ID and co-existing mental health difficulties. Their review highlighted some improvements in anxiety and depression scores following therapy, however, noted that some included studies did not find improvements. One study which used idiosyncratic measures found that mood deteriorated throughout therapy. The variety of third-wave therapies that Patterson et al. (2019) included within their review, the number of presenting problems, and the mixture of group and individual therapy makes it difficult to establish whether third-wave therapies are effective treatments for this population group. Furthermore, it was not reported whether the studies included comparison groups, so it is possible that any improvements seen may have been made without therapy.

Discussion

The first aim was to assess the quality of the existing systematic reviews. The AMSTAR-2 (Shea et al., 2017) indicated that all twelve systematic reviews were ‘critically low’ in quality. Many of the reviews failed to justify their publication restrictions, did not report whether an independent rater had been used, or did not adequately report the components of PICO. The utility of the AMSTAR-2 will be further discussed in limitations.

The second and third aims of this review were to investigate the effectiveness of psychological therapy, comparing the reported effectiveness of different therapeutic modalities. The majority of the reviews focused on CBT, with only two focusing on psychodynamic therapy, and three focusing on third-wave approaches. The seven CBT reviews all reported some positive findings across a variety of presenting difficulties, including reduced ruminations, distress, anxiety, depression, anger, and increased confidence and calmness. All reported at least one study which found either no significant difference between intervention and control, or an increase in the difficulty such as anger. Mixed findings were found in the psychodynamic reviews and a heavy reliance on therapist observations were noted, however, formal measures did show some improvements in self-esteem and anger. When exploring third-wave therapies, two of the reviews focused purely on mindfulness. These reported wholly positive findings, including reductions in aggressive behaviour and improvements in well-being and activity engagement. The review by Patterson et al. (2019) focused on third-wave therapies more broadly and reported mixed findings. Two studies found no improvements on measures of anxiety and depression, and idiosyncratic measures of mood further deteriorated throughout therapy. It is difficult to determine from the current review whether CBT, psychodynamic therapy or third-wave approaches are most effective for adults with ID. There appears to be less evidence for psychodynamic therapy due to limited use of standardised outcome measures, and also minimal support for third-wave therapies, with the exception of mindfulness. Research suggests that a wide range of therapeutic modalities are now offered in clinical practice (Beail, 2016), but this review shows a lack of evidence for approaches beyond CBT.

The final aim of this review was to highlight the strengths and limitations within the evidence base and offer recommendations for future systematic reviews. Some limitations are highlighted above, however, further limitations were evident following data extraction. For example, the target of psychological work was often unclear, with some studies reporting diagnoses such as personality disorder but not clearly stating whether this was the target for therapy. Many of the systematic reviews did not report who delivered therapy and consequently we are unable to identify whether clients have better outcomes when therapy is delivered by a qualified psychologist or psychotherapist. Six studies reported who therapy was delivered by, i.e. ‘therapist’; however, no information regarding their qualifications or experience was provided. Only CBT studies included comparison groups which included either waiting list or treatment as usual; consequently, it is unclear whether benefits made in psychodynamic or third-wave therapies could have been made without therapy. Finally, 48 standardised outcome measures were used across the studies which highlights the breadth of psychological problems and makes it difficult to conclude which treatments are more effective for particular presenting problems.

Strengths and Limitations

This review is the first to systematically explore the existing systematic reviews on the effectiveness of psychological therapy for adults with ID and mental health difficulties. It attempted to bring the existing literature together and develop a clearer understanding of what is currently offered and what works for this population group. A total of 78 studies, with a total of 1,056 participants with ID, were identified across the 12 systematic reviews. This review has highlighted that the current evidence base typically includes more males with ID (male n = 607, 57%; female n = 380, 35.98%). Out of the 502 participants who were described as having either mild, moderate or severe ID, 72% of participants were classified as having mild ID. Out of the 46 studies which reported age, 54.35% of these only included participants who were below age 50. This highlights a bias in the literature, potentially towards males, with mild ID, and below age 50. Studies have suggested that mental health difficulties may be similar in older adults with ID, however, they are likely to present with more physical health difficulties and this may consequently mean that different therapeutic approaches are needed (Torr & Davis, 2007).

A limitation of this systematic review is that it intended to focus on adults with a diagnosis of ID, however, many of the reviews included participants with co-morbid diagnoses including Autistic Spectrum Disorder and Downs Syndrome. Comorbidity is common in individuals with ID. Moreover, due to the difficulties with conducting randomised controlled trials, the majority of the systematic reviews included studies which had taken place in clinical practice and are consequently less controlled (Cooper et al., 2015; Willner, 2005). As such, it is impossible to determine the impact of comorbidity on therapy effectiveness for adults with ID in this review.

Secondly, whilst 78 relevant studies were identified after removing duplicates, all relevant studies within each systematic review were subject to data extraction. This resulted in 27 studies having their data extracted more than once. Whilst we have tried to be transparent about the number of duplicate studies throughout the write up, it was difficult to separate these duplicate studies out within the narrative synthesis when reflecting on individual systematic reviews. Consequently, studies which have been included more frequently will dominate the evidence provided in this review.

Thirdly, the authors aimed to include studies on anger but exclude studies on challenging behaviour. This decision was made as it was felt that in clinical practice clients with ID are often referred due to difficulties with regulating anger. Research indicates a significant overlap between mental health and anger in the ID population, and mental health problems may not be as easily identified due to diagnostic overshadowing (Hemmings, Deb, Chaplin, Hardy & Mukherjee, 2013; Mason & Scior, 2004; Whittle, Fisher, Reppermund & Trollor, 2017). Many of the included studies used ‘anger’ and ‘aggression’ simultaneously; consequently, studies on challenging behaviour have been included. Costello and Bouras (2006) emphasised a lack of consensus on what constitutes a mental health problem for individuals with ID and that challenging behaviour is regularly highlighted as a mental health difficulty in this population group. The authors suggested that this is because mental health is typically identified by individuals struggling to maintain their roles in parenting or work, and a significant number of individuals with ID would not be in these roles for mental health problems to be readily identified. The authors highlighted the need for a clearer distinction between mental health and challenging behaviour in future research and clinical practice, and this review supports this.

Lastly, the AMSTAR-2 was chosen as it is one of the only available tools which focuses on the methodological quality of systematic reviews. The tool requires that systematic reviews meet a number of criteria to receive a score and many of our reviews failed to do so. Recent literature highlights difficulties with the AMSTAR-2. Matthias et al. (2020) reviewed systematic reviews exploring interventions of adults with depression and found that 53 out of 60 studies were of ‘critically low’ quality, suggesting possible floor effects or insufficient discriminating capacity. The authors recommended removing or replacing critical items which inform the overall confidence rating. Foss, Oldervoll, Fretheim, Glenton and Lewin (2019) conducted a scoping overview and adapted the AMSTAR-2 by simplifying some items into ‘yes’ or ‘no’ responses. It was unclear how their adaptations impacted their quality scores and all included studies had four or more minor limitations. Out of a possible 39 studies, 27 were excluded due to major methodological problems and it is possible that more studies would have been excluded without amendments to the tool.

It is evident that the AMSTAR-2 does not provide the most efficient items for assessing the quality of practice-based research, which dominates research on psychological therapies for people who have ID. It is likely that many of the reviews failed to justify why particular study designs were included (item three) because RCT’s are deemed aspirational rather than achievable in outcome studies with people with ID and this is well reported in the literature (Beail, 2010). Authors did not sufficiently report on PICO elements (item eight) and it is likely that this information was not adequately reported in their included studies. Assessing risk of bias (item nine) is certainly vital but a difficult task in practice-based research where confounding and sample selection bias is hard to diminish. Furthermore, pre-specifying outcomes is problematic when studies include a diversity of participants and presenting problems. This is likely due to a difficulty obtaining homogeneous samples in small populations such as individuals with ID and mental health difficulties. Consequently, the AMSTAR-2 may require simplifying or the removal of particular critical items, however, this is the case for all fields where practice-based research dominates rather than adjusting the bar solely for research within the ID field. Ultimately, we feel that the significant problem is in relation to authors’ adherence to reporting guidelines rather than the tool itself.

Recommendations

The findings of this review highlight the need for higher quality research exploring the effectiveness of psychological therapy for adults with ID. Whilst the AMSTAR-2 could be used by researchers conducting systematic reviews to ensure that they report clearly on the core components, this review highlights that there are also difficulties with the quality of the studies within the included systematic reviews. Furthermore, future research should attempt to make a clearer distinction between mental health difficulties and aggression or challenging behaviour. This would support a better understanding of the target of psychological therapy. The Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS-ADD) has been used by researchers to identify mental health difficulties in adults with ID and more consistent use of this measure in clinical practice may help identify clients where a mental health problem is present in comparison to challenging behaviour alone (Moss et al., 1993; Moss et al., 2000). Lastly, this review found that the majority of the reviews focused on the effectiveness of CBT and identified a lack of comparators other than waiting lists or treatment as usual. Ideally, it would be beneficial for future research to have a more clearly defined presenting problem and to compare therapeutic modalities on their effectiveness in treating the problem. This would enable clinicians to make more informed decisions about which therapeutic approach to use. However, we acknowledge that approximately only 2.16% of adults have a diagnosed ID and only a subset of these individuals will have a mental health difficulty (Mencap, 2020). Consequently, researchers may continue to have difficulties focusing on a specific condition in the timescales of a funded research project.

Conclusions

Twelve systematic reviews were identified which focused on CBT, psychodynamic therapy and third-wave therapies. The findings of this review tentatively suggest that psychological therapy can have benefits for adults with ID presenting with a wide range of mental health problems. This includes reductions in depression and anxiety, and improvements in wellbeing. However, psychological therapy did not always result in positive changes and some studies reported further deterioration. Due to the limitations described above, no conclusions can be made with regards to which psychological therapy is most effective for adults with ID. All twelve systematic reviews were rated as critically low in quality and consequently any findings should be interpreted with caution.

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Appendix A - AMSTAR-2 Checklist

AMSTAR-2 has been removed due to copyright.

Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., ... & Henry, D. A. (2017). AMSTAR 2: A critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *The BMJ*, *358*, 1-9. https://doi.org/10.1136/bmj.j4008

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Section II: Research report

Clinical Psychologists' perspectives on what makes an effective therapist for adults with intellectual disabilities: An exploration into the feasibility of an innovative Q-methodological study

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Abstract

Background

There is a paucity of research exploring the behaviours and attitudes of effective therapists for adults with intellectual disabilities (ID). This study had two main aims: (1) explore the feasibility of three innovations to the typical Q-methodology, including online delivery, providing cluster feedback, and conducting further statistical analysis; and (2) explore whether clusters of clinical psychologists (CPs) could be defined with regards to their views on effective therapists for adults with ID.

Method

Twenty-seven CPs completed an online study including a Q-sorting task, demographic questions, and psychometric measures of burnout, job satisfaction and confidence. Principle component analysis was conducted to identify CP clusters and a Kruskal-Wallis test was used to test for significant differences between identified clusters on the measures. Participants were provided with their cluster interpretation and asked for feedback.

Results

It was found that online delivery of the Q-sorting task resulted in participant frustration, a high drop-out rate, and consequently insufficient numbers for meaningful statistical analysis. There was a high interest in receiving cluster interpretations. Three distinct participant clusters (25/27 participants) were identified and accounted for 49% of the variance. No significant differences were found between the three clusters on psychometric measures.

Conclusions

This feasibility study shows that online delivery of Q-methodology needs refinement to ensure recruitment, or alternatively, a hybrid approach utilising face-to-face methods may be more appropriate. The three distinct viewpoints identified indicate that CPs vary considerably in what they believe is clinically effective in their work. Future research should explore the relationship between cluster membership and clinical outcome.

Practitioner Points

- Practitioners working with adults with ID should consider their assumptions and beliefs regarding what makes an effective therapist for this population group.
- Practitioners should utilise clinical supervision to discuss their assumptions and beliefs of what makes an effective therapist and how this informs their work with ID clients.
- Practitioners should consider routinely monitoring their client outcomes during therapy.

Keywords: Effective therapists, intellectual disability, psychotherapy, Q-methodology.

Introduction

Psychotherapy is a complex process and researchers have attempted to disentangle which factors contribute to clients making positive change, whilst others deteriorate, experience stasis or are harmed by the intervention (Lindon, 2013). Research exploring the role of the therapist in client outcomes has increased in recent years and studies consistently report that between 5-8% of therapy outcome can be attributed to the therapist (Johns, Barkham, Kellett & Saxon, 2019; Norcross & Lambert, 2018). Some therapists are found to be significantly more effective, achieving almost double the amount of client change each session (Firth, Barkham, Kellett & Saxon, 2015). Johns et al. (2019) suggests that there has been an ‘over-attention’ on comparing treatment modalities and that further research is needed to identify what it is about effective therapists that differentiate them from their colleagues.

What Makes an Effective Therapist?

Wampold (2011) indicated fourteen core qualities of an effective therapist, which included having sophisticated interpersonal skills, being able to develop a therapeutic relationship with a broad range of individuals, monitoring progress, being flexible and adaptive, and not avoiding difficult topics. The therapist’s ability to develop and maintain a strong therapeutic relationship is consistently highlighted as important (Baldwin, Wampold & Imel, 2007). Norcross and Lambert (2018) focused on the therapist-client relationship and suggested the following as important: the therapist’s ability to develop an alliance; support collaboration, agreement on therapy goals; collect and deliver feedback throughout therapy; and show empathy and positive regard towards the client.

Another key addition to the evidence base has been research on therapist’s facilitative interpersonal skills (FIS). Schöttke, Flückiger, Goldberg, Eversmann and

Lange (2017) assessed the FIS of postgraduate trainees who were training in cognitive behavioural therapy or psychodynamic therapy. Trainees assessed as having greater FIS in a group format had better therapeutic outcomes, even after controlling for therapeutic orientation. Anderson and Perlman (2020) described eight core FIS of the therapist, including their communication skills; portrayal of positive expectations for change; persuasiveness; emotional expression; warmth, acceptance and understanding towards the client which displays genuine care; level of empathy; the therapist's capacity to develop a strong alliance; and their ability to respond to and repair any ruptures which arise. Importantly, FIS can be enhanced when therapists practice their skills (Anderson, Perlman, McCarrick & McClintock, 2020).

It is likely that many factors influence therapist effectiveness rather than a sole reliance on individual therapeutic skills. For example, Delgadillo, Saxon and Barkham (2018) found that when therapists experienced higher burnout and lower job satisfaction, their clients had significantly poorer treatment outcomes in comparison to those receiving treatments from therapists with low burnout and high job satisfaction. Other factors such as the therapist's confidence has also been debated. Ackerman and Hilsenroth (2003) suggested that the therapist's confidence in their ability to support their clients was vital, and in turn generates greater trust and confidence in the therapeutic process. However, Evans-Jones, Peters and Barker (2009) explored the impact of various factors on the therapeutic relationship and found that therapist's confidence was not significantly associated with greater therapeutic relationships. Therapeutic outcome was not explored.

Effective Therapists for Clients with Intellectual Disabilities (ID)

There has remained a paucity of literature exploring what makes an effective therapist for clients with ID and research typically focuses on the effectiveness of specific therapeutic modalities (Jones, 2013; Willner, 2005). The ID literature champions adapting therapy, suggesting that therapists should be flexible rather than sticking rigidly to manuals, should set simpler goals, simplify techniques and include others (such as caregivers) in treatments when appropriate (Hurley, Tomasulo & Pfadt, 1998; Stavrakaki & Klein, 1986). The National Institute for Health and Care Excellence (NICE, 2016) also provides guidance but again focuses largely on adaptations. There is a clear lack of consideration of the role of the therapist and how they may contribute to client outcomes in therapy. As with the general population, it is thought that a number of factors are likely to influence therapy outcomes for clients with ID, including client, environmental and therapist factors (Raffensperger, 2009).

Qualitative literature has shed some light on the significance of the therapist for clients with ID. Giffords, Evers and Walden (2013) explored how individuals with ID experienced working with a clinical psychologist. Participants (*n* = 8) highlighted the importance of developing a strong therapeutic relationship, which was developed through setting boundaries, showing understanding, being flexible and managing expectations. Jones (2013) interviewed eight counselling psychologists on their experience of the therapeutic relationship with clients with ID. Participants felt the therapeutic relationship was vital, although acknowledged it was difficult to establish at times due to having to involve others in the work. Interestingly, participants differed in their views around whether the therapist should have a direct or a client-led approach.

Rose (2013) compared the therapy outcomes achieved by clinical psychologists and by assistant psychologists in individual anger management treatment for clients with ID. Positive change was found in both groups, however, clinical psychologists accounted for more client change and clinically significant change. Whilst Rose (2013) suggests that this is due to greater ‘experience’ of the qualified psychologists, it is unclear how much experience the assistants had in either delivering anger management treatments or working with clients with ID. It is possible that the difference in outcomes were associated with other variables, for example, confidence.

The current evidence base for psychological treatments for ID is limited due to small sample sizes and a lack of standardised outcome measures available to therapists (Vereenooghe & Langdon, 2013). Moreover, therapy often needs to be individually adapted, making it difficult to standardise therapy and assess contributory factors to therapeutic improvement (Beail, 2017; Bhaumik, Gangadharan, Hiremath & Russell, 2011). Quantitative studies are scarce, underpowered or of low quality, making it difficult to establish what makes an effective therapist for clients with ID. Johns et al. (2019) suggested that studies on therapist effects should include a minimum of 50 therapists and approximately 1200 patients. Given the difficulties with conducting high quality quantitative research in the field of ID, it is unlikely that research of this magnitude could be easily conducted.

The Current Study

Gaining practitioner consensus has been highlighted as a useful way to increase knowledge of an under-researched area (Haddock & Jones, 2006). In the ID field, expert knowledge and consensus has been used to develop treatment guidelines (Sullivan et al., 2018). Q-methodology is a ‘qualiquantological’ method which can be utilised to explore practitioner consensus (Watts & Stenner, 2005). It is an underused methodology that adopts a hybrid approach, enabling subjective perspectives to be identified and a way of objectively exploring the patterns of beliefs which emerge through statistical analysis (Ramlo, 2016). Q-method is ‘qualitative dominant’ and prioritises theoretical rather than statistical significance (Ramlo, 2016). Q-method uses a form of factor analysis to identify clusters of participants that share a consensus of common thoughts and feelings. It is different from traditional R factor analysis (Coogan & Herrington, 2011) because participants are classed as variables and the statements (Q-set) are the study sample (Watts & Stenner, 2012). Watts and Stenner (2005) provides a useful summary of the common misunderstandings in Q-methodology highlighting that it is not typical to have large participant numbers and statistical power is not usually considered.

Q-method techniques have previously been used to explore the views of psychologists. For example, Stamoulos et al. (2016) explored psychologists' views on the common factors which lead to positive outcomes in psychotherapy. However, no know studies have explored psychologists' views on what makes an effective therapist for adults with ID. The forced quasi-normal distribution used in Q-methodology means that participants have to carefully consider their beliefs, helping to minimise social desirability bias and revealing conscious and unconscious beliefs of the participants (Cross, 2005; Paige & Morin, 2016). It was thought by the researchers that other methods of qualitative research would not enable participants to acknowledge the areas of their therapeutic work which they pay less attention to.

A preliminary study is required to explore whether Q-methodology is suitable for developing a greater understanding into effective therapists for adults with ID. To aid this exploration, this study intends to build upon extant Q-methods, but also explore the feasibility of three methodological innovations. These innovations are: (1) delivering the Q-sorting task online, as it is most typically delivered face to face; (2) providing participants with feedback on their cluster allocation and gaining feedback on the acceptability of this; and (3) conducting further statistical analysis on the clusters, to identify whether group membership differs on factors highlighted within the literature as contributing to positive therapist outcomes. Feasibility studies aim to determine whether a future study can and should be done, and what modifications are necessary (Eldridge et al., 2016). Feasibility studies do not always focus on the intention of conducting future trials or intervention studies, but often focus on testing out new design features and the ability to recruit a sufficient number of participants (Lancaster & Thabane, 2019).

Aims and Hypotheses

The primary aim is to explore the feasibility of three innovations to the typical Q-methodology. Orsmond and Cohn (2015) identified five feasibility objectives which have guided our approach, as follows:

1) Recruitment: Can a suitable number of participants be recruited for the Q-sorting task online?
2) Data collection and outcome measures: Do participants find it manageable to complete the variety of measures in addition to the sorting task? Are the measures appropriate to determine any differences between the factors?
3) Study procedure acceptability: What is the rate at which participants abandon the study whilst online? Do participants want to receive their group interpretation?
4) Resources: Is there enough capacity and time allowed to conduct the study within a manageable time frame?
5) Overall response and success of innovations: To what extent do participants agree with their cluster allocation? Have any challenges been highlighted throughout the process?

Our secondary aim is to assess whether clusters of clinical psychologists working with adults with ID can be defined with regards to effective practice and to characterise the practice of the differing clusters. Due to the exploratory nature of Q-methodology, no hypotheses are typically formed (Watts & Stenner, 2005). However, due to the addition of psychometric measures within our study it was hypothesised that cluster membership would differ according to age, experience, job satisfaction, confidence or burnout. The direction of these differences are not specified.

Method

This study received ethical approval from the University of Sheffield (registration number: 170149400; see Appendix A). Q-methodology was utilised and the design can be defined by three core phases. Methodological innovations are discussed in phases two and three. Our feasibility objectives are discussed throughout this section.

Q-Method Phases

Phase one: Creating the Q-set

The main aim in phase one was to generate a set of statements representative of the views on what makes an effective therapist for adults with ID. This collection of statements is called the ‘Q-set’ and can be developed from the existing literature on a topic or through interviews with participants who have knowledge and experience in the area (Watts & Stenner, 2005). In this study, the Q-set was generated by four qualified clinical psychologists who engaged in individual semi-structured interviews. The interviews lasted between 45 to 90 minutes and focused on: the core features of the participant’s therapeutic work; what participant’s believed maximise outcomes and could impede progress; the core skills of an effective therapist; and how they personally adapted therapy (see Appendix B).

Interviews were recorded, transcribed and analysed using thematic analysis. The key stages highlighted in Braun and Clarke (2006) were followed, including: becoming familiar with the data, generating initial codes, sorting codes into potential themes, reviewing the themes, and defining and naming the themes. The final stage involved defining the final statements which were used in phase two. The first author and an assistant psychologist completed the analysis independently and met following this to agree on final proposed statements. It is generally agreed that between 40 to 80 statements is manageable for participants to sort (Stainton Rodgers, 1995) and 49 statements were included in this study (see Appendix C).

Phase two: Online study and Q-sorting task

An online study was created using Qualtrics (see Appendix D). Participants were asked for demographic data, including: age, number of years qualified, number of years' experience with clients with ID, preferred therapeutic modality, further qualifications, service setting, and supervision frequency. Participants completed psychometric measures on confidence, burnout and job satisfaction. Following this, participants were provided with a list of the 49 statements and a series of instructions which led to them sorting the statements into a quasi-normal distribution shape, ranging from -5 (least important) to +5 (most important). Participants were asked to: select the two statements they felt were the most important skills of an effective therapist and transfer them into the '+5 most important' box; select the three second most important skills and transfer them into the '+4' box; complete the same process for the least important skills and transfer the items into '-5' and '-4'; and sort the remaining statements from +3 to -3. Participants were asked if any important statements were missing from the list.

Phase three: Interpretations of the Q-sort

Participant's responses on the Q-sorting task were analysed using PQ Method. Principle Component Analysis (PCA) or Centroid Factor Analysis (CFA) can be used to analyse Q-sort data, and both have strengths and limitations (Thornhill, Kellett, &

Davies, 2012; Watts & Stenner, 2005). CFA is the oldest and most commonly used technique due to the researcher's ability to explore their data fully. In contrast, PCA provides the best mathematical solution (Watts & Stenner, 2012). The two techniques typically result in similar outcomes (Harman, 1976; Watts & Stenner, 2012). PCA was chosen as the best method for this study as we aimed to capture as many of the participants' views as possible so that participants could be provided with their group interpretation.

Group interpretations were generated by the lead researcher, following guidance by Watts and Stenner (2012). Consenting participants were emailed their interpretations and asked to rate the following five statements from one (completely disagree) to five (completely agree): 'This description is an accurate summary of an effective therapist for clients with ID'; 'This description reflects my values as a clinician'; 'Being in this group reflects my clinical practice'; 'I am satisfied with being in this group'; and 'Being in this group fits with my sense of identity as a clinical psychologist'. Participants were also asked: 'What are the implications for your clinical practice?'.

To enhance our interpretation of the PCA, our aim was to conduct further statistical analysis to explore whether significant differences existed between the participant clusters on three psychometric measures (see measures section). No statistical analysis was pre-determined, however, it was hoped that enough participants would be recruited to run a one-way ANOVA in SPSS. A Kruskal-Wallis test was conducted due to non-normal data distribution.

Participants

Participants were recruited from the British Psychological Society – Intellectual Disability faculty in two phases. In both phases, only qualified clinical psychologists who were currently working with adults with a diagnosis of ID in England could take part. There were no restrictions on service settings. Participants were contacted via email and were provided with a brief description of the study in the body of the email and an in-depth information sheet was attached (see Appendix E and F).

Phase one focused on recruiting three to five qualified clinical psychologists with eight years or more experience in working with adults with ID to take part in individual semi-structured interviews. Four participants consented (see Appendix G) and their experience working with adults with ID ranged from 11 to 28 years. Two participants worked in a community team, one participant worked in an intensive support service, and one participant worked in an inpatient service. The participants' preferred therapeutic modalities included psychodynamic, positive behaviour support, systemic therapy and narrative therapy (see Table 1). Due to the small number of clinicians working in the field of ID, the gender and age of participants has been retained to protect their anonymity.

Phase two was open to all qualified clinical psychologists who were working with adults with ID at the time of the study. Feasibility studies typically include smaller sample sizes and power calculations are not usually undertaken (Arain et al., 2010). This complements a typical Q-study as statistical power is not usually considered in this method (Watts & Stenner, 2012). However, it is recommended that a satisfactory Q-methodological study should include between 40 to 60 participants (Stainton Rodgers, 1995). The current study aimed to achieve this recommendation and hoped that online delivery would enable us to recruit this number of participants within a relatively short time frame. Previous Q-methodological studies recruiting psychologists have included participant numbers as low as 21 and have been able to identify distinct viewpoints (Stamoulos et al., 2016). Consequently, the authors in the current study agreed that 21 participants would be the lowest acceptable sample size to conduct a pilot Q-methodological investigation in an ID context. Participants provided their consent at the start of the online study (see Appendix H).

Feasibility Summary

To summarise, our feasibility objectives explored recruitment; outcome measures acceptability; study procedure acceptability; resources; and overall response. *Recruitment* was defined as the total number who consented to start the online study and our minimum aim was 21 participants. *Outcome measure acceptability* was explored by calculating the number of participants who exited the study during the measures section and also our ability to find statistically significant differences between the clusters and the psychometric measures. *Acceptability of the procedure* (Q-sorting task and cluster interpretations) was explored by calculating the percentage of participants who exited the study at the Q-sorting task and calculating the percentage of participants who consented to receiving their group interpretation. *Resources* was tested by the time taken to recruit a suitable number of participants and our aim was to recruit a minimum of 21 participants within one month, however, we hoped to recruit between 40 – 60. *Overall response* was tested by asking participants to provide feedback on the acceptability of their cluster interpretation using five statements, as described above in phase three, and by reflecting on any challenges encountered in the above areas.

Psychometric Measures

Copies of the measures can be found in Appendix I.

The Therapy Confidence Scale – Intellectual Disabilities (TCS-ID)

The TCS-ID is a 14-item measure which asks participants to reflect on their confidence in working with clients with ID during assessment, intervention, and the therapy ending (Dagnan, Masson, Cavagin, Thwaites & Hatton, 2015). Example items include “how confident are you that you can explain results of an assessment process to a client with ID?" and "use knowledge about mental health intervention to work effectively with a client with ID?". Participants rate their confidence on a five-point scale which includes: 'not confident - 0'; 'slightly confident - 1'; 'moderately confident - 2'; 'confident - 3'; and 'highly confident - 4'. Higher scores consequently indicate higher levels of confidence. The authors reported Cronbach's alpha of 0.93 and test-retest reliability of 0.83.

The Copenhagen Burnout Inventory (CBI)

The CBI is a 19-item measure on burnout which acknowledges that fatigue and exhaustion are central to the concept of burnout (Kristensen, Borritz, Villadsen & Christensen, 2005). The measure includes three domains: personal, client and work-related burnout. Example items include "how often do you feel tired?", "do you feel burnt out because of your work?", and "do you feel that you give more than you get back when you work with clients?". Response items include: 'always or to a very high degree - 100'; 'often or to a high degree - 75'; 'sometimes or somewhat - 50 '; 'seldom or to a low degree - 25'; 'never/ almost never or to a very low degree - 0'. An average domain score is calculated and higher scores indicate higher levels of burnout. The authors reported Cronbach alphas between 0.85 to 0.87 for the three domains.

Job satisfaction

A single item measure of job satisfaction developed from the 16-item Job Satisfaction Scale was used. Participants were asked to rate the following statement from one (extremely dissatisfied) to seven (extremely satisfied): 'Taking everything into consideration, how do you feel about your job as a whole?' (Dolbier, Webster, McCalister, Mallon & Steinhardt, 2004).

Table 1

Demographics of phase 1 participants

Participant	Years qualified	Further qualifications	Experience in ID (years)	Preferred modality	Service setting	Direct work (% time)	Supervision of others
1	20+	Diploma and postgraduate in psychodynamic approaches	25+	Psychodynamic	Community	Yes – 30%	Yes – psychologists (assistants, trainees & qualified), other therapists
2	20+	No	25+	Positive Behaviour Support	Community & inpatient	Yes – 30%	Yes - psychologists (assistants, trainees & qualified), other therapists, doctors
3	15	Narrative therapy & Positive Behaviour Support	25+	Narrative therapy	Intensive support & community	No	Yes - psychologists (assistants & trainees), support staff
4	11	No	11	Systemic	Community	Yes – 40%	Yes – trainee psychologists

Results

Feasibility

Recruitment

Initial recruitment resulted in a total of 78 participants consenting to take part in the study. Only 26 (33.33%) participants completed the entire study (demographic questions, psychometric measures and the Q-sorting task). One participant only completed the Q-sorting task. Whilst this is above our minimum number of participants (21), we were unable to achieve our ideal aim of recruiting between 40 to 60 clinical psychologists.

Measure Acceptability

A total of 77 participants (98.72%) completed the three psychometric measures, with only one participant completing the Q-sorting task but not the measures. This suggests that participants found the measures acceptable to complete. We are unable to report reliably on whether our three measures were suitable for identifying significant differences between the clusters. A Kruskal-Wallis test indicated no significant differences between the three factor groups on all measures, however, due to the small sample size it is likely that the study was not powered sufficiently to detect an effect.

Study Procedure Acceptability

The Q-sorting task appeared less acceptable to participants as only 27 participants completed this (34.62%), highlighting a drop-out rate of 65.38%. Four participants informed us that they found it a frustrating procedure. Two participants reported that it was difficult to complete on a mobile or tablet device, and two participants reported that they felt unable to choose the most important skills of an effective therapist. Whilst we did stipulate that a computer would be needed to complete the study, we acknowledge that many individuals prefer to access information on their smart phones and a more accessible format may have increased the participant completion rate. Out of the Q-sort completers, a high percentage of participants consented to receiving their group interpretation (20/27; 74.07%), indicating a high interest in this innovation.

Resources

Our study aimed to recruit a minimum of 21 participants within one month. Our study opened on the 16th December 2019 and after repeatedly re-advertising the study, we recruited 21 participants by the 23rd May 2020. This was 21 participants who had completed all elements of the study. We closed the study on the 13th July 2020 when 26 participants had completed all elements. We were significantly over our target of one month for recruitment which suggests that online delivery of Q-methods is not effective in terms of resource (time particularly).

Overall Response

Twenty participants consented to receiving their group interpretation but only five provided feedback on this (25%). This limits our ability to ascertain the usefulness or determine whether participants felt that it was an accurate summary of effective therapists for adults with ID. Only one participant indicated that they were completely satisfied with being in their cluster (see Table 2). Some participants provided qualitative feedback and reported: “I think this is a helpful description for other professionals to understand the role of a therapist in ID and the nature of psychological therapy.” With regards to the overall study response, there was clearly a high level of frustration when completing the study online and this will need further consideration in future studies.

Table 2

Mean, standard deviation and range for the feedback responses

Question	M	SD	Range
This description is an accurate summary of an effective therapist for clients with ID	3.80	0.45	3 - 4
This description reflects my values as a clinician	3.60	0.55	3 - 4
Being in this group reflects my clinical practice	3.40	0.55	3 - 4
I am satisfied with being in this group	3.40	1.14	2 - 5
Being in this group fits with my sense of identity as a clinical psychologist	3.40	0.55	3 - 4

Q-Sort Analysis

Sample Characteristics of the Q-Sort Completers

Twenty-six participants completed the sorting task, demographic questions, and the three measures. The majority were female (*n* = 20) and between the ages of 30 to 39 years (*n* = 15). Most participants had been qualified psychologists for one to four years (*n* = 7), five to nine years (*n* = 8) or ten to 19 years (*n* = 8). One participant had been qualified for less than one year and two participants had been qualified for more than 20 years. Fourteen participants reported that they had over ten years' experience in working with clients with ID. All participants worked in community settings, however, two participants also worked in an inpatient service. A range of preferred therapeutic modalities were identified and cognitive analytic therapy (CAT) was the most commonly reported (*n* = 7). Five participants selected 'other', with four reporting that they had an 'eclectic' approach. The majority of participants received supervision monthly (*n* = 17) and twenty-three participants supervised others (*n* = 23). This included supervising trainee psychologists (*n* = 15), assistant psychologists (*n* = 7), qualified psychologists (*n* = 6), nurses (*n* = 7), and behaviour therapists (*n* = 1). See Table 3.

Table 3

Demographic data for phase two participants

	Gender	Age	Years Qualified	Years' experience	Therapy model	Further training	Work setting	Supervision received	Supervising others
Q-sort completers	Male (6) Female (20)	30 – 39 (15) 40 – 49 (9) 50 – 59 (1) 60 – 69 (1)	< 1 (1) 1 – 4 (7) 5 – 9 (8) 10 – 19 (8) 20 – 29 (1) 30 – 39 (1)	< 1 (1) 1 – 4 (5) 5 – 9 (6) 10 – 19 (8) 20 – 29 (5) 30 – 39 (1)	ACT (2) CAT (7) CBT (3) DBT (1) Psychodynamic (2) Systemic (6) Other – (5)	Yes (14) No (12)	Community (24) Community & inpatient (2)	Weekly (2) Fortnightly (7) Monthly (17)	Yes (23) No (3)
Q-sort non-completers	Male (4) Female (47)	20 – 29 (4) 30 – 39 (33) 40 – 49 (12) 50 – 59 (1) 60 – 69 (1)	< 1 (4) 1 – 4 (16) 5 – 9 (11) 10 – 19 (18) 20 – 29 (1) 30 – 39 (1)	< 1 (2) 1 – 4 (14) 5 – 9 (12) 10 – 19 (15) 20 – 29 (6) 30 – 39 (2)	ACT (3) CAT (7) CBT (6) DBT (1) Psychodynamic (2) Systemic (16) Other (16)	Yes (27) No (24)	Community (39) Inpatient (5) Other (7)	Weekly (4) Fortnightly (8) Three weekly (3) Monthly (31) Other (5)	Yes (42) No (9)
Total	Male (10) Female (67)	20 – 29 (4) 30 – 39 (48) 40 – 49 21) 50 – 59 (2) 60 – 69 (2)	< 1 (5) 1 – 4 (23) 5 – 9 (19) 10 – 19 (26) 20 – 29 (2) 30 – 39 (2)	< 1 (3) 1 – 4 (19) 5 – 9 (18) 10 – 19 (23) 20 – 29 (11) 30 – 39 (3)	ACT (5) CAT (14) CBT (9) DBT (2) Psychodynamic (4) Systemic (22) Other (21)	Yes (41) No (36)	Community (63) Inpatient (5) Community & inpatient (2) Other (7)	Weekly (6) Fortnightly (15) Three weekly (3) Monthly (48) Other (5)	Yes (65) No (12)

Acceptance and Commitment Therapy (ACT); Cognitive Analytic Therapy (CAT); Cognitive Behavioural Therapy (CBT); Dialectical Behaviour Therapy (DBT).

Principle Component Analysis

A three-factor solution using Principle Component Analysis (PCA) accounted for 49% of the variance and 25 out of 27 participants loaded significantly onto a factor. See Table 4 for Q-sort loadings and corresponding factors. Fifteen participants loaded significantly onto factor one; four participants loaded significantly onto factor two; and six participants loaded significantly onto factor three. The three factors and their corresponding Q-sort values and Z scores can be found in Table 5. This table highlights the viewpoints between each factor which informed the interpretations below.

Table 4

Q-sort loadings on each factor. An asterisk (*) indicates a participant.

Q-sort	Factor 1	Factor 2	Factor 3
1	0.5261*	0.1911	0.3270
4	0.7162*	0.1566	-0.1322
9	0.5127*	0.0951	0.3377
10	0.6502*	0.2275	0.3569
11	0.5442*	-0.2072	0.1838
12	0.5585*	0.2284	0.3817
13	0.5172*	0.5019	0.0800
14	0.6912*	-0.0238	0.1565
16	0.7802*	-0.0750	0.1169
17	0.5079*	0.2886	0.2575
21	0.6306*	0.2330	0.1623
23	0.5005*	0.1809	0.3857
24	0.5654*	0.1892	0.1384
26	0.5523*	0.1334	0.3942
27	0.6210*	0.0181	0.4846
2	0.3584	0.5059*	-0.2843
6	0.1913	0.4951*	0.3139
7	0.0337	0.8896*	-0.0963
15	0.2366	0.4794*	0.2625
8	0.0917	0.1646	0.7505*
18	0.2807	-0.1863	0.4475*
19	0.4206	0.2597	0.6266*
20	0.1071	0.1182	0.7731*
22	0.1983	0.1345	0.5667*
25	0.0874	0.2817	0.5679*
3	0.5266	-0.2157	0.5272
5	0.3465	0.3401	0.2755
Explained variance (%)	23%	10%	16%

Table 5

Q-sort values and Z scores for each factor.

Q-statement	Factor 1		Factor 2		Factor 3	
	Q-sort value	Z score	Q-sort value	Z score	Q-sort value	Z score
11. can adapt their style to suit the client's needs	5	2.08*	1	0.31	-1	-0.23
37. is able to be flexible within a therapeutic model, rather than sticking rigidly to a manualised treatment	4	1.73*	0	0.05	2	0.54
40. works collaboratively to support the client to find their own answers	4	1.43*	-1	0.23	0	0.42
9. has the ability to be playful and creative in therapy	3	1.31*	-2	-0.88	-4	-1.61
10. will build on the skills that a client already has	1	0.52*	-5	-1.70*	-2	-0.58*
43. keeps a focus on what they are doing within therapy and why	0	-0.13*	2	0.77	3	0.81
14. adopts more than one role in the clients care beyond a therapist when necessary and appropriate	-1	-0.44*	-5	-2.11	-3	-1.61
31. is aware of the defences that clients use due to the history of intellectual disability and how they are accepted within society	-2	-0.67*	4	1.30	2	0.58
49. makes use of counter-transference to understand the impact of the client on others	-3	-0.93*	5	1.78*	0	-0.02*
23. is aware when they are pulled to discharge clients because they find them difficult to work with	-3	-1.24*	0	-0.01	-1	-0.21
36. will use outcome measures regularly	-5	-1.49*	0	0.10*	-5	-2.33*
46. can use the therapeutic relationship to bring about change	2	0.68	5	1.69*	1	0.51
41. understands the full history of a client	0	-0.40	4	1.63*	0	0.07

7. considers whether the client knows what psychology can offer before commencing psychological work	-2	-0.71	3	1.28*	-2	-0.75
32. tries to understand the personal meaning of having an intellectual disability	-2	-0.68	2	0.92*	-3	-0.83
22. will have an awareness of their own personal and emotional needs and ensures that these do not get in the way of client's needs	-3	-0.77	1	0.56*	-2	-0.72
3. has knowledge about other diagnoses	-4	-1.42	1	0.28*	-3	-1.49
47. will work indirectly through others to support clients when appropriate	3	0.95	-1	-0.37*	3	0.99
48. does not over focus on techniques, but has a greater focus on developing the relationship and trust with clients	4	1.54	-3	-1.04*	5	1.96
2. considers the client's needs holistically	2	0.82	-3	-1.09*	1	0.45
34. does not make assumptions about the client	1	0.54	-3	-1.11*	2	0.56
45. will utilise informal and formal guidance from other multi-disciplinary professionals when necessary	-1	-0.46	-4	-1.68*	-1	-0.11
24. will help the wider team or system around the client to formulate and think psychologically about a client	1	0.48	0	-0.13	5	1.69*
16. has awareness of power and how this can impact the therapeutic work	0	0.11	0	-0.03	4	1.66*
27. has awareness of the 'stuckness' that can occur outside of the therapy room when systems, families, or carers are not yet ready for the client to change	0	-0.37	-3	-1.04	4	1.44*

25. spends time offering consultation, training and supervision to other staff members	-1	-0.56	-1	-0.27	3	0.73*
18. is aware when they are getting drawn into helping with other areas of a client's life which may not be useful to the therapeutic relationship	-3	-0.89	-3	-1.31	1	0.50*
28. spends time considering the practicalities of a client attending therapy and makes any necessary adaptions	1	0.42	3	1.07	-3	0.85*
1. can co-create a formulation that is accessible and meaningful	5	1.95	3	1.28	4	1.21
4. will think thoroughly about risk	0	-0.12	2	0.61	0	0.28
5. will manage safeguarding concerns and attempt to repair any ruptures that may arise consequently †	2	0.76	2	0.72	0	0.30
6. Can discuss with a client when it is not the right time for them to engage in therapy †	-1	-0.51	-2	-0.73	-1	-0.06
8. has empathy and unconditional regard †	2	0.92	3	1.11	2	0.58
12. will seek advice from the client's family members or other professionals	-1	-0.65	-2	-0.99	-1	-0.08
13. understands the boundaries of the therapeutic role †	0	-0.04	0	0.10	1	0.54
15. acknowledges that there may be areas of their own life which are inaccessible to some clients with intellectual disabilities †	-4	-1.47	-4	-1.34	-5	-1.88
17. is aware when they are getting pulled into trying to rescue a client	0	-0.19	1	0.25	1	0.49
19. has good self-awareness †	-2	-0.69	-2	-0.98	-2	-0.47
20. can acknowledge when they are not a good fit for the client and offer a new therapist	-4	-1.29	-2	-0.78	-4	-1.79

21. is clear and transparent about the process of therapy, what it will entail and explains this in a way that the client understands	1	0.19	0	0.16	3	0.83
26. realises that it is not always appropriate to work with both the client and their family members simultaneously †	-3	-0.90	-1	-0.24	-2	-0.58
29. will follow the client's pace in therapy †	3	1.16	4	1.34	2	0.55
30. makes use of and has access to formal and informal clinical supervision †	2	0.57	1	0.47	3	1.06
33. acknowledges that clients are often reliant on others	-2	-0.73	-1	-0.22	-3	-1.11
35. understands the nature of a client's cognitive difficulties and the impact of these	3	1.09	2	0.83	0	0.06
38. is flexible with regard to the amount of sessions that a client is offered and the length of the sessions †	1	0.37	-1	-0.15	0	0.13
39. thinks about consent and what information the client is happy to be shared with others in their system †	3	1.01	3	1.09	1	0.45
42. has a good understanding of their own reasons for being a psychologist and can reflect on the possible impact of this †	-5	-2.25	-4	-1.59	-4	-1.79
44. has an awareness of their own limitations	-1	-0.64	1	0.33	-1	-0.30

* Significant distinguishing statements, $p < .01$
† Statements that did distinguish between any factors.

Factor One: The Creative Collaborator

Factor one included 15 participants (12 females; 3 males), had an eigenvalue of 6.21 and explained 23% of the variance. Most of the participants were aged between 30 to 39 (*n* = 11) and had been qualified for either one to four years (*n* = 5) or five to nine years (*n* = 6). A large proportion of the participants reported that CAT was their preferred therapeutic modality (*n* = 6), followed by systemic therapy (*n* = 4). The majority of participants received supervision monthly (*n* = 9) and supervised others (*n* = 13). This group had the lowest mean confidence rating (M = 44.87; SD = 6.21), with scores ranging from 35 to 56. Job satisfaction ranged from five to seven (M = 5.67, SD = 0.72). With regards to burnout, the lowest mean score in this group was for client burnout (M = 26.11, SD = 16.10) and the highest was for personal burnout (M = 47.5, SD = 13.16). Mean, standard deviation and range for all three measures and the three groups can be found in Table 6. Factor one's group interpretation:

'An effective therapist for adults with intellectual disabilities needs to be creative and playful with their therapeutic approach (9: +3). An effective therapist does not tend to over focus on therapeutic techniques and is not concerned with sticking rigidly to a model or manual (37: +4). Outcome measures are rarely considered necessary and at times the therapist may lose focus on what they are doing and why (36: -5; 43: 0). The main focus remains on developing a strong and trusting relationship with the client (48: +4). Working collaboratively with clients and their family members is vital and this should result in a co-created formulation which is accessible and meaningful, not just to the therapist but to the client (1: +5; 26: -3). An effective therapist conducts holistic assessments with clients and develops a good understanding of the nature of their cognitive difficulties and how they impact (2: +2; 35: +3). An effective therapist will use this information to ensure that they adapt their style to suit the client's needs (11; +5). Whilst a good understanding of intellectual disability is important, it is not important to have a great deal of knowledge about other diagnoses (3: -4). An effective therapist realises that clients themselves come to therapy with a wide range of skills. The therapist does not take an 'expert' position but instead builds on the skills that the client already has and supports them to find their own answers to their difficulties throughout therapy (10: +1; 40: +4). Focusing on being creative, playful and flexible can mean that there is less time for reflection within the therapeutic work. To be effective for clients, a therapist does not need to spend significant time reflecting on their own personal and emotional needs, their reasons for being in the job, or whether there may be areas of their own life which are inaccessible to the clients they work with (22: -3; 42: -5; 15: -4).'

Table 6

Mean (M), standard deviation (SD) and range (R) for each factor group on the psychometric measures

	Factor 1	Factor 2	Factor 3	Total completers	Total non-completers
Confidence	M: 44.87 SD: 6.21 R: 35-56	M: 46.67 SD:10.41 R: 35-55	M: 49.83 SD: 5.23 R: 42-56	M: 46.27 SD: 6.45 R: 35-56	M: 44.69 SD: 6.91 R: 28-56
Job satisfaction	M: 5.67 SD: 0.72 R: 5-7	M: 5.67 SD: 1.15 R: 5-7	M: 4.83 SD: 1.17 R: 3-6	M: 5.38 SD: 1.02 R: 3-7	M: 5.00 SD: 1.34 R: 1-7
Personal burnout	M: 47.5 SD: 13.16 R: 12.5-66.67	M: 30.56 SD: 13.39 R: 20.83-45.83	M: 58.33 SD: 23.12 R: 33.33-91.67	M: 49.68 SD: 18.82 R: 12.5-91.67	M: 49.75 SD: 16.44 R: 16.67-83.33
Work burnout	M: 40.71 SD: 16.24 R: 17.86-75	M: 27.38 SD: 7.43 R 21.43-35.71	M: 51.19 SD: 14.40 R: 35.71-75	M: 43.41 SD: 17.75 R: 17.86-75	M: 46.08 SD: 17.12 R: 7.14-89.29
Client burnout	M: 26.11 SD: 16.10 R: 0-54.17	M: 12.50 SD: 7.22 R: 8.33-20.83	M: 27.78 SD: 13.86 R: 12.50-50	M: 26.12 SD: 16.27 R: 0-54.17	M: 25.41 SD: 16.59 R: 0-83.33

Factor Two: The Reflective Expert

Four participants (1 female; 2 males; 1 unreported) were significantly associated with factor two, which had an eigenvalue of 2.7 and explained 10% of the variance. One participant did not provide demographic data or complete the measures. All three participants worked in community settings and two participants reported psychodynamic therapy as their preferred therapeutic modality. Two of the participants were aged 30 to 39, and one participant was between 60 and 69. All participants reported a different number of years qualified and experience of working with clients with ID, ranging from one to 39 years. Factor two participants reported the lowest levels of personal, work and client burnout in comparison to the other two factor groups (M = 30.56, 27.38 and 12.50 respectively). Factor two's group interpretation:

'An effective therapist for adults with intellectual disabilities does not jump straight into offering therapy. Whilst it is not vital that the client understands every element of what therapy entails, an effective therapist will consider whether the client understands what psychology can offer before it commences (21: 0; 7: +3). They will also think about risk and whether adaptations will make it easier for clients to attend therapy (4: +2; 28: +3). Building relationships with clients based on empathy and unconditional regard is important as this helps to bring about positive change within the client's life (8: +3; 46: +5). The therapist will follow the client's pace in therapy and will take the time to understand the full history of the client (29: +4; 41: +4). This in addition to therapeutic techniques supports the development of a strong relationship (48: -3). The therapist takes a more 'expert' position within therapy and relies less on the skills of the client, those within the client's system, or other multi-disciplinary professionals (10: -5; 12: -2; 45: -4). An effective therapist will make some assumptions about their clients and understands the defences that clients typically present with due to the history of intellectual disability and how clients are currently accepted within society (34: -3; 31: +4). An effective therapist holds this in mind while also developing a more personal understanding of what it means to the client to have an intellectual disability (32: +2). One to one client work is important and the therapist maintains therapeutic boundaries, ensuring a focus on psychological need rather than having a holistic approach (47: -1; 14: -5; 2: -3). Self-reflection is a core skill. The therapist remains aware of their own personal and emotional needs so that they do not get in the way of the client's needs (22: +1). They also use their skills to reflect on their feelings towards clients and will consider what this tells them about the client's relationships outside of therapy (49: +5).'

Factor Three: The System Integrator

Factor three included six participants (five females; one male), had an eigenvalue of 4.32 and explained 16% of the study variance. All six participants worked in the community and supervised others, however, one also worked in an inpatient setting. The majority were aged between 40 to 49 (*n* = 4) and had been qualified between 10 to 19 years (*n* = 4). Experience working with clients with ID varied in the group, with participants reporting one to four years' experience (*n* = 2), 10 to 19 years (*n* = 2), and 20 to 29 years' experience (*n* = 2). Half of the participants reported that they were 'eclectic/ integrative' in their approach. This participant cluster had the highest mean confidence (M = 49.83, SD = 5.23) but the lowest mean job satisfaction (M = 4.83, SD = 1.17). In comparison to the other clusters, they had the highest levels of personal, work and client burnout (M = 58.33, 51.19, and 27.78 respectively). Factor three's group interpretation:

'An effective therapist for adults with intellectual disabilities understands the importance of working beyond the client. The therapist will work with a client's family, their care staff or the wider team and will aim to increase psychological thinking within these systems and develop a shared understanding (24: +5; 1: +4). Sometimes these systems are not ready for the client to change and this can lead to the client struggling to make improvements (27: +4). The therapist remains aware of this and is ready to offer consultation, training or supervision when needed (25: +3). An increased focus on systems working can mean that the therapist has less focus on the adaptations that may need to be made to support clients with intellectual disabilities to attend therapy and they may not adapt their style to suit the client's needs (28: -3; 11: -1). Whilst therapeutic boundaries can be important, it is sometimes necessary to help with other areas of a client's life which are not always useful to the therapeutic relationship (18: +1). An effective therapist knows what they are doing and why, and acknowledges that at times it is necessary for boundaries to become blurred (43: +3). The therapist is conscious of power differences which can occur and will strive to develop positive and trusting relationships with clients (16: +4). The therapist will prioritise this over focusing on specific therapeutic models and techniques (48: +5). Consequently, outcome measures are seldom used (36: -5). It is not important that the therapist is a particularly playful or creative person and it is rarely important for the therapist to consider offering a new therapist to work with the client because they themselves are not a good fit (9: -4; 20: -4). The therapist will sometimes struggle to acknowledge that there may be areas of their own life which are inaccessible to their clients, however, the therapist values their clinical supervision and will make use of this when needed (15: -5; 30: +3)'.

Cluster Consensus

Twelve statements did not distinguish between any pair of factors (see Table 4). Across the groups, four statements were rated positively (score of >0); five statements were negatively rated (score of <0); and three statements appeared more neutral (scores ranging from -1 to 2). Positive statements included following the clients pace in therapy (item 29, F1: 3, F2: 4, F3: 2); thinking about consent (item 39, F1:3, F2: 3, F3:1); making use of supervision (item 30, F1: 2, F2: 1, F3: 3); and having empathy and unconditional regard for clients (item 8, F1: 2, F2: 3, F3: 2). Negative items included having an understanding of their own reasons for being a psychologist (item 42, F1: -5, F2: -4, F3: -4); acknowledging that areas of their life may be inaccessible to some clients with ID (item 15, F1: -4, F2: -4, F3: -5); realising that working with the client's family is not always appropriate (item 26, F1: -3, F2: -1, F3: -2); has good self-awareness (item 19, F1: -2, F2: -2, F3: -2); and can discuss when it is not the right time for the client to engage in therapy (item 6, F1: -1, F2: -2, F3: -1).

Statistical Analysis and Group Differences

Due to recruitment difficulties, logistic regression was considered as a way to explore any statistically significant differences in the completers and non-completers groups on demographic variables and measures of burnout, job satisfaction and confidence. However, due to the small sample size the model could not be run successfully. We attempted to collapse some of the variables, as many category responses within the variables did not have a sufficient number of responses. This was unsuccessful and consequently the analysis was rejected, as it was felt that the meaningfulness of the data would be lost if we were to collapse variables further. When exploring between cluster differences, the Kruskal-Wallis test indicated no significant differences between the three factor groups on measures of confidence ($H(2) = 2.58$, $p = .275$), job satisfaction ($H(2) = 2.3$, $p = .317$) and work-related ($H(2) = 4.99$, $p = .082$), client-related ($H(2) = 2.66$, $p = .264$), and personal burnout ($H(2) = 3.88$, $p = .143$). No further statistical analyses were conducted or planned.

Table 3 and 6 provides descriptive information on the completers (C) group (*n* = 26) and the non-completers (NC) group (*n* = 51). In both groups the majority were female (C: *n* = 20, 76.92%; NC: *n* = 47, 92.16%), aged between 30 – 39 (C: *n* = 15, 57.69%; NC: *n* = 33, 64.71%), received monthly supervision (C: *n* = 17. 65.38%; NC: *n* = 31, 60.78%), supervised others (C: *n* = 23, 88.46%; NC: *n* = 42, 82.35%), and had been qualified for less than 10 years (C: *n* = 16, 61.54%; NC: *n* = 31, 60.78%). The completers group had more participants with over 10 years' experience (C: *n* = 14, 53.85%; NC: *n* = 23, 45.10%). There were no clear differences between the groups on job satisfaction, personal burnout or client burnout. However, the completers group did have higher mean confidence (C: M = 46.27; NC: 44.69) and lower levels of work burnout (C: M = 43.41; NC: M = 46.08).

Discussion

This study had two main aims. The first aim was to explore the feasibility of three innovations to a typical Q-methodological study. Our second aim was to assess whether clusters of clinical psychologists could be defined with regards to their views on what makes an effective therapist for adults with ID.

Recruitment Issues and Utilising Online Means

Significant difficulties with recruitment were found. A high number of participants consented to the study, but a much lower number completed the entire study (27/78). With exception of one participant, all participants exited the study at the Q-sorting task, which indicates that this was the main difficulty for participants. Furthermore, recruitment took significantly longer than our anticipated one-month, taking five months to recruit our minimum number of participants. Postlethwaite, Kellett and Simmonds-Buckley (2020) used a hybrid approach with participants completing the sorting task online or in person. They reported a high drop-out rate online (50.56%) but no drop-out in person. In our study, participants were not able to complete the study face to face. Some participants reported that it was difficult to choose the most important skills of an effective therapist, whilst others found the format inaccessible to complete on mobile devices. We would argue that the former is an indication that a method such as Q-methodology is important, as it was speculated that alternative qualitative methods may have resulted in participants discussing the equal importance of skills and attributes rather than focusing on what they really view as most important (Cross, 2005). Despite this, participant frustrations resulted in a significant drop-out rate using the online method which suggests that this was not a feasible approach to gain a wide variety of voices and opinions. Future studies using online means may wish to consider how the resources within the research team are utilised and offer participants the opportunity to receive online support to help minimise frustrations. Equally, a hybrid approach such as the one described in Postlethwaite, Kellett and Simmonds-Buckley (2020) may be more successful.

Acceptability of Cluster Interpretations and Statistical Analysis

Difficulties with recruitment had a significant impact on our ability to assess the acceptability of our cluster interpretations or conduct statistical analysis. It is not typical in Q-methodology to have additional measures, however, we included these as research indicates that therapist's levels of burnout, confidence and job satisfaction can have an impact on therapeutic outcomes (Ackerman & Hilsenroth, 2003; Delgadillo, Saxon & Barkham, 2018). We hypothesised that clinical psychologist's views on effective therapists may be informed by these variables, however, no significant differences were found between the clusters. A number of alternative measures could have been used as many factors are associated with therapist effects (Johns et al., 2019). Our main concern was regarding the acceptability of completing measures in addition to the Q-sorting task. We tentatively conclude that the measures were acceptable due to a high percentage of participants completing them but it is possible that the study felt too burdensome to complete both the measures and the sorting task. It is important to acknowledge that whilst we reiterate that our participant numbers were too low, this conflicts with the original ethos of Q-methodology where participants numbers and power and not overly considered (Watts & Stenner, 2012). However, if future studies hope to include further measures then statistical power does need to be considered prior to ensure that analyses can reliably detect an effect (Yang, 2016).

With regards to the cluster interpretations, a high percentage of participants were interested in this (74.07%) but minimal feedback was gained from participants about how they found their interpretations. Participants were only provided with two weeks to respond to this due to the increased time spent on recruitment. We suggest that due to the high interest rate, future Q-methodological studies should trial cluster interpretations again but provide participants with a greater time frame to respond.

Effective Therapists for Clients with ID

The PCA did reveal three main viewpoints on what makes an effective therapist for adults with ID. ‘Creative Collaborators’ (CC) typically favoured working with clients and their families, and tended to work creatively and jointly rather than taking an expert position. ‘Reflective Experts’ (RE) tended to favour a more expert role within therapy, valued one-to-one work with clients, and emphasised the importance of being a reflective practitioner. ‘System Integrators’ (SI) also tended to involve families in their work, but their focus appeared to be more on the systems around the client rather than the client themselves. The SI group suggested that effective therapists for clients with ID have less emphasis on therapeutic models and that ‘role blurring’ is vital at times.

Twelve statements were not significantly associated with either of the three groups which suggests some consensus. However, participants had more agreement on skills and attributes that did not make for an effective therapist such as reflecting on their reasons for being a psychologist and the areas of their life which may be inaccessible to the ID population. Interestingly, skills such as ‘positive regard’ which are frequently highlighted in the literature as essential skills for effective therapists (Farber, Suzuki & Lynch, 2018) were not rated as one of the most important skills in any group. This could suggest there is a gap in the current evidence base regarding what is viewed as important in clinical practice by clinicians. Alternatively, what is viewed by clinicians as important in clinical practice may differ in general and ID populations.

From descriptive analysis, CC’s were typically younger, had less experience than the other groups, and identified CAT as their preferred therapeutic modality. There appeared to be a leaning towards psychodynamic therapy in the RE group (50%) and a more integrative way of working in the SI group (50%). The largest differences were found on measures of burnout, with REs showing lower burnout. Whilst there is limited research exploring the impact of therapeutic modality on levels of burnout, this is contradictory to the available literature which suggests that counsellors with a preference for psychodynamic therapy have higher burnout levels (Tartakovsky & Kovardinsky, 2013).

Limitations

Firstly, individuals with ID were treated as a homogenous group and participants were not asked whether they worked typically with clients with mild or severe levels of ID. Clinicians tend to believe that psychotherapy is less effective for clients with more severe ID (Mason, 2007). Consequently, is possible that participants in this study may believe there are different skills needed to work with clients with differing ID levels and the summaries generated in this study are more appropriate for a specific level of ID.

Secondly, the Q-set was generated by clinical psychologists with eight years or more qualified experience. It is common in Q-methodology to recruit participants who are deemed to have experience in an area and this informed our decision not to include newly qualified psychologists in this phase (Watts & Stenner, 2012). Research within the general population highlights that client outcomes typically decrease as therapist experience increases (Goldberg et al., 2016). It is possible that our phase one participants were less effective in their practice than newly qualified psychologists and this may have influenced their views on what makes an effective therapist. On reflection, keeping this phase open to all qualified clinical psychologists would have been beneficial. However, when phase two participants were asked to identify any missing skills or attributes from the Q-sort, we had minimal feedback or concerns.

Conclusions

The feasibility results highlighted significant difficulties with delivering the Q-study online, resulting in a low participant sample and inadequate numbers for further statistical analysis. Recruitment was also slow and therefore future studies need to set more conservative recruitment targets or plan to have a longer recruitment period. The manner in which Q-sorts are presented online needs future exploration and studies could compare acceptability evidence across differing formats. The innovation of providing participants with cluster feedback was easy to implement and can be a feature of future studies. The use of additional measures to contextualise Q-sort results needs to be carefully considered in terms of participant burden and whether measures do actually confer an added benefit. Future Q-studies need to carefully consider the resources invested if delivering the Q-sorting task online and our study indicates that a hybrid approach or face-to-face may better support recruitment. Q-methodology still has useful features and testing out methodological innovations is indicated in future feasibility studies. Q-methodology did enable us to find three distinct viewpoints amongst clinical psychologists on what makes an effective therapist for adults with ID, however, it is unclear at this stage whether any particular cluster group has more effective outcomes with their clients.

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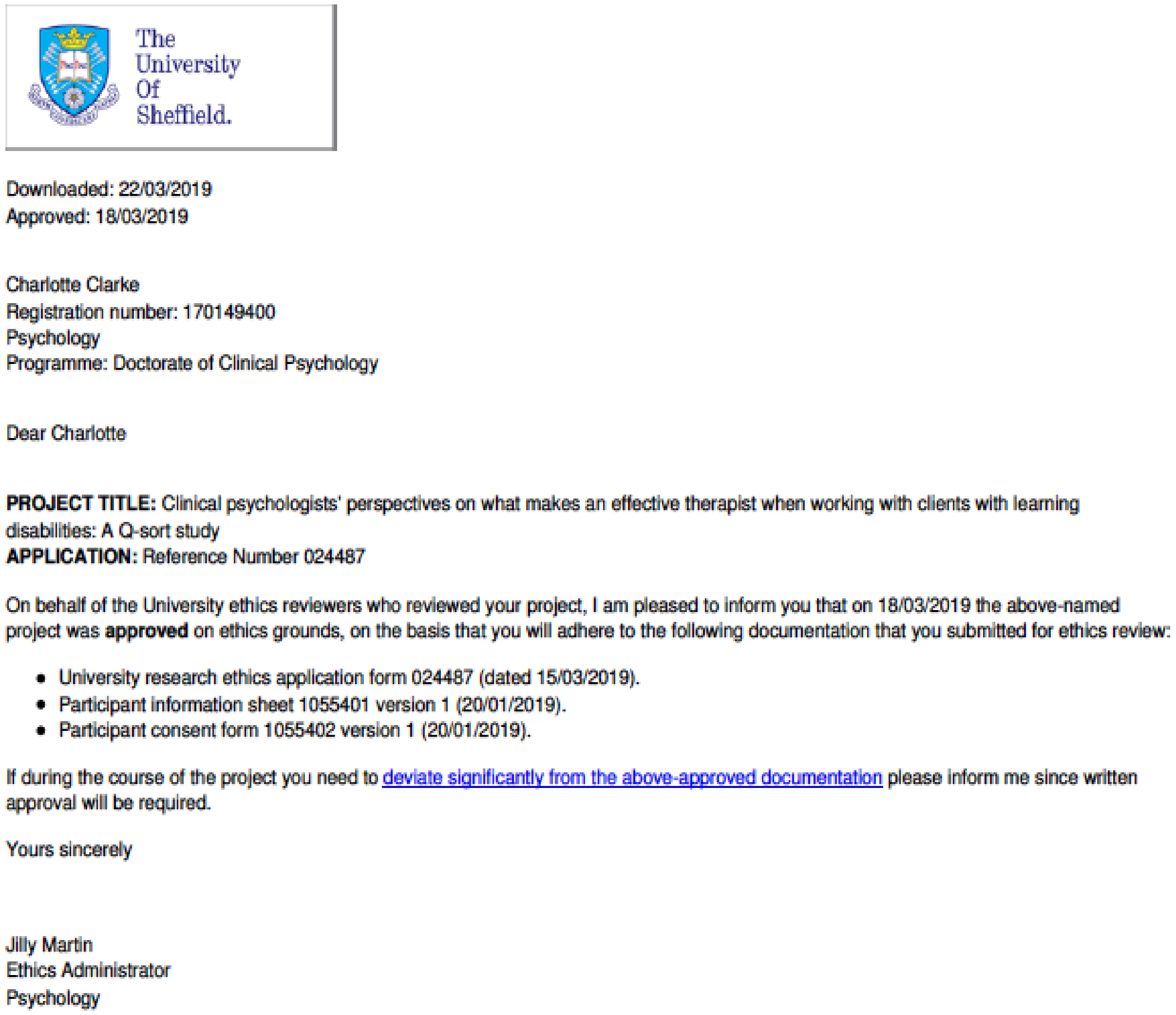
Appendix A - Ethical approval



The
University
Of
Sheffield.

Downloaded: 22/03/2019
Approved: 18/03/2019

Charlotte Clarke
Registration number: 170149400
Psychology
Programme: Doctorate of Clinical Psychology

Dear Charlotte

PROJECT TITLE: Clinical psychologists' perspectives on what makes an effective therapist when working with clients with learning disabilities: A Q-sort study
APPLICATION: Reference Number 024487

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 18/03/2019 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 024487 (dated 15/03/2019).
- Participant information sheet 1055401 version 1 (20/01/2019).
- Participant consent form 1055402 version 1 (20/01/2019).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Yours sincerely

Jilly Martin
Ethics Administrator
Psychology

Appendix B – Interview questions

Note: Semi-structured interviews - questions to be used as a guide only. Explain that ID will be used as an acronym for intellectual disabilities.

Question 1: Tell me about the core features of your psychological therapy work with clients with intellectual disabilities (ID).

Question 2: What do you do that maximises the likelihood of a good outcome in psychological therapy with clients with ID?

Question 3: What are the things that you can get drawn into during psychological therapy that you have noticed impede you or slow progress?

Question 4: What do you think are the key skills and competencies needed to work effectively during psychological therapy with clients with ID across engagement, treatment and termination?

Question 5: Tell me about the way in which you adapt psychological therapy for clients with ID.

Appendix C – Q sort statements

1. can co-create a formulation that is accessible and meaningful

2. considers the client’s needs holistically

3. has knowledge about other diagnoses

4. will think thoroughly about risk

5. will manage safeguarding concerns and attempt to repair any ruptures that may arise consequently

6. Can discuss with a client when it is not the right time for them to engage in therapy

7. considers whether the client knows what psychology can offer before commencing psychological work

8. has empathy and unconditional regard

9. has the ability to be playful and creative in therapy

10. will build on the skills that a client already has

11. can adapt their style to suit the client’s needs

12. will seek advice from the client’s family members or other professionals

13. understands the boundaries of the therapeutic role

14. adopts more than one role in the clients care beyond a therapist when necessary and appropriate

15. acknowledges that there may be areas of their own life which are inaccessible to some clients with intellectual disabilities

16. has awareness of power and how this can impact the therapeutic work

17. is aware when they are getting pulled into trying to rescue a client

18. is aware when they are getting drawn into helping with other areas of a client’s life which may not be useful to the therapeutic relationship

19. has good self-awareness

20. can acknowledge when they are not a good fit for the client and offer a new therapist

21. is clear and transparent about the process of therapy, what it will entail and explains this in a way that the client understands

22. will have an awareness of their own personal and emotional needs and ensures that these do not get in the way of client's needs

23. is aware when they are pulled to discharge clients because they find them difficult to work with

24. will help the wider team or system around the client to formulate and think psychologically about a client

25. spends time offering consultation, training and supervision to other staff members

26. realises that it is not always appropriate to work with both the client and their family members simultaneously

27. has awareness of the 'stuckness' that can occur outside of the therapy room when systems, families, or carers are not yet ready for the client to change

28. spends time considering the practicalities of a client attending therapy and makes any necessary adaptions

29. will follow the client's pace in therapy

30. makes use of and has access to formal and informal clinical supervision

31. is aware of the defences that clients use due to the history of intellectual disability and how they are accepted within society

32. tries to understand the personal meaning of having an intellectual disability

33. acknowledges that clients are often reliant on others

34. does not make assumptions about the client

35. understands the nature of a client's cognitive difficulties and the impact of these

36. will use outcome measures regularly

37. is able to be flexible within a therapeutic model, rather than sticking rigidly to a manualised treatment

38. is flexible with regard to the amount of sessions that a client is offered and the length of the sessions

39. thinks about consent and what information the client is happy to be shared with others in their system

40. works collaboratively to support the client to find their own answers

41. understands the full history of a client

42. has a good understanding of their own reasons for being a psychologist and can reflect on the possible impact of this

43. keeps a focus on what they are doing within therapy and why

44. has an awareness of their own limitations

45. will utilise informal and formal guidance from other multi-disciplinary professionals when necessary

46. can use the therapeutic relationship to bring about change

47. will work indirectly through others to support clients when appropriate

48. does not over focus on techniques, but has a greater focus on developing the relationship and trust with clients

49. makes use of counter-transference to understand the impact of the client on others

Appendix D – Online Questionnaire

Demographic Questions

Please tell us what age category you fall into:

- ☐ 20 – 29
- ☐ 30 – 39
- ☐ 40 – 49
- ☐ 50 – 59
- ☐ 60 – 69
- ☐ 70+
- ☐ I prefer not to answer

What gender do you identify as?

- ☐ Male
- ☐ Female
- ☐ Other, please state.
- ☐ I prefer to not answer

How long have you been qualified as a Clinical Psychologist?

- ☐ <1 year
- ☐ 1 – 4 years
- ☐ 5 – 9 years
- ☐ 10 – 19 years
- ☐ 20 – 29 years
- ☐ 30 – 39 years
- ☐ >40 years

How long have you worked with adults with intellectual disabilities?

- ☐ <1 year
- ☐ 1 – 4 years
- ☐ 5 – 9 years
- ☐ 10 – 19 years
- ☐ 20 – 29 years
- ☐ 30 – 39 years
- ☐ >40 years

What is your preferred therapeutic modality?

- ☐ Acceptance and Commitment Therapy
- ☐ Cognitive Analytic Therapy
- ☐ Cognitive Behavioural Therapy
- ☐ Dialectical Behaviour Therapy
- ☐ Psychodynamic Therapy
- ☐ Systemic Therapy
- ☐ Other, please state

Please state if you have any further therapy qualifications or have attended relevant training for working with clients with intellectual disabilities.

What type of service setting do you currently work in with clients with intellectual disabilities?

- ☐ Community
- ☐ Inpatient
- ☐ Residential
- ☐ Other, please state

How often do you receive clinical supervision?

- ☐ Weekly
- ☐ Fortnightly
- ☐ Three weekly
- ☐ Monthly
- ☐ Other, please state

Do you supervise others in their clinical practice with clients with intellectual disabilities?

- ☐ Yes
- ☐ No

Measures

[Measures: burnout, confidence, job satisfaction, see Appendix I]

Q sorting task

Below are a list of statements about possible skills and attributes that an effective therapist working with clients with a diagnosis of intellectual disabilities may have.

Please consider what you feel are the most important skills or attributes for this population group and sort the statements depending on their importance from '+5 most important statements' to '-5 least important statements'.

Please follow the instructions carefully:

1. Read all of the statements below before you begin sorting. Take a minute to reflect on how you feel about them.

2. Select two statements which you think are the most important skills and attributes and transfer these into the '+5 most important statements' box.

3. Select three statements which you think are the next most important skills and transfer these into the '+4 next most important statements' box.

4. Continue to sort the statements you think are important, rating them from +3 to +1 depending on their degree of importance. Statements that you rate as +3 would be more important than those in +1. Only put the number of statements highlighted in each box.

5. Select two statements which you think are the <u>least important skills</u> and transfer these into the '-5 least important statements' box.

6. Select three statements which you think are the next least important and transfer these into the '-4 next least important statements' box.

7. Continue to sort the statements you think are less important, rating them from -3 to -1, depending on their degree of importance. Statements that you rate as -3 would be less important than those in -1. Only put the number of statements highlighted in each box.

8. Sort your remaining seven statements into the 'neutral' box.

Once you have completed your sort, please check back and see whether you are happy with where you have placed the statements.

☐ I have entered the correct number of statements into the boxes above

Are there any other skills or attributes which you feel are missing from the list of statements? If yes, please provide details.

Once the data has been analysed, you are being offered the opportunity to receive some feedback based on your responses.

This study uses Q-methodology which produces clusters of participants. If you would like to receive feedback on the cluster you sit in, please provide your email address below. You will be asked how much you agree with this interpretation and given the opportunity to respond. Your email address will be deleted once you have been emailed your feedback.

Enter email address:

Thank you for taking the time to complete this study!

Please check your responses before you click below, as you will be unable to amend your responses afterwards. If you would like a copy of the participant information sheet, consent form, or have any further questions, please email Charlotte Clarke (Trainee Clinical Psychologist) at cblackburn3@sheffield.ac.uk.

Appendix E – Information sheet for phase 1 (Q sort creation)

INFORMATION SHEET

Date: 27th March 2019

Exploring what makes an effective therapist when working with adults with intellectual disabilities.

You are being invited to take part in the development stage of a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and please contact us if there is anything which is unclear or if you would like any further information.

What is the purpose of this project?
The aim of this study is to gain Clinical Psychologists' views on what skills and attributes effective therapists need to have when working with clients with intellectual disabilities (ID). There is currently limited research within the ID field and as such, the national guidelines and recommendations for psychologists working with clients with ID are also limited. This research will be part of my Doctorate in Clinical Psychology qualification and will be submitted in May 2020.

Why have I been chosen to take part?
You have been asked to take part because you are a Clinical Psychologist working with clients with ID in England. **We are currently recruiting a small number of experienced Clinical Psychologists to help us with the development stage of our research project.** Later in the project, we will be recruiting a larger number of Clinical Psychologists by contacting the British Psychological Society Intellectual Disability faculty and asking them to circulate our study to their members.

Do I have to take part?
No. Taking part in this study is entirely voluntary and there will be no negative consequences if you do not wish to take part. Please note, that once your data has been analysed it will be difficult to remove your data from the study. We ask that if you wish for your data to be removed you let us know no later than one month after you have taken part. If you wish to withdraw from the research then please contact the Research Support Office, Mr Amrit Sinha on 0114 2226650 who will be able to take a message and Charlotte Clarke will call you back. Finally, if you do decide to take part then you will be asked to sign a consent form and you will be unable to take part in the later research project.

What does the study involve?
This study will use Q-methodology, which is a research method used to explore peoples' views on a particular area. Q-methodology provides participants with a number of opinion statements about a topic, in this case, statements about skills and attributes which you may consider are important to be an effective therapist for clients with ID. Participants

will be asked to sort these statements into how important they think they are. They will also be asked to complete measures on confidence, burnout and provide demographic information.

To develop these opinion statements, we need to interview a small number of Clinical Psychologists who have 8+ years post-qualification experience working with clients with ID. Interviews will last no longer than 90minutes and will be semi-structured, using an open-ended questioning style. Interviews can take place at The University of Sheffield, Clinical Psychology department or over the phone, depending on your preference. The interviews will ask about your views on what constitutes an effective therapist or what may impede a therapist from being effective. This may involve discussing particular therapy modalities, specific skills, adaptations, involvement of others, therapist confidence or service resources. Interviews will be recorded and transcribed using a transcriber who has been approved by the University of Sheffield. The transcriber will adhere to rules around confidentiality and follow the university guidance. The lead researcher, Charlotte Clarke, will thematically analyse these interviews, with the aim of identifying a set of statements which can be used within the research project.

After analysis, we would like to offer you the opportunity to review these statements. Reviewing these statements is optional; however, if you choose to participate then you will be emailed the statements and asked to provide feedback on the clarity of the statements, whether they are representative, and whether there are important statements missing. You will be asked at the end of your interview if you would like to review the set of statements prior to the next part of the study commencing.

What are the advantages and disadvantages of taking part?

We appreciate that 90minutes out of your time is a long time to give to a study when psychologists are already very busy. Whilst there are no immediate benefits for those participating in the project, we hope that the study will be able to highlight positive ways of working with clients with ID. Due to the current lack of randomised controlled trials and other research within this field, professional consensus of what works is highly valuable to inform and influence practice for clients and clinicians.

Confidentiality and data protection

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team, myself, Charlotte Clarke (Trainee Clinical Psychologist) and my supervisors Professor Nigel Beail and Dr Stephen Kellett. A university approved transcriber will have access to your interview and will also adhere to rules around confidentiality. We will not be recording any names or services which you work in when we complete the interviews and we will ask you not to state any other staff members or clients' names throughout the interview. You will be assigned a participant number to help with the analysis of the interview data, however, these will not be used within the study itself. Your interview recording will be deleted after successful completion of the course.

If you would like to review the opinion statements, you will need to provide us with an email address at the end of your interview. In accordance with the General Data Protection Regulation (2018), we aim to limit the amount of identifiable information that we store. In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'. Email addresses will be asked for when the interviewer stops recording and these will be stored on a secure computer. Email addresses will be deleted once feedback has been received. The results of the study will be published following completion of the Doctorate in Clinical Psychology and you will not be able to be identified in any reports or publications.

Data controller and funding

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. The University of Sheffield is the organisation responsible for funding of this project.

Ethics

This project has been ethically approved by the University of Sheffield's ethics committee.

Complaints

If you wish to raise a complaint then you should contact Charlotte Clarke at the University of Sheffield on 0114 2226650. However, if you feel your complaint has not been handled to your satisfaction, then you can contact Professor Glenn Waller, the Head of Department for Clinical Psychology at The University of Sheffield. If your complaint relates to your how personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice at https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Contact for further information

Please contact either Charlotte Clarke (Trainee Clinical Psychologist) by email at cblackburn3@sheffield.ac.uk or Professor Nigel Beail (Thesis supervisor) at n.beail@sheffield.ac.uk.

Finally, thank you for taking the time to read this information!

If you wish to take part then please contact Charlotte Clarke via email: cblackburn3@sheffield.ac.uk**. You will then be sent a consent form to complete and will be asked for your availability to be interviewed.**

Appendix F – Information sheet for phase 2 (Q sort task)

INFORMATION SHEET

Exploring what makes an effective therapist when working with adults with intellectual disabilities.

Please note: The term 'intellectual disability (ID)' is used in this study, rather than 'learning disability'.

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information and contact us if you are unclear on anything or would like further information.

What is the purpose of this project?

The aim of this study is to gain Clinical Psychologists' views on what skills and attributes effective therapists need to have when working with clients with intellectual disabilities (ID). There is currently limited research within the ID field and as such, the national guidelines and recommendations for psychologists working with clients with ID are also limited. This research will be part of Charlotte Clarke's Doctorate in Clinical Psychology qualification and will be submitted in November 2020.

Why have I been chosen to take part?

You have been asked to take part because you are a Clinical Psychologist working with clients with a diagnosis of ID in England. If you know of other Clinical Psychologists who may like to take part, then we are happy for you to share the link to the study. If you do decide to take part then you will be asked to provide consent.

Do I have to take part?

No. Taking part in this study is entirely voluntary and there will be no negative consequences if you do not wish to take part. You may discontinue with the study or withdraw your data without giving reason. Please note that once the data has been analysed, it will be difficult to remove your data from the study. We ask that you let us know if you wish for your data to be removed before February 2020. If you wish to withdraw from the research then please contact Charlotte Clarke (Trainee Clinical Psychologist) via email at cblackburn3@sheffield.ac.uk or Mr Amrit Sinha (Research Support Officer) on 0114 2226650.

What does the study involve?

You will be asked to complete an online questionnaire which includes demographic questions, and short measures exploring burnout and your confidence of working with clients with ID. You will be presented with a set of opinion statements about possible skills and attributes that an effective therapist for clients with ID may have. You will be asked to rate these by importance.

The study uses Q-methodology and this produces clusters of participants. If you would like to receive feedback on the cluser you sit in based on your responses, you will be asked to provide your email towards the end of the study. If you choose to receive the group cluster feedback, you will be asked how much you agree with it and this information will be used in the write up of the study.

What are the advantages and disadvantages of taking part?
Taking part in the study may take some time to complete, as it asks you to sort a series of statements into a normally distributed pattern. This means that you will not be able to easily put a lot of statements into 'highly important' for example. You will have to take some time to consider which statements really mean the most to you.

There are no immediate benefits for participating, however, we hope that the study will be able to highlight positive ways of working with clients with ID. Due to the current lack of randomised controlled trials and other research within this field, professional consensus of what works is highly valuable to influence and inform best practice guidance for clients and clinicians.

Confidentiality and data protection
All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team: Charlotte Clarke (Trainee Clinical Psychologist) and research supervisors Professor Nigel Beail and Dr Stephen Kellett. To receive your group cluster feedback, you will need to enter your email address when completing the study. In accordance with the General Data Protection Regulation (2018) we aim to limit the amount of identifiable information that we store. In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'. Email addresses will be stored on a secure laptop. Email addresses will be deleted once feedback has been sent to participants. The results of the study will be published following completion of the Doctorate in Clinical Psychology and you will not be able to be identified in any reports or publications.

Data controller and funding
The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. The University of Sheffield is the organisation responsible for funding of this project.

Ethics
This project has been ethically approved by the University of Sheffield's ethics committee (registration number - 170149400).

Complaints
If you wish to raise a complaint then you should contact Charlotte Clarke at the University of Sheffield on 0114 2226650. If you feel your complaint has not been handled to your satisfaction, you can contact Professor Glenn Waller (Head of Department for Clinical Psychology) at The University of Sheffield by emailing dclinpsy@sheffield.ac.uk. If your complaint relates to your how personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice at https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

Contact for further information
Please contact either Charlotte Clarke (Trainee Clinical Psychologist) by email at cblackburn3@sheffield.ac.uk or Dr Stephen Kellett (research supervisor) on 0114 2226650. If we are unavailable, please leave a message with Amrit Sinha (Research Support Officer) and we will call you back.

If you would like to take part, please ensure that you have read the above information and please click below to continue to the consent form.

Appendix G – Consent form for phase 1 (Q sort creation)

Exploring what makes an effective therapist when working with adults with intellectual disabilities.

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 27/03/2019 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. I understand that taking part in the project will include taking part in a semi-structured interview. This will be recorded and transcribed by a university approved transcriber. My data will be analysed and used to create a set of statements which will be used in the study later.	☐	☐
I understand that my taking part is voluntary and that I can withdraw from the study up to one month following the interview. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	☐	☐
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

Name of participant [printed]	Signature	Date

Name of Researcher [printed]	Signature	Date

Project contact details for further information:
Please contact Charlotte Clarke (Trainee Clinical Psychologist) or Professor Nigel Beail (thesis supervisor) on 0114 2226650, or by email at cblackburn3@sheffield.ac.uk. If we are unavailable, then please leave a message with Amrit Sinha (Research Support Officer). In the event of a complaint, please contact Charlotte Clarke. If your complaint has not been sufficiently resolved, please contact Professor Glenn Waller at: Clinical Psychology Unit, University of Sheffield, Cathedral Court, Sheffield, S1 2LT or by email at dclinpsy@sheffield.ac.uk

Appendix H – Consent form for phase 2 (Q sort task)

Online consent form embedded in Qualtrics questionnaire.

Please read the following statements and select 'yes' if you agree.

Please tick the appropriate boxes	**Yes**
I have read and understood the project information sheet above. If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.	☐
I have been given the opportunity to ask questions about the project.	☐
I agree to take part in the project. I understand that taking part in the project will include taking part in an online questionnaire	☐
I understand that my taking part is voluntary and that I can withdraw my response from the study up until February 2020. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	☐
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	☐
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐

Appendix I – Psychometric measures

The Therapy Confidence Scale–Intellectual Disabilities

Dagnan, D., Masson, J., Cavagin, A., Thwaites, R., & Hatton, C. (2015). The development of a measure of confidence in delivering therapy to people with intellectual disabilities. *Clinical Psychology & Psychotherapy*, *22*, 392-398. https://doi.org/10.1002/cpp.1898

Questionnaire removed due to copyright.

Job Satisfaction

Dolbier, C. L., Webster, J. A., McCalister, K. T., Mallon, M. W., & Steinhardt, M. A. (2005). Reliability and validity of a single-item measure of job satisfaction. *American Journal of Health Promotion*, *19*, 194-198. https://doi.org/10.4278/0890-1171-19.3.194

Questionnaire removed due to copyright.

The Copenhagen Burnout Inventory

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress*, *19*, 192-207. https://doi.org/10.1080/02678370500297720

Questionnaire removed due to copyright.