The feasibility and acceptability of a therapist measure of assimilation of problematic experiences for clients with Intellectual Disability

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Declaration

I confirm that the literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

Word Count

Literature Review:	7,708	excluding references
	9,381	including references
Empirical Paper:	10,898	excluding references
	12,651	including references
Total:	18,606	excluding references
	22,032	including references
	29,641	including appendices

Overall Abstract

The aim of this thesis is to develop a measure for therapists of clients with Intellectual Disability (ID) to assess change in psychotherapy. This thesis consists of two sections; a systematic literature review and an exploratory research study. Using systematic review methodology, thirteen studies were identified that investigated the effectiveness of psychoanalytic and psychodynamic psychotherapy with clients with ID. The studies were assessed for quality using a widely used quality rating tool and a narrative synthesis was used to describe the results. The studies were of generally poor quality; however, research has advanced from using single case studies and more robust designs are gradually being implemented, such as controlled methodologies. Continuing this trend in the implementation of more robust designs and the development of outcome measures standardised for clients with ID should be a focus of future research.

The research report explored the feasibility and applicability of a measure of change in psychotherapy in routine practice with clients who have ID. The Therapist Assimilation Measure (TAM) has been designed for use with the general population and is based on the Assimilation of Problematic Experiences Scale (APES). Twelve therapists adapted the TAM and piloted its use in their practice, additionally providing feedback on their experiences with using the measure. The feedback was used in combination with item analysis and frequency distribution to further modify and shorten the TAM. The reliability of the final 24-item measure, the TAM-ID, was tested and good internal consistency (α = .58 to .92) and high inter-rater reliability (*ICC* = .84 to .90) was found. The assimilation model was found to be an acceptable framework to use with clients with ID.

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I would like to thank all the participants who made this study possible. To the therapists who dedicated their time and energy, and to the client who generously agreed to be part of the study, thank you.

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Literature Review

Assessment of the quality of research into the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with clients with intellectual disability: A systematic review.

Abstract

Objectives. This systematic review aimed to identify and critically appraise the empirical literature on the effectiveness of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy with adults with intellectual disability (ID).

Method. A systematic search of four major electronic databases was carried out (Web of Science, MEDLINE, PsychArticles, and CINAHL). The methodological quality of the studies was assessed using a widely used quality assessment tool and comparisons were made with a review of the quality of research on the effectiveness of Cognitive Behavioural Therapy (CBT) for people with ID.

Results. The search yielded thirteen papers that met the inclusion/exclusion criteria**.** No studies describing psychoanalysis were found. The papers reviewed provided evidence for the effectiveness of psychoanalytic and psychodynamic psychotherapy with people with ID. The quality of the research was generally poor compared to the current research on the effectiveness of CBT with people with ID. However, some improvements in quality were found with eight studies showing developments in methodological design. No studies employed controlled methodologies.

Conclusions. Positive outcomes have been indicated for psychoanalytic and psychodynamic psychotherapy with clients with ID. Future research would benefit from the development and adaptation of an outcome measure for this client group. Larger scale, more controlled research is necessary to advance the evidence base for psychoanalytic and psychodynamic psychotherapies in line with other psychotherapeutic approaches with clients with ID.

An influential review by Roth and Fonagy (2005) demonstrated the efficacy of psychotherapy within the general population[1]. Despite the prevalence of co-morbid mental health and behavioural difficulties present in individuals with Intellectual Disability (ID), research into psychotherapy for this population is limited. Previous research assumed that cognitive deficits present in individuals with ID, rendered psychotherapy ineffective (Hurley, 1989). However, there is a growing body of evidence into the effectiveness of various types of psychotherapy for people with ID. In the general population, Roth and Fonagy (2005) found a larger body of evidence supporting the effectiveness of Cognitive Behavioural Therapy (CBT) than for psychodynamic psychotherapy and this appears to be replicated, to some extent, in the current literature.

The effectiveness of CBT with individuals with ID has been reviewed in three recent meta-analyses. Two reviewed the effectiveness of CBT for anger (Hamelin, Travis, & Sturmey, 2012; Nichol, Beail, & Saxon, 2013) and the other reviewed studies addressing the effectiveness of CBT for a range of difficulties (Vereenooghe & Langdon, 2013). Hamelin et al. (2012) reviewed two randomized control trials (RCTs) and six pre-test – post-test control studies and found effect sizes (ESs) between 0.73 and 1.54, considered medium to large using Cohen's (1988) criteria. Although this seemed to suggest anger management was an effective intervention for clients with ID, Hamelin et al. (2012) concluded that the studies did not meet Chambless and Hollon's (1998) criteria for evidence-based practice. A further examination of the studies they considered led to Hamelin et al. (2012) suggesting it was unreasonable to conclude that the benefits observed were due to the effects of the intervention. It was therefore concluded by Hamelin et al. (2012) that CBT for anger with

[1] Term used in the intellectual disability literature to refer to individuals who do not have intellectual disability.

clients with ID was not empirically supported. Nichol et al. (2013) reviewed 12 studies, concluding a good level of methodological rigour. The authors performed a meta-analysis on nine of the 12 studies with outcome data and found an overall uncontrolled ES of 0.88. Estimates of treatment efficacy were based on uncontrolled ESs, as studies that did not employ RCT methodology or use control groups were included in the analysis. The third review by Vereenooghe and Langdon (2013) found a moderate ES of 0.55 for five randomised trials and a large ES of 0.85 for five non-randomised trials. They concluded CBT was an effective treatment for anger and depression with adults with ID. However, their review of the quality of the studies highlighted the need for improved reporting standards and larger samples.

These reviews highlight the development of research in CBT for individuals with ID. The concept of "hierarchy of evidence" provides a framework to evaluate health care interventions. It is conceptualised as a pyramid, in which studies most susceptible to threats to internal validity reside at the bottom, and those least prone reside at the top (Ho, Peterson, & Masoudi, 2008). In this framework, RCT methodology is considered the gold standard as it minimises the risk of confounding factors, thus providing the most reliable evidence on effectiveness (Akobeng, 2005). The reviews of CBT for people with ID all included studies using RCT methodology, suggesting that CBT research with this client group has progressed in reducing bias. Research into other forms of psychotherapy with individuals with ID has seemingly struggled to achieve this degree of progression. This is likely due to a number of factors, for instance many professionals consider individuals with ID unsuitable for psychotherapy, and ID is routinely used as a criterion to exclude individuals from research (Fletcher, 1993). Studies with people with ID tend to make

adaptations to accommodate differences and the impact of the individual's disability on the process of therapy. Thus, manuals of psychotherapy for people with ID needed for RCTs have been slow to develop. Practical issues, such as achieving large enough homogenous groups to ensure statistical power so that outcomes can be attributed to the intervention, hinder the implementation of controlled studies. Individuals with ID form only two per cent of the population (British Institute of Learning Disabilities, 2011), therefore individuals presenting with psychological problems at any one time will be even smaller. If factors such as co-morbidity and level of ID are also controlled for, this limits the number of potential participants further (Royal College of Psychiatrists, 2003). Funding for research in this client group is also a major barrier. Funding agencies for services for individuals with ID are often split and limited, which results in services struggling to offer psychotherapy and little or no funding for research (Butz, Bowling, & Bliss, 2000).

This lack of progression up the hierarchy of evidence is particularly evident from the psychodynamic and psychoanalytic psychotherapy sphere. Flynn (2012) argues "psychodynamic therapies remain the least well investigated of the psychological therapies in intellectual disabilities" (p. 344). Reviews by Beail (1995) and Nezu and Nezu (1994) show that research in the area of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with individuals with ID usually takes the form of descriptive or narrative case studies. Case studies tend to lack the methodological rigour of controlled studies due to their very nature of being conducted on one or two participants, yet they demonstrate the feasibility of psychoanalysis, psychoanalytic and psychodynamic psychotherapy for individuals with ID (Nezu & Nezu, 1994). One of the most recent reviews in this field has suggested that case studies

remain popular (Jackson & Beail, 2013). Their search produced ‘largely case study papers; very few research reports’ (p. 3). However, their review only explores the process and practice of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy; it does not address outcome or effectiveness.

The disparity between research into the cognitive behavioural and psychoanalytic schools of therapy with individuals with ID can be viewed in relation to Salkovskis (1995) hourglass model. Salkovskis (1995) explains the process of development in clinical practice in terms of an hourglass, conceptualising three phases required to build a sound evidence base. The first phase is exploratory and focuses on in-depth investigation of few participants. This phase uses less stringent methodological criteria and consists of case studies, single case designs, or uncontrolled studies. As research continues to develop, it moves to the second phase and must conform to standards that are more rigorous. These types of studies are considered the pinch of the hourglass, mainly taking the form of RCTs investigating the efficacy of interventions. The third phase investigates the applicability of research to the real world using practice-based designs (Salkovskis, 1995). Thornicroft, Lempp, and Tansella (2011) also propose a schema to explain the process of development and implementation of interventions. There are five phases, the first being ‘basic discovery’ in which research aims to generate and appraise theories and hypotheses. During the second phase, research identifies key components of the intervention and the third phase finalises the components and considers alternatives. Phase four includes well-controlled studies with large numbers of participants and the final phase identifies factors that may hinder the uptake of the evidence–based practice found in the previous phases. Thornicroft et al.’s (2011) schema places equal importance on all phases. They

are considered essential stepping-stones in the research process to establish efficacy and effectiveness of an intervention.

Previous reviews have shown that research on psychodynamic psychotherapy has yet to progress to the pinch of the hourglass. Prout and Nowak-Drabik (2003) originally aimed to carry out a meta-analysis of psychotherapy research with adults with ID. However, as only behavioural interventions provided adequate data for analysis they used expert consensus ratings, concluding that psychotherapy was moderately effective. They did not distinguish between models of psychotherapy in their conclusion. Beail's (2003) review did distinguish different forms of psychotherapy, and found that the only form for which controlled studies had been conducted was CBT. The evidence for the effectiveness of psychodynamic psychotherapy relied on case studies, with the addition of some pre-post reports. Willner (2005) provided a descriptive review of the available literature and found that RCTs of psychotherapies in ID were sparse. Beail (1998) and Beail and Warden (2010) reported outcomes from psychodynamic approaches, which showed beneficial effects in the short and slightly longer term, but it was highlighted that control groups were not used for comparison. Willner (2005) commented that, whilst psychotherapy research within the general population has developed to address the process components that impact outcome, research in intellectual disabilities is still addressing the feasibility of using psychotherapies.

Prout and Browning (2011) summarised the conclusions of other published reviews on psychotherapy with children and adults with ID. They concluded that the research showed positive results of psychotherapy with moderate effectiveness for a variety of conditions. Brown, Duff, Karatzias, and Horsburgh (2011) produced a descriptive review that discussed the challenges

of delivering psychological therapies to this client group and concluded that adapted psychological interventions can be beneficial, but there is a lack of systematic studies. Furthermore, they argue that subjective clinical impressions are reported as outcomes rather than reliable and valid measurements (Brown et al., 2011). Bhaumick, Gangadharan, Hiremath, and Russell (2011) also report that research into psychotherapy with individuals with ID is poor quality in design and lacks outcome measurement.

James and Stacey (2014) were the first to focus solely on the effectiveness of psychodynamic psychotherapy. They reviewed 13 studies that examined the effectiveness of psychodynamic approaches, including approaches with a psychodynamic component, such as Cognitive Analytic Therapy (CAT). The review provided some support for the use of psychodynamic psychotherapy and CAT with clients with ID, across a range of presenting problems. Whilst James and Stacey (2014) offer some general critiques of the research, no criteria were applied to critically evaluate the studies methodologies.

In conclusion, there remains a need to critically appraise the psychoanalysis, psychoanalytic and psychodynamic psychotherapy literature with individuals with ID. The aim of this systematic review was to assess the quality of the research into the effectiveness of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy with individuals with ID.

Method

Search strategy

The initial strategy involved searching four major electronic databases (Web of Science, MEDLINE, PsychInfo, and CINHAL) between 2nd and 25th

January 2014. Beail (1995) conducted the most recent review on the outcome of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy with people with ID, therefore the period searched was from 1995 to 2014. Applied search terms in the topic field were combinations of: '*psychodynamic* OR *psychoanalytic* OR *psychoanalysis* OR *psychotherapy* AND *learning disabilit** OR *intellectual disabilit** OR *mental retardation* OR *developmental disabilit*'. This returned 1452 references from the combined databases.

Screening

Duplicate papers were removed and the remaining studies were screened for relevance based on title and abstract. The following inclusion criteria were applied: (i) published in English; (ii) examined psychoanalysis, psychoanalytic or psychodynamic psychotherapy; (iii) therapy was with adults with ID; and (iv) psychotherapy outcomes were measured. Studies were excluded based on the following criteria: (i) psychotherapy was not based, at least partially, on psychodynamic or psychoanalytic models; (ii) the target population was not adults with ID (i.e. children or adolescents with intellectual disabilities; the general population); (iv) reviews of the literature; and (v) research published in book chapters. Applying these criteria yielded 13 relevant studies. No papers were found that described the intervention as psychoanalysis, therefore only psychoanalytic and psychodynamic interventions have been reviewed in this thesis. The screening process can be seen in Figure 1.

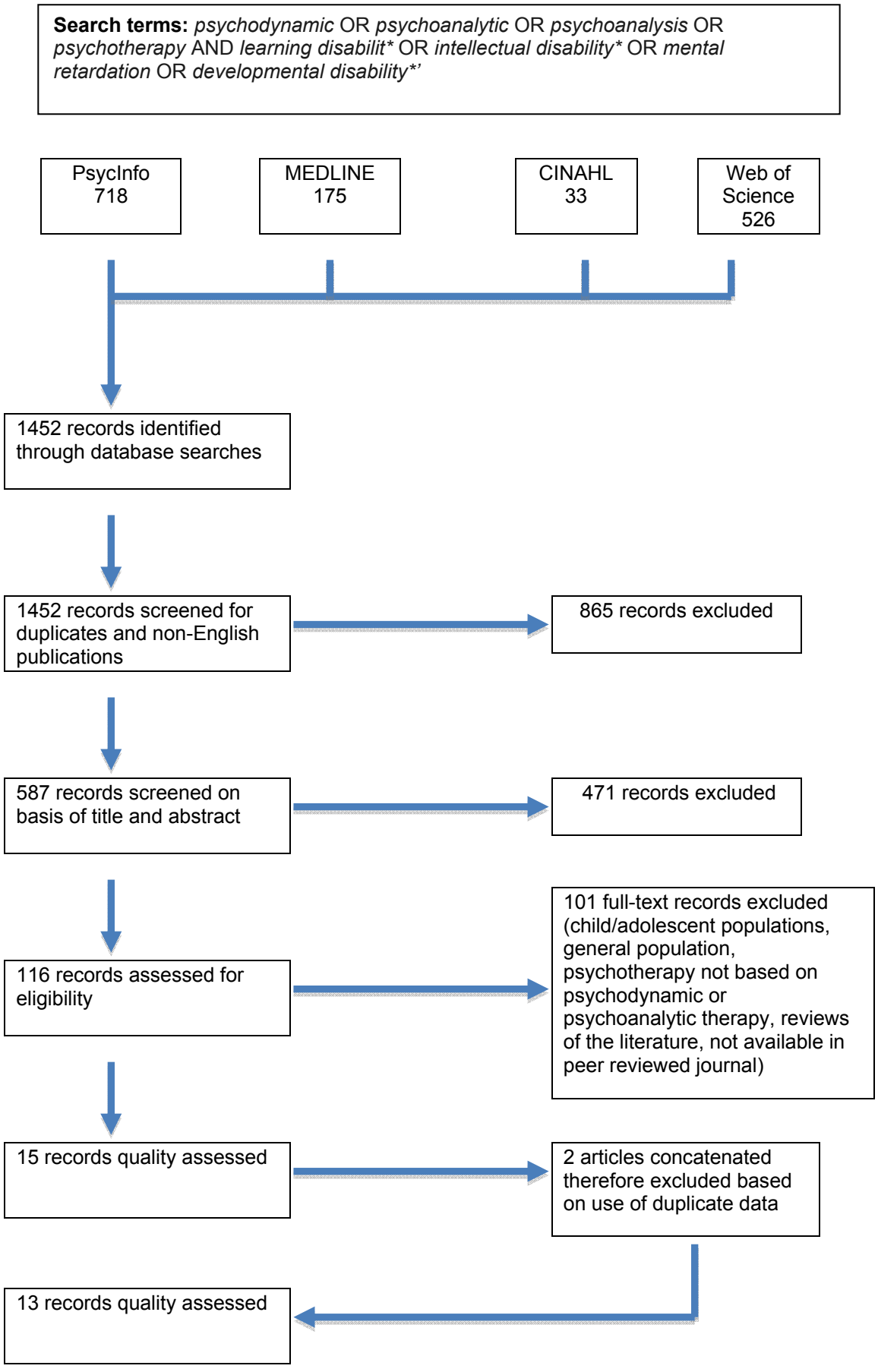

Figure 1. PRISMA flow diagram. This figure illustrates screening process for inclusion of studies.

Data extraction

Data was extracted from 15 full copy texts that met the above criteria (see Appendix A for example data extraction form). This revealed that some papers were concatenated with later papers, using the same data set. Studies for which the results were published in a later article were excluded to avoid double counting evidence. The final 13 studies are listed in Table 1.

Quality assessment

Poor study design, misconduct in data collection and analysis, and poor quality reporting of methods and results can all result in under- or overestimation of the true effect of an intervention (Centre for Reviews and Dissemination, 2009). When reviewing studies it is therefore necessary to assess the quality of research in these areas. Quality assessment instruments consider the risk of bias and the standard by which the study has been conducted; therefore quality assessment tools should be used to assess each study in a systematic review (Higgins & Altman, 2008).

A number of tools are recognised for quality assessment. The CASP tools (CASP, 2006) were considered for this review, however they produce separate scores depending on study design, which would not allow for comparison across studies. The Downs and Black checklist (1998) is a highly regarded and widely implemented tool for systematic reviews (Wells & Littell, 2009). It evaluates both quality and internal validity, and purports to appraise randomised and non-randomised research. However, Cahill, Barkham, and Stiles (2010) found it to be ill matched and unresponsive to the design features of practice-based research. Cahill et al. (2010) adapted Downs and Black (1998) to allow for the assessment of a wider range of methodological designs

(Appendix B). Some features in Downs and Black, such as a heterogeneous population, are seen only as deficits yet these features enable practice-based evidence to reflect practice (Cahill, 2014). As previous reviews have shown, much of the current research in this area is based within clinical practice and Cahill et al.'s checklist (2010) enables more aspects of this practice-based research to be captured.

Furthermore, Cahill et al.'s checklist (2010) was used to assess quality of research in Nichol et al.'s (2013) review of CBT, the only review of psychotherapy with clients with ID to use a quality assessment tool. Use of the checklist in this review therefore allows for the quality of research into CBT to be compared to the quality of research into psychoanalytic and psychodynamic psychotherapies with individuals with ID. The checklist assesses overall quality as well as four separate subscales:

i) *Reporting:* assesses the extent to which the reader is able to make unbiased assessment of the findings.

ii) *External Validity*: assesses whether the findings can be generalised.

iii) *Internal Reliability*: addresses the rigour of the measurement of the intervention.

iv) *Internal Reliability Sampling:* addresses confounding factors and selection bias.

(Nichol, Beail, & Saxon, 2013).

Results

Table 1.
Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author & year	Design	Sample/Degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Case Series								
Bichard et al. (1996)	Case Series/ Contrast Group	11 adults/ IQs <30-69 / stealing, self-injury, depression, social isolation	Indiv'l	1–3 years	A cognitive test e.g. WAIS-R, Draw-a-Person (DAP)	Therapy group showed improved DAP scores, only one contrast group showed improvement. Therapy did not have an impact on IQ.	None	16
Beail (1998)	Case series	25 Men/ IQ not stated/ aggression, behavioural problems, offending	Indiv'l	3-43mths	Frequency of behaviour at end of therapy and follow-up or re-offending	In 11 cases behaviour was eliminated and had not re-emerged at follow-up. In one case behaviour reduced and reduction was maintained at follow-up. None re-offended during therapy or at follow-up.	6mths	13

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Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author & year	Design	Sample/Degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Carlsson (2000)	Case series	4 Women, 3 Men/ IQ 35-58/ Psychosis, MPD, depression, ASD, behavioural disorders	Indiv'l	18mths	WAIS-R Defense Mechanism Test (DMT) Perceptgenetic Objection Relations Test (PORT) Secondary Handicap	WAIS-R no change DMT & PORT – increased integration, better ego functioning, decreased defense mechanisms. Secondary handicap diminished.	None	10
Beail (2001)	Case series	13 Men/ IQ not stated/ sexual offences, theft, arson	Indiv'l	4-43mths (mean=16.15)	Recidivism rates	None re-offended during treatment. 11 had not re-offended at follow-up.	4 yrs	16
Beail *et al.* (2005)[2]	Case series/open trial	17 Men, 3 Women/ IQ not stated/ aggression, sexually inappropriate behaviour, psychotic, relationship difficulties, OCD, self-harm, bulimia	Indiv'l	5-48 session (mean =13.2)	Symptom Checklist Revised (SCL-90R); Inventory of Interpersonal problems (IIP); Rosenberg Self-Esteem inventory	SCL-90R scores fell to below caseness Significant change in IIP scores from intake to follow-up. Self-esteem inventory score rose significantly at outcome and follow-up. Effect sizes modest to large.	3 mths	21

Table 1.
Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author & year	Design	Sample/Degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Newman & Beail (2005)[2]	Case series	2 Women, 6 Men/ IQ 45-65/ anxiety, behavioural, sexual offending	Indiv'l	8 sessions (1,4,& 8 recorded)	APES level	APES level higher at end of session. Significant increase between 1 & 8.	None	12
Newman & Beail (2010)	Case Series	2 Women, 6 Men/ IQ 45-65/ anxiety, behavioural, sexual offending	Indiv'l	8 sessions (1,4,& 8 recorded)	Defense mechanism rating scale (DMRS)	No change in defense functioning.	None	12
				Single Case				
Kellet *et al.* (2009)	Single Case	1 Man, 1 Women/ IQ 55, other not stated/ hypochondriasis, ambulophobia	Indiv'l	1 = 13 sessions 2 = 8 sessions	Idiographic data	1 = significant change 2 = non-significant clinical change	1 = 1mth continuous post treatment 2 = 3mths	14
				Case Studies				
Salvadori & Jackson (2009)	Case Study	1 Man/ not stated/ epilepsy	Indiv'l	10 session (short-term psychodynamic)	Subjective reports APES level	Appeared meaningful, more assertive APES increased 0 to 4.	None	7

Table 1.
Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author & year	Design	Sample/Degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Alim (2010)	Case Study	1 Man/ mild/ aggression	Indiv'l	18 sessions	Malan's model; Novaco Anger Scale; Behaviour incidents records; BSI; Rosenberg Self-Esteem Scale; & IIP	Reached highest level (9) of Malan at session 9 but this fell to 6 by end of therapy. Reduction on all scales except IIP which showed an increase.	None	8
Service User Satisfaction								
MacDonald, Sinason, & Hollins (2003)	Qualitative interview, IPA	5 Women, 4 Me/not stated, men sexual offenders	Group	Attending group between 2mths & over a yr.	Semi-structured interview	Valued therapy and talking about painful emotions but group emotionally painful, no positive change identified.	None	7
Merriman & Beail (2009)	Qualitative, IPA	6 Men, mild-moderate/ not stated	Indiv'l	2+ yrs	Qu-aires generated by team	Positive about therapists & therapy, positive changes in behaviour & emotions. Difficult changing therapists and criticising service	None	10

Table 1.
Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author & year	Design	Sample/Degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Khan & Beail (2013)	Qu'aire	8 Female, 12 Men, mild-moderate ID/ bereavement, sexually inappropriate behaviour, anger, offending, low mood	Indiv'l	10-31 sessions (mean 14.1) (15 had psychodynamic, 2 integrated counselling, 3 CBT)	Experience of Service Qu'aire (ESQ) Satisfaction with therapy & therapist scale (STTS-R)	Improvement in ESQ & STTS-R scores. High level of satisfaction with therapy.	None	13

Note: MPD, Multiple Personality Disorder; ASD, Autism Spectrum Disorder; IQ, Intelligence Quotient; WAIS-R, Wechsler Adult Intelligence Scale-Revised (Wechsler, 1981); APES, Assimilation of Problematic Experiences Scale (Stiles et al., 1990); OCD, Obsessive Compulsive Disorder; BSI, Brief Symptom Inventory, (Derogatis & Spencer, 1993); ² denotes studies that are concatenated with one other study.

Table 2

Scores and corresponding percentages of checklist criteria address by the studies.

Studies	Reporting subscale		External Validity subscale		Internal Reliability subscale		Internal Reliability Sampling subscale		Overall Quality Rating	
	Score	**% score***	**Score**	**% score**	**Score**	**% score**	**Score**	**% score**	**Score**	**% score**
Case Series (n = 6)	38	49.4	36	46.7	20	57.1	7	20	101	45.1
Single Case (n = 1)	6	54.5	5	45.5	3	60	0	0	14	43.8
Case Study (n = 1)	7	31.8	6	27.3	2	20	0	0	15	23.4
Service User Satisfaction (n = 3)	14	42.4	12	36.4	4	26.6	0	0	30	31.3
All studies (N = 11)	65	45.5	59	41.3	29	44.6	7	10.8	160	38.5

Note. *% score is the quality criteria score achieved by the study (score), divided by the total possible score for the subscale. A 100% score would indicate that all quality criteria had been met by the study.

To increase inter-rater reliability, the first author rated the quality of full text copies and a doctoral level student acted as an independent rater, rating a random subsample of four papers. Pairwise agreement for these ratings was *K* = 0.80. Based on Landis and Koch's (1977) classification of Kappa this rating falls within the 'substantial' range of agreement.

Table 2 shows the combined scores and percentages of the overall quality and subscales for the studies using Cahill et al.'s (2010) checklist. Overall, the studies addressed 38.5% of the quality appraisal criteria. A Spearman's Rank correlation was calculated to explore whether there had been improvement in the quality of the studies over time, no relationship was found, r_s = -.27(11), p > .5. Studies were split based on design (case series, single case, case studies and qualitative). The overall quality criteria addressed were 45.1%, 43.8%, 23.4%, and 31.3%, respectively. Within the subscales, *Reporting* scores were generally highest (45.5%) with the lowest levels observed in *Internal Reliability Sampling* scores (10%). The final column of Table 1 shows the studies' individual quality ratings**;** the mean quality rating score for all studies was 12.2 (SD = 4).

It can be seen from Table 2 that the percentage of overall quality rating addressed by the studies did not exceed 50% for any subscale. Thus, they could not be considered to be of high quality. These were all lower than those reported by Nichol et al. (2012) for CBT with adults, where all studies achieved scores of 70% or more. The papers were reviewed in terms of the subscales and their quality relative to each other. The narrative results are provided in the following sections.

Reporting

The studies reviewed were relatively strong in this area, meeting 45.5% of the quality rating criteria in this subscale. This suggests that the studies provided some information for the reader to make an unbiased decision about the findings of the research. The majority of the studies stated their aim and presented the findings clearly. Only Beail, Warden, Morsley, and Newman (2005) stated a specific, directional hypothesis: 'psychodynamic psychotherapy would produce significant reductions in recipients' psychological distress and improve interpersonal functioning' (p. 246). Salvadori and Jackson (2009) was the only study not to state their aims clearly.

Overall, characteristics of clients were well reported. There were a higher proportion of male participants (*n* = 95) than female participants (*n* = 25) across the studies. Bichard et al. (1996) did not state the gender of their participants. Participants were aged between 17 and 64 years with the most common age range across the studies being 20 to 40 years. Ten studies described the intervention as 'psychodynamic' (Alim, 2010; Beail, 2001; Beail, Warden, Morsley, & Newman, 2005; Kellett, Beail, Bush, Dyson, & Wilbram, 2009; Khan & Beail, 2013; MacDonald, Sinason, & Hollins, 2003; Merriman & Beail, 2009; Newman & Beail, 2005, & 2010; Slavadori & Jackson, 2009). Three studies described the intervention as psychoanalytic (Beail, 1998; Bichard et al., 1996; Carlsson, 2000). The detail of the intervention was generally poorly described across the studies. The two case studies (Alim, 2010; Salvadori & Jackson, 2009) provided the most comprehensive description of the process of their psychodynamic intervention, describing each phase of the therapy with detailed formulations. Carlsson's (2000) individual psychoanalytic psychotherapy aimed to allow the individual to acknowledge and express their feelings through

interpretation and communicating non-verbal processes. Beail's (1998) description of psychoanalytic psychotherapy is almost identical to his description of psychodynamic psychotherapy (Beail, 2001), suggesting the terms are used interchangeably. Ten of the eleven studies assessed weekly individual psychotherapy. Only MacDonald et al. (2003) evaluated weekly group psychotherapy. The two groups evaluated were described as a 'sexual offenders group' and a 'women's group' (p.43). However, no descriptive details of the content of the groups were provided, making it difficult to assess which elements of the intervention were likely to be effective.

There was large variability in the duration of therapy provided in the studies. Five was the lowest number of sessions as reported by Beail at al. (2005); however, he also reported the largest range in number of sessions (from 5 to 48; *M* = 13.2). Therapy lasted for two or more years in five of the studies (Beail, 1998; Beail, 2001; Birchard et al., 1996; Carlsson, 2000; Merriman & Beail, 2009). Three of the case series studies and the single case study provided follow-up data (Beail, 1998; Beail, 2001; Beail et al., 2005; Kellet et al., 2009), which ranged from one month to four years. Beail (1998, 2001) reported participants (two and one, respectively) requested continued support on completion of therapy. These participants continued to see their therapist on a less frequent basis during the follow-up period. Neither of the papers addresses this confound as an issue that may impact upon the outcome at follow-up. Whilst *Reporting* scores were a relative strength, only three studies scored above half (Beail, 2001; Beail et al., 2005; Kellett et al., 2009). Salvadori and Jackson (2009) was the poorest study in this area scoring only three out of 11.

Internal Reliability

This subscale considers the rigour of measurement used to assess the outcome of the intervention. The overall quality rating addressed from all the studies on this scale was 44.6%. Three of the 13 studies used measures validated for people with ID, Alim (2010), Beail et al. (2005), and Kellett et al. (2009). Beail et al. (2005) used the Symptom Checklist Revised (SCL-90; Derogatis, Lipman, & Covi, 2007). The SCL-90-R has been found to have good reliability and discriminative validity in an assisted completion format with individuals with ID and some normative data has been reported (Kellett, Beail, Newman, & Mosley, 1999).

Alim (2010), Beail et al. (2005), and Kellett et al. (2009) used the Inventory of Interpersonal Problems (IIP-32; Barkham et al., 1996) and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The IIP-32 has been found to have sufficient stability and sensitivity with individuals with mild ID. Four of the eight subscales and the full-scale IIP-32 were replicated in people with ID; however, caution is advised if considering the other four subscales independently (Beail, 2001; Kellett, Beail, & Newman, 2005). Kellett et al. (2009) found no change in IIP-32 scores at therapy completion or follow-up, whilst Alim (2010) found IIP-32 scores worsened. Alim (2010) concluded that this was due to the participants' anger decreasing, enabling the client to work through interpersonal difficulties. In contrast, Beail et al. (2005) found a statistically significant change in scores on the IIP-32 from intake to follow-up. However, only 14 of the 20 participants were able to complete the measure due to the complexity of language, suggesting adaptation is required.

Kellett et al. (2009) found no significant change in RSES scores at the end of therapy or at follow-up. Alim (2010) and Beail et al. (2005) found a

significant change in RSES at outcome, which was maintained at follow-up. The change in RSES scores showed the largest ES in Beail et al.'s study. Unlike the IIP-32, the RSES has been found to have moderate reliability and poor validity with clients with ID (Davis, Kellett, & Beail, 2009), which questions its suitability in this area of research and Alim (2010) and Beail et al.'s (2005) findings should be interpreted with caution. Alim (2010) and Kellett et al. (2009) also used the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993), which has been found to be a reliable assessment and treatment outcome measure for people with ID. These authors found improvement in BSI scores following therapy (Kellett, Beail, Newman, & Frankish, 2003), providing some evidence for the effectiveness in reducing symptoms.

Two studies used projective tests to measure specific psychoanalytic concepts. Carlsson (2000) used the Defence Mechanism Test (DMT; Kragh, 1969) and the Perceptgenetic Object Relation Test (PORT; Nilsson, 1995) and found a decrease in primitive defensive functioning. Birchard et al. (1996) used the 'Draw-A-Person' (DAP) part of the 'House-Tree-Person' test (Buck, 1948). Birchard et al. (1996) compared the DAP scores of participants who received weekly psychoanalytic psychotherapy to participants in a contrast group seen annually. Clients in the therapy group showed improved DAP scores, while only one participant in the contrast group showed improved scores. However, these projective measures are questionable in their standardisation and objectivity and are not considered to be reliable or valid measures of change.

The Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990) was used to assess change in two studies (Newman & Beail, 2005; Salvadori & Jackson, 2009). The APES proposes that individuals progress through stages during psychotherapy gaining more understanding with

decreasing negative affect. Both studies found an increase in APES levels across therapy, suggesting a positive impact of psychodynamic psychotherapy. Newman and Beail (2005) also used the DMRS to measure changes in defence functioning as an indication of positive outcome of psychotherapy but found no significant change. Recidivism rates were used as an outcome measure in two studies where some or all of the participants were offenders (Beail, 1998; Beail, 2001). Of the 21 male participants across the studies, none re-offended during therapy and only two had re-offended at follow-up.

Three studies measured service user satisfaction with therapy as an outcome (Khan & Beail, 2013; MacDonald et al., 2003; Merriman & Beail, 2009). Macdonald et al. (2003) and Merriman and Beail (2009) used qualitative, semi-structured interviews analysed using Interpretative Phenomenological Analysis (IPA). MacDonald et al. (2003) interviewed four men who attended a group for sexual offending and five women who attended a women's group. Themes emerging from the interviews were defined as both positive and negative. Positive themes included 'ability to communicate with others about difficult experiences' and 'feeling valued within the group' (p.346). There was also an overarching theme of positive feelings towards the therapist. The negative themes that emerged were participants' desire to 'avoid the emotional pain', 'finding the characteristics of other group members difficult', and 'feeling that the group had not had an impact (p.347)'. Merriman and Beail (2009) interviewed six male clients receiving individual psychodynamic psychotherapy and found similar positive feelings towards therapy and therapists. Unlike MacDonald et al. (2003), the authors found that clients did identify positive changes in behaviour and emotion as a result of psychotherapy. Whilst the use of qualitative methods from service user perspective provided in depth

information, no objective measure of outcome was included. These studies did therefore not score highly on the *Internal Reliability* subscale.

Khan and Beail (2013) used adapted versions of the Experience of Service Questionnaire (ESQ; Commission for Health Improvement, 2002) and the Satisfaction with Therapy and Therapist scale (STTS-R; Oei & Green, 2008) for service user views during routine clinical practice. Qualitative data from 20 participants showed similar results to MacDonald et al. (2003) and Merriman and Beail (2009). Positive feelings towards both therapy and therapist were expressed, however if appropriate adaptations to the therapy had not been made, participants expressed dissatisfaction. Quantitative data from the ESQ and STTS-R showed high levels of satisfaction with therapy.

Overall, the studies indicate positive change following psychoanalytic or psychodynamic psychotherapy with clients with ID. A variety of outcome measurements were used in the studies showing change across a wide range of difficulties. However, of the measurements used, a number had been adapted from the original versions and only a small proportion had been validated for individuals with ID. This limits the confidence with which findings from these studies can be interpreted and highlights the need for reliable and valid outcome measurements for this client group.

External Validity

The *External Validity* subscale addresses whether the findings of the studies included in the review can be generalised. The overall quality rating addressed in this subscale was 41.3%. An influential factor in this subscale was the study participants' level of intellectual ability. There was generally poor reporting of level of intellectual ability. Carlsson (2000) and Newman and Beail (2005)

reported IQ score ranges of 35 to 58 and 45 to 65, respectively. Kellett et al. (2009) reported an IQ of 55 for one of their single case participants but no score was reported for the other participant. Of the remaining studies, two described participants as having a mild to moderate ID (Khan & Beail, 2013; Merriman & Beail, 2009), whilst the remaining five studies simply described participants as having an ID. Salvadori and Jackson's (2009) case study is the only participant to have an acquired ID due to childhood meningitis.

A second variable of interest in this subscale is the presenting problem for which participants were referred to therapy. Participants were referred for a range of psychological and behavioural issues including: sexually inappropriate behaviour (Beail et al., 2005; Beail, 1998; Newman & Beail, 2005, 2010); offending (Beail, 1998, 2001); psychotic symptoms (Beail et al., 2005; Carlsson, 2000); self-harm (Bichard et al., 1996; Beail et al., 2005); anger or aggression (Alim, 2010; Beail, 1998; Beail et al., 2005); and hypochondriasis and ambulophobia (Kellett et al., 2009). There were differences in presentation both between and within study participants.

Whilst the range of level of intellectual ability and presenting problem is more representative of clinical practice, it creates heterogeneous groups, which limits the generalization of findings. Impacts of the intervention, both positive and negative, may also be diluted with in such heterogeneous groups. This might lead to unclear or incorrect conclusions being drawn from the results.

Internal Reliability Sampling

This subscale assesses the handling of confounding variables within the research. Only 10.8% of the quality rating was achieved by the studies reviewed, making it the weakest area for study quality. This score reflects the

poor designs and methods employed by the studies. The only studies to contribute to this score were those with a case series design. However, they still only addressed 20% of the quality rating. This was due to the fact that no control group was used in any of the case series design; therefore there was no protection against confounding variables and sampling bias.

Bichard et al. (1996) received the highest score on this subscale due to the inclusion of a contrast group. The group consisted of individuals referred to the service but who were unable to begin therapy, as there were no therapeutic vacancies. It was called a contrast group by the authors because participants in this group were seen once a year for two years, whilst the other participant group received weekly psychoanalytic psychotherapy. The yearly contact was thought to have a positive impact; therefore the participants in this group were receiving an intervention in some form. The group could therefore not be called a control group. Within the contrast group there was also no attempt to match or randomise the groups. Although Beail (1998) did not use a control group, four participants who did not complete treatment were followed up and their problematic behaviour had remained stable.

Discussion

The aim of this review was to systematically evaluate the quality of available literature pertaining to the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy for individuals with ID. No papers that were found from the systematic searches used psychoanalysis, therefore the review focused on psychoanalytic and psychodynamic psychotherapy. Thirteen studies examining the effectiveness of psychoanalytic and psychodynamic psychotherapy were included in this review. Overall, the

studies suggest that psychoanalytic and psychodynamic psychotherapy can be effective in reducing psychological distress among clients with ID. Improvements in self-esteem, interpersonal problems, and level of assimilation were reported. Symptomatic behaviour and offending were found to decrease and clients' satisfaction with therapy was high. However, there was variability in the findings across the studies.

The quality of the research was assessed using Cahill et al.'s (2010) checklist. The hierarchy of evidence model conceptualises RCTs as the highest quality of evidence at the top of the methodology pyramid. No RCTs were found during the searches, suggesting that research in the psychoanalytic and psychodynamic sphere has yet to follow CBT's progression towards the top of the pyramid. However, if viewed in relation to Salkovskis hourglass model (1995), studies are beginning to populate the levels before this. Of the studies reviewed, those that employed case series designs were assessed to be the highest quality across all subscales. No studies utilised a control group however, Bichard et al. (1996) and Beail (1998) used a comparison of some form. The single case design and the more explorative service user satisfaction studies provided some measure of quality however; as they did not include a comparison group they were considered to be a lower level of evidence (National Institute of Clinical Excellence (NICE), 2004). The case study design was the poorest quality of research reviewed.

The overall quality of the studies reviewed was poorer than the quality of studies utilising the cognitive behavioural psychotherapy, reviewed by Nichol et al. (2013) using the same quality assessment framework. Quality rating scores for CBT research in Nichol et al.'s review ranged from 15 to 29 (M = 23.8), overall the studies addressed 74.6% of the checklist quality criteria with no less

than 62% of checklist criteria being addressed across all subscales. Quality rating scores for psychoanalytic and psychodynamic research in this review ranged from 7 to 21 (*M* = 12.2), overall the studies addressed only 38.5% of the checklist quality criteria however, some studies addressed up to 60% of the quality criteria on certain subscales. Comparing the quality ratings of the studies in the current review and Nichol et al.'s (2013) review indicates that the research conducted into the effectiveness of CBT for clients with ID is currently of a higher quality (as judged by Cahill et al.'s checklist) than the research conducted into the effectiveness of psychoanalytic and psychodynamic psychotherapy for clients with ID. However, there is evidence that designs are being employed with psychoanalytic and psychodynamic research that is similar to CBT research in some aspects of quality.

Although the studies reviewed in this thesis scored reasonably well in the *Reporting* subscale, there remains a lack of clarity about what the intervention involved, making replication of the research difficult. The studies reviewed offer evidence for both short- and longer-term psychotherapy with individuals with ID. However, there are large discrepancies in length of therapy, limiting comparison of the effectiveness of different durations of therapy. Few studies include follow-up data but those that do suggest improvements are maintained. However, the small amount of follow-up data limits the inferences that can be made about the long-term impact of psychotherapy. Further research to understand the interaction between therapy length and outcome is therefore required.

Historical examination of robustness and assessment of internal reliability using a quality-rating tool evidenced an increasing integrity in the outcome measures being utilised in ID research; for example, the SCL-90

(Derogatis, Lipman, & Covi, 2007) and BSI (Derogatis & Spencer, 1993). The use of standardised tools such as the IIP-32 (Barkham et al., 1996) and RSES (Rosenberg, 1965) might have some advantages over subjective reporting of outcomes; however these measures have been found to be less reliable with people with ID. Only three of the thirteen studies utilised such standardised measures and they did not produce consistent findings. More psychotherapy outcome measures need to be adapted and standardised for clients with ID to enable a greater body of higher quality research to be built.

Reporting of IQ across the studies was variable. Improving this will allow researchers to begin to evaluate the effectiveness of psychodynamic psychotherapy for specific levels of ID. Participants in all the studies reviewed were able to communicate verbally to some level. Individuals with limited or no verbal communication are not represented in the current body of research. Research with participants with limited or no verbal communication clearly poses challenges, such as consent and measurement, which are still being overcome with participants with ID who have verbal abilities. However, researchers should begin to consider how to evaluate the outcome of psychotherapy with clients who are non-verbal.

The small sample sizes, substantial male bias, variety of presenting problems, and variability in the level of intellectual disability resulted in poor *External Validity* scores. Whilst these factors may be a realistic representation of the clinical setting, it limits the generalisability of the findings. The studies do not allow for the effectiveness of psychoanalytic and psychodynamic psychotherapy for specific levels of ID and presenting problems to be assessed. The difficulty faced when researching this population is that within each subset of presenting problems, or level of ID, the numbers of referrals are extremely

small. A national, multi-centre initiative may need to be undertaken to allow for discrete groups within clients with ID to be analysed as independent variables.

Review Critique

There are limitations to the present review. For example, studies not published in English were excluded, as translation was not possible. A number of studies in French and Dutch journals were identified but were not included due to lack of translation. This may mean that some relevant papers were excluded from the review. Book chapters were also excluded. Whilst there are a number of studies relevant to this topic within book chapters, the majority are case studies and this review aimed to focus on the development of research away from the case study.

Previous reviews have failed to use quality rating assessments. The use of Cahill et al.'s (2010) quality checklist provided a consistent template for appraising the studies. Its use allowed for comparison with Nichol et al.'s (2013) review of CBT and enabled psychoanalytic and psychodynamic psychotherapies to be considered in relation to the hourglass model and the hierarchy of evidence. However, even though the checklist was adapted to suit practice-based evidence, it was still unresponsive to the details of uncontrolled studies. The low score on the *Internal Reliability* sampling subscale highlights this. As none of the studies were controlled, a floor effect was created on this subscale in understanding the development of research around interventions. The quality assessment framework chosen for this review placed more weight on research that would sit within the third and fourth phase of Thornicroft et al.'s (2011) schema. It fails to evaluate the studies that sit within the discovery phases of Thornicroft et al.'s (2011) schema. Hollins and Sinason (2001) argue

this is short sighted and there is a valuable place for research with good qualitative material, such as case studies, as they have powerful face validity. The view that more highly controlled studies provide a higher quality of evidence is largely driven by NICE, who develop guidelines based on the best quality evidence, which are often RCTs. If however, we are to view research in terms of Thornicroft et al.'s (2011) schema we need to begin to view all research as a necessary and important part of a whole process and the tools used to assess research quality need to reflect this.

The three service user studies included in this review also highlight the disadvantages of using the quality rating assessment chosen for this review. Increasing importance is being placed on involving service users in the planning, delivery, and evaluation of services (Care Quality Commission, 2009). Services frequently evaluate if clients have improved, but commissioners are focused on how satisfied service users are with the service they receive. Qualitative methods, such as IPA, provide a valuable insight into individuals' experience of psychotherapy. Yet, as theses studies are based on subjective feedback, assessing these qualitative methods against the parameters of the Cahill et al. (2010) tool devalues the findings such studies have to offer, as more weighed is placed on objective measures. This is evidenced by the fact Khan and Beail's (2013) study is considered the highest quality service user study, which was largely due to their use of more objective, quantitative measures. Whilst these measures provided a more objective measure of satisfaction than in the other service user studies, Khan and Beail emphasise the importance of the inclusion of open-ended, qualitative questions to illicit dissatisfaction, which were not captured by the ESQ or STTS-R.

Conclusion

The results of this review indicate that psychoanalytic and psychodynamic psychotherapy can be effective in reducing psychological distress in individuals with an ID. Research design within the field psychoanalytic and psychodynamic psychotherapy with people with ID is beginning to advance from the descriptive case study. This review found eight studies that showed developments in design. However, no controlled studies have been published and in comparison to the cognitive-behavioural psychotherapy research with clients with ID, studies in this area were of poorer quality. This review has highlighted the limited body of evidence for the effectiveness of psychoanalytic and psychodynamic psychotherapy despite 30 years of application in practice (Jackson & Beail, 2013). There is a need for more research at all levels of evidence, but in particular there needs to be methodologies with greater control and comparison to furnish the current conceptualisation of evidence-based practice. Further, particular consideration should be paid to participants' level of ID and presenting problem to begin to develop an understanding of what works for whom. Development of outcome measures, standardised for clients with ID, should also be a focus of future research. This review highlights the caution that should be taken when assessing the quality of research with a quality rating tool. The specific tool chosen for this review was deemed to be most appropriate for less controlled, practice-based evidence. However, it still lacked sensitivity to the uncontrolled, qualitative nature of many of the studies reviewed here. In order to overcome this issue, studies could be rated within their own subgroup of design, or a more comprehensive tool, which covers strengths and weaknesses of all designs

rather than considering the design itself to be a weakness, should be developed.

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Appendix A: Data Extraction Form

Data Extraction Form

Authors:
Title:
Journal:

		Assessment Clear/Unclear/Exclude	Comments
Study Characteristics			
Aims/Objectives			
Study Design			
Recruitment procedures			
Participant Characteristics			
Diagnosis (co-morbidities?)			
Referred for			
Age			
Gender			
Inclusion/Exclusion			
Number			
Intervention & Setting			
Setting delivered in			
Intervention (theoretical basis, control, duration, individual/group, administered by)			
Co-interventions?			
Outcome data/results			
Unit of assessment/analysis			
Outcomes measures used			
Pre/post/length of follow up			
Number of participants in final analysis (withdrawals, exclusions, lost to follow up)			
Results			
Stats/analysis used			
Data (means, sd's, etc.)			
Main Findings			

Appendix B: Quality Rating Tool (Cahill et al., 2010)

Downs and Black rating sheet: Adapted version	ID

Reporting Yes = 1 No = 0 Unable to determine = 0

1	Is the hypothesis/aim/objectives of the study clearly described	☐	
2	Are the main outcomes to be measured clearly described in the introduction or methods section	☐	If the main outcomes are first mentioned in the results section, the question should be answered No
3	Are the characteristics of the clients included in the study clearly described	☐	Inclusion and/or exclusion criteria should be given. Emphasis on inclusion and exclusion criteria, other characteristics are age/gender/morbidity
4	Are the interventions/treatments of interest clearly described?	☐	Treatments and placebo (where relevant) that are to be compared should be clearly described
5	Are the distributions of principal confounders in each group of clients to be compared (or within a single group) clearly described?	☐	A list of principal confounders is provided. Morbidity, co-morbidity, age, gender, previous history. Good qual will include adjustment regression or matching
6	Are the main findings of the study clearly described?	☐	Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. This question does not cover statistical testes which are considered below
7	Does the study provide estimates of the random variability in the data for the main outcomes?	☐	In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation, or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes
8	Have all the important adverse events that may be a consequence of the intervention/treatment been reported?	☐	This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events (A list of adverse events is provided). E.g. early discontinuation of therapy
9	Have the characteristics of clients lost to follow-up been described?	☐	This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up. Follow – up = post – therapy, or loss from study at baseline

Reporting Yes = 1 No = 0 Unable to determine = 0			
10	Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.01	☐	
11	Have sufficient data been provided to enable calculation of outcomes such as pre-post ESs, estimates of reliable a nd clinically significant change	☐	If data are provided to enable calculation of any one of these outcomes score the question yes

External valitity/clinical representativeness Yes = 0 No = 0 Unable to determine = 0			
12	(a) Were the clients asked to participate in the study representative of the entire population from which they were recruited	☐	The study must identify the source population for clients and describe how the patients were selected. Clients would be representative if they comprised the entire source population, an unselected sample of consecutive clients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived the question should be answered as unable to determine
	(b) Were clients referred through usual clinic routes	☐	
13	Were those clients who were prepared to participate representative of the entire population from which they were recruited?	☐	The proportion of those asked who agreed should be stated. Validation that the sample was representative would included demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population
14	(a) Were client heterogeneous in personal characteristics	☐	
	(b) Were clients heterogeneous in terms of presenting problems	☐	
15	(a) Were the staff, places, facilities where the patients were treated representative of the treatment the majority of patients receive?	☐	For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population
	(b) Was the treatment conducted in a non university setting	☐	The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend
	(c) Was implementation of treatment monitored (R)	☐	

External validity/clinical representativeness Yes = 0 No = 0 Unable to determine = 0		
16	Were therapists experienced, professionals with regular caseloads	☐
17	Were therapists free to use a wide variety of procedures in treatment and not just limited to one treatment procedure	☐
18 (R)	Were therapists trained immediately before the study and in the specific treatment being studied	☐

Internal reliability Yes = 1 No = 0 Unable to determine = 0		
19	If any of the results of the study were based on 'data dredging' was this made clear	☐ Any analysis that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analysis were reported, then answer yes
20	Were the statistical tests used to assess the main outcomes appropriate	☐ The statistical techniques used must be appropriate to the data. For example, non parametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken, but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes
21	Was the compliance with the intervention/s/treatments reliable?	☐ Where there was non compliance with the allocated the question should be answered no
22	Were the main outcome measures used accurate (valid and reliable)	☐ For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered yes
23	Do the analyses adjust for different lengths of follow-up of patients in different treatment groups?	☐ Where no comparison group score 0. Where lengths of follow-up the same score 1

Internal reliability confounding (selection) bias Yes = 1 No = 0 Unable to determine = 0			
24	Were the clients in different intervention/treatment groups recruited from the same population	☐	For example, clients for all comparison groups should be selected from the same source population. The question should be answered unable le to determine where there is no information concerning the source of patients included in the study. Where no comparison group score 0
25	Were the clients in different intervention/treatment groups recruited over the same period of time?	☐	For a study which does not specify the time period over which clients were recruited, the question should be answered unable to determine. Where no comparison group score 0
26	Was there adequate adjustment for confounding in the analysis from which the main findings were drawn	☐	This question should be answered no if the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders was not described; or the distribution of confounders differed between the treatment groups but was not taken into account in the analyses. if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses, the question should be answered no
27	Were losses of clients to follow-up taken into account?	☐	If the numbers of clients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion of lost to follow-up was too small to affect the main findings, the question should be answered yes
28	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%	☐	Sample sizes have been calculated to detect a difference of x and y%. Has power analysis been performed

Size of smallest intervention group		
A	<N1	0
B	N1–N2	1
C	N3–N4	2
D	N5–N6	3
E	N7–N8	4
F	N8 +	5

Empirical Paper

The feasibility and acceptability of a therapist measure of assimilation of problematic experiences for clients with Intellectual Disability

Abstract

Objectives. There is a shortage of reliable and valid outcome and process measures available to evaluate change in psychological therapies for people with intellectual disabilities (ID). The Assimilation of Problematic Experiences Scale (APES) has been used in research with the general population[2] and with people who have ID to explore the process of change in psychotherapy. However, it does not easily lend itself to use in routine clinical practice. Two quantitative scales based on the APES have therefore been developed for use with the general population in routine clinical practice: the Client Assimilation Measure (CAM), and the Therapist Assimilation Measure (TAM). The aim of this study was to explore the feasibility and acceptability of using the TAM in routine psychological therapy practice with people who have ID to monitor change.

Method. Twelve therapists working in two ID services worked in two task groups to examine the appropriateness and applicability of the items of the TAM and generate items for the lowest level of assimilation, which was not included in the measure. The revised version of the TAM was then piloted for one month in routine clinical practice. Therapists' feedback was combined with item analysis leading to further modification of the TAM. This resulted in the TAM-ID, which was tested for reliability using Intra-Class Correlation. .

Results. The therapist task groups generated three new items for the lowest level of assimilation and suggested changes to the wording of items to make them more applicable to clients with ID. After the first revision of the TAM therapists' reported it to be feasible, applicable, and useful for monitoring change in psychotherapy with clients with ID but too for long use in routine practice. The measure was therefore reduced to 24-items and the TAM-ID was

[2] Term used with in the intellectual disability literature to refer to individuals who do not have a disability.

found to have acceptable internal reliability (α = .58 to .92) and high inter-rater reliability (*ICC* = .84 to .90).

Conclusions. Clinicians consider the TAM-ID to be applicable to clients with ID and feasible for use in routine clinical practice. Found to be reliable, it is a promising measure of the process of change in psychotherapy with this client group. Further research is necessary to ensure its validity as a measure of assimilation.

Decades of research have investigated whether psychological therapy leads to change for clients. However, less attention has been paid to how clients change during psychological therapy (Lambert & Ogles, 2004). To shed light on these areas, research into psychotherapy has increasingly taken the form of outcome and process research (Schanche, Høstmark, McCullough, Valen, & Mykletun, 2010). Outcomes research attempts to determine which type of psychological therapy works for whom. Process research aims to provide explanations about why and/or how therapies work for certain individuals. Research often separates outcome and process focusing either on evaluating therapeutic outcomes, or concentrating instead on the interactions between therapists and client during the therapy session (Garfield, 1990). Greenberg (1986) introduced the term Change Process Research (CPR) as a way of overcoming this process - outcome dichotomy. CPR refers to *"the processes by which change occurs in psychotherapy, including both in-therapy processes that bring about change and the unfolding sequence of client change"* (Elliot, 2010, p. 1). CPR compliments studies with outcome designs such as randomised control trials, which can focus narrowly on the existence of a causal relationship between client change and therapy (Elliot, 2010).

The Assimilation of Problematic Experiences Model

The Assimilation of Problematic Experiences Model (Stiles et al., 1990) attempts to describe common change processes that occur in successful therapy (Honos-Webb, Stiles, Greenberg, & Goldman, 1998). It is a trans-theoretical model of psychotherapeutic change that draws on a range of theories, such as developmental and cognitive, as well as integrating a number of different models of therapy (Stiles, et al., 1991). According to the assimilation

model, a client's therapeutic progress involves the assimilation of a problematic experience into their schemata (Stiles et al., 1990). Problematic experiences might include painful memories, destructive relationships, or threatening feelings, which cannot be adequately explained by the client's existing knowledge system (Stiles, 2001). Due to the trans-theoretical nature of the model, a schema can be viewed as a frame of reference, script, narrative, or philosophy (Stiles et al., 1990). The concept of assimilation is comparable to the process of assimilation and accommodation in Piaget's (1962) theory of adaptation (Halstead, 1996). In that the process of assimilation involves integration of new experiences into existing schemata. The simultaneous process of accommodation involves the alteration of these existing schemata as a result of the new information. During psychotherapy, the client's problematic experience is assimilated and accommodated into new ways of thinking, feeling, and behaving (Stiles et al., 1990). The change is fostered through the therapist-client interaction and the task of therapy is seen as helping the client develop an understanding of their problematic experience (Halstead, 1996).

The model proposes that the process of change the client goes through during therapy occurs in a predictable, developmental sequence of recognising, reformulating, and understanding which leads to the resolution of the problematic experience (Stiles & Angus, 2001). The eight levels of the developmental sequence are summarised in the Assimilation of Problematic Experiences Scale (APES; Stiles, et al., 1991), shown in Table 1. The levels are numbered 0 to 7 from *warded off, or active avoidance of emotionally disturbing topics,* to *mastery, or the ability to use solutions in new situations*. The APES is considered a continuum, with the levels representing anchor points rather than discrete states. Clients can enter therapy at any level and therapeutic progress

is conceptualised as movement along the continuum (Stiles et al., 1990). Different cognitive and affective features characterise each level of the APES. In successful therapy, clients will move through emerging awareness and understanding from a preconscious, dissociated position, to a position of problem solving and mastery. The affect experienced in each level does not follow the same continual progressive pattern as the cognitive elements. Only with the increasing cognitive awareness from levels one and two does the client experience intense negative affect. The most intense emotional pain is expected at level 2 or, *vague awareness*. As clients move up through the levels, affect becomes more manageable and positive until they return to a position with no affect once the problematic experience has been assimilated. This pattern of affect means that clients' distress and symptom intensity will vary across the APES levels and this relationship is not linear (Stiles, Osatuke, Glick, & Mackay, 2004). Clients who enter therapy at APES levels 0 or 1 are likely to become more distressed as they begin therapy. The conventional way of measuring outcome by assessing symptom intensity is only appropriate when individuals enter the middle section of the APES continuum. As affect is not a central feature of the highest APES levels, assessment of outcome which focuses on affective distress, rather than positive affective, might not reflect clients' progress through the entirety of psychotherapy.

Table 1

A Summary of Assimilation of Problematic Experiences Scale (APES)

---

0. ***Warded Off:*** Content is unformed; client is unaware of the problem. There is evidence of active avoidance of emotionally disturbing topics. Affect may be minimal, reflecting successful avoidance.

1. ***Unwanted thoughts:*** Content is distressing thoughts. Client prefers not to think about it; topics are raised by therapist or external circumstances. Affect is often more salient than the content and involves strong negative feelings of anxiety, fear, anger, sadness.

2. ***Vague Awareness and Emergence:*** Client acknowledges the existence of a problematic experience and describes distressing associated thoughts but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic thoughts and experiences.

3. ***Problem Statement / Clarification:*** Content includes a clear statement of a problem - something that could be worked on. Affect is negative but manageable, not panicky.

4. ***Understanding / insight:*** The problematic experience is placed into a schema, formulated, understood, with clear connective links. Affect may be mixed, with some unpleasant recognition, but also with curiosity or even pleasant surprise.

5. Application / Working through: The understanding is used to work on a problem; there are specific problem-solving efforts. Client may describe considering alternatives or systematically selecting courses of action. Affective tone is positive, business-like, and optimistic.

6. ***Problem Solution:*** Client achieves a solution for a specific problem. Affect is positive, satisfied, and proud of accomplishment. As the problem recedes, affect becomes more neutral.

7. Mastery: Client successfully uses solutions in new situations; this generalizing is largely automatic, not salient. Affect is neutral (i.e., this is no longer something to get excited about).

(Stiles, Shapiro, & Harper, 1994)

The sequence of changes proposed in the assimilation model resembles those set out in Prochaska and DiClimente's (1984) stages of change model. The stages of pre-contemplation and contemplation in the stages of change model could be considered similar to level 0 and level 3 of the APES. The additional two levels in the APES therefore allows a more detailed exploration of the process of change as the client moves from a position of pre-consciousness to consciousness during psychotherapy than the stages of change model allows. The APES also provides a way of linking psychotherapy process with outcome by tracking sessional change (Brinegar, Salva, & Stiles, 2008). The APES provides a framework that allows for CPR to be conducted in a way that is of interest to both researchers and practitioners (Newman & Beail, 2010).

Research following the development of the APES has largely used from a series of intensive case studies, focusing on the meaning of events during therapy within a contextual understanding (Osatuke & Stiles, 2011). Early research into the assimilation of problematic experiences model supported the regular, sequential nature of the levels of assimilation (Shapiro, Barkham, Reynolds, Hardy, & Stiles, 1992; Stiles et al., 1991; Stiles, Meshot, Anderson, & Sloan, 1992). This research has supported the model's hypothesis that clients' problematic experiences progress through a sequence that generally moves from lesser to greater assimilation (Stiles, Shapiro, Harper, & Morrison, 1995). Most studies have selected successful cases of psychotherapy to study. However, a number of researchers have compared good and poor outcome cases for their assimilation of problematic experiences during psychotherapy (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006; Honos-Webb et al., 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999). These studies found that

good outcome cases showed progress in assimilation, frequently reaching level 4 (*understanding/insight*) or above. Poor outcome cases were associated with difficulties with assimilation. Gabalda (2006) analysed a case of therapeutic failure and found that a level of *understanding/insight* was never achieved. These studies provide empirical endorsement for the progression up the continuum as proposed by the assimilation model (Detert et al., 2006).

More recently the sequential progression, i.e. progression without any major jumps or regressions, has been shown not to be empirically sound (Gabalda & Stiles, 2013). Rather than the smooth ascension along the assimilation continuum, a saw-tooth pattern has been more commonly found. Clients have often been found to make progress only to fall back before making further progress (Gabalda & Stiles, 2009; Goodridge & Hardy, 2009; Osatuke et al., 2005). There has been evidence for this being the case even when the overall pattern reflected increasing assimilation (Newman & Beail, 2002). This finding has not however, been consistent across therapeutic modality. Experiential and Psychodynamic approaches have continued to show the relatively regular progression originally proposed (Honos-Webb et al., 1999). Cognitive therapies however have more commonly been found to follow the saw-tooth pattern (Osatuke et al., 2005). Gabalda and Stiles (2013) examined this pattern of assimilation further and termed the pattern "*setbacks*". The authors concluded that setbacks were a result of "*subtle shifts in topic from a more assimilated to a less assimilated strands of problematic experiences*" (p. 46). The expectation that clients will be working on different problematic experiences assimilated at different levels has always been present in the assimilation model (Halstead, 1996). However, Gabalda and Stiles (2013) provide elaboration of the model by proposing reasons for these shifts. These

authors found that setbacks occurred in response to therapists either pushing the client to the limit of their therapeutic zone of proximal development (ZPD) or directing the client's attention to a less developed strand of the problematic experience. It is possible that these elaborations reflect how setbacks are theoretically and clinically understandable and are a normal part of the therapeutic process. This appears to demonstrate that this conceptualisation of setbacks fits with the findings that the saw-tooth pattern is more evident in cognitive therapies. Cognitive therapists tend to take a more directive stance than humanistic-experiential approaches therefore more setbacks would be expected (Gabalda & Stiles, 2013). These most recent findings suggests that although assimilation might occur in the sequence proposed by the APES, within this sequence gains may alternate with setbacks particularly within more directive therapies.

Therapist Assimilation Measure

Although a small number of studies have employed both qualitative and quantitative measurement, the use of the APES as an indicator for change is essentially an interpretative and qualitative process (Stiles, 2001). The predominant research into the assimilation model is therefore within the qualitative paradigm. A shift in this paradigm came from Halstead's (1996) work that developed a set of rating scales that provide a quantitative measure of assimilation. Whilst Halstead (1996) acknowledged that clients might be working on different problematic experiences at the same time, he considered it likely that one experience would dominate. If this were the case then the general level of assimilation activity could therefore be quantified. Halstead developed two process measures, collectively known as the Stage of

Assimilation Measures (SAM), to detect and measure the sequence of stages proposed by the APES. They were designed to measure the extent of client activity at each level of the assimilation of problematic experiences model. Client activity corresponds to a clients' logical thinking, feeling, and doing at each level of assimilation. The overall question that the SAM seeks to provide information on is, "*to what extent, during this session that has just ended, was the client engaged in activities characteristic of a particular level of assimilation?"* (Halstead, 1996, p. 83).

The Stage of Assimilation Measures contain two quantitative rating scales, one that is completed by the client (Client Assimilation Measure; CAM) and one completed by the therapist (Therapist Assimilation Measure; TAM). The measures were designed to assess the predominant stage, or stages, of assimilation a client is working on. They address elements of client cognitive, behavioural, and affective activity during the therapy session. Due to the focus on client activity the SAM does not attempt to measure the *warded off level* as it was considered, by definition, to represent a total lack of awareness (Halstead, 1996).

Halstead primarily developed a 56-item Client Assimilation Measure, which was later shortened to a 44-item measure. The CAM-44 was then converted to a Therapist Assimilation Measure (TAM) to provide comparison between client and therapist. Items in the CAM were altered by changing the wording from "*I…*" to "*my client…*". The measures structure was confirmed on two separate data sets and was found to be reasonably robust.

Psychotherapy with clients with ID

The majority of research into the assimilation model has been conducted with the general population. This reflects a trend in psychotherapy research, in which people with ID are frequently not represented (Wilner, 2005). This may be a result of the over reliance on behavioural interventions with individuals with ID, due to the belief that they cannot benefit from psychotherapy (Hurley, 1989). Scotti, Evans, Myer, and Walker (1991) reviewed interventions used for problematic behaviours in individuals with ID and of the 403 studies reviewed, none employed psychotherapeutic techniques. Didden, Duker, and Korzilius (1997) conducted a meta-analysis on over 1400 studies and found that non-behavioural techniques were employed in only one per cent of studies. In more recent years however there has been an increasing belief that individuals with ID can benefit from psychotherapy. It has been reported that psychotherapy has been used with individuals with ID referred for a variety of problems including anxiety, anger, and trauma (Cooke, 2003; Lindsay, Nielson, & Lawrence, 1997; Taylor, Novaco, Gillmer, & Thorne, 2002). Shepherd (2015) conducted a systematic review of the literature addressing the effectiveness of psychoanalytic and psychodynamic psychotherapy with individuals with ID. The research indicates that psychoanalytic and psychodynamic psychotherapy can be effective at reducing psychological distress among clients with ID. However, the review also suggests that the methodological paradigm in this area is developing and, there remains a lack of well-controlled studies that match the quality of research being conducted in the area of CBT for clients with ID. Shepherd (2015) also draws attention to the need for the development of outcome measures applicable to clients with ID.

One study to date has investigated psychotherapy with clients with ID using the assimilation model (Newman & Beail 2002, 2005). Newman and Beail (2005) found that clients with ID entered therapy at the lowest levels of the APES (*warded off, unwanted thoughts*) but were able to assimilate their problematic experience. Their participants did progress through the levels and they concluded that the APES is a promising framework to consider changes across psychotherapy with people with ID.

Present study

This study aimed to build on Newman and Beail's (2002, 2005) research, using the assimilation model as a framework for investigating change across psychotherapy, as well as explore the feasibility and acceptability of the TAM with clients with ID and adapt the measure for use in routine clinical practice with clients with ID. Unlike much of the assimilation research to date, which utilised intensive case studies, this study employed Halstead's quantitative paradigm and measure. Although Halstead's (1996) CAM and TAM measures have not been published, they could provide a promising basis for the development of a quantitative measure for use with people with ID. Despite the CAM being the originally developed measure, the focus of the current study is the TAM based on Newman and Beail's (2005) finding that the majority of their participants entered therapy at the preconscious level and then progressed towards the conscious levels and beyond. Thus, a measure was needed that could identify clients at the lowest levels of assimilation. Neither the CAM nor TAM taps into these levels as they are outside conscious awareness. However, Newman and Beail (2005) provided evidence that therapists could identify the

lowest levels in their clients. Thus, it was considered feasible to develop this aspect of the TAM.

The adaptation of the TAM could potentially provide a measure of assimilation to allow further investigation into the process of assimilation and add to the currently limited literature on the process of change that occurs for clients with ID. A quantitative measure such as this has the potential to produce data, which can be analysed for a large number of individuals for service audits and research. This may provide a means of creating the more rigorous experimental data that is currently lacking from the area.

General Method

In order to achieve the aims the study was broken in to four phases. Each phase required a different design and analysis, which will be discussed within the description of each phase in the following methods section. The common features of the phases are presented in the following general method.

Procedure

The four phases were as follows: (1) Therapists who work with individuals with ID were recruited and were asked by the researcher to examine the appropriateness and applicability of the 44 items of the TAM to their work. (2) As there were no items for the "*warded off*" level, therapists were asked to generate items and these were incorporated into the TAM depending on suitability. (3) The revised TAM was then piloted and therapists fed back their experiences of using it in practice. (4) Feedback and statistical analysis of the data led to further modifications and the reliability of the resultant measure was tested.

Participants.

Following ethical approval from Leeds and Bradford Regional National Health Service (NHS) ethics committee (Appendix A) two NHS outpatient services providing psychotherapy to adults with ID participated in the study. Across the services 15 therapists were deemed eligible to participate in the research. The eligibility criteria were that therapists were currently, or had historically delivered individual psychotherapy to clients with ID. The researcher approached staff members during service team meetings to communicate the aims and objectives of the research and provide information sheets and consent forms (Appendix B & C). Twelve therapists consented to participate and demographic data (Appendix D) showed that eight of the 12 therapists were female, and the dominant psychological approach used by therapists was psychodynamic, two therapists used CBT and one described their approach as integrative. Therapists stated their professional roles were clinical psychologist (*n* = 5), counselling psychologist (*n* = 1), trainee psychologist (*n* = 4), or assistant psychologist (*n* = 2). Participants' experience providing psychotherapy ranged from 3 to 30 years (*M* = 9.5*, SD* = 8.20) and the number of years participants had worked with clients with ID ranged from 1 to 30 (*M* = 6.75, *SD* = 9.15). Participants were also asked to rate their level of knowledge of the assimilation model from *none at all* to *extremely well*; all reported at least *a little* knowledge with the majority (*n* = 8) reporting they knew it *well* or *extremely well*.

Measures.

The current study used the Therapist Assimilation Measure (TAM; Halstead, 1996 see Appendix E). The TAM is an adaptation of the Assimilation

of Problematic Experiences Scale. It consists of 44 statements relating to client activity at different levels of assimilation. The therapist completes the measure after every therapy session with a client. Statements are rated on a seven-point scale (1-7) from *strongly disagree* to *strongly agree*, with a *neutral* centre point. To score, the mean score of the statements within each assimilation level is computed. This creates a profile of scores, which indicates the levels in which the client is displaying most activity. The scale, in its original form, is described as reasonably robust and showed stability across samples. Internal consistency was found to be good for all TAM scales with all $\alpha = \geq .78$. Correlations between TAM scales were consistent with theoretical predictions that adjacent scales would correlate more highly than non-adjacent scales (Halstead, 1996). It was found to correlate with other global and specific session impact and process scales (Halstead, 1996). Good internal consistency was found for all TAM scales ($\alpha = \geq .78$ for all levels). As the measure is unpublished Halstead gave written permission to use the measure in any capacity.

Phase One: Development of the Therapist Assimilation Measure for use with clients with Intellectual Disability

Procedure

Participants took part in task groups run by the researcher at their place of work. The aims of the task groups were to generate items for the assimilation level *warded off* and consider the appropriateness of the existing TAM items for clients with ID. Participants were provided with written and verbal descriptions of the levels of assimilation. This was considered sufficient as all participants had some prior knowledge of the assimilation model and both services were

actively using the model in supervision and case consultations. A number of the participants had also been in involved in previous research that had provided specific training on the assimilation model. The descriptions of the assimilation model included cognitive, affective, and behavioural aspects of each of the levels. This was to ensure any new items developed reflected these three aspects ensuring consistency with Halstead's item development. All participants had been given a copy of the TAM a week prior to attending the task group to familiarise themselves with the statements.

The 44 statements were evaluated for their appropriateness and applicability to clients with ID. The groups were largely unstructured with little input from the researcher, except to clarify areas and keep the focus on the tasks. This was in line with Nassar-McMillan and Borders (2002), who stated that when generating items groups should have an unstructured agenda. The groups ran for an hour and a half and were not audio recorded as it was the output, not the process, of the groups that was of interest.

Results

The overall consensus of participants during the task groups was that overall the TAM items would be relevant to the clients they work with. The groups reflected that the phraseology of *"his/her"* and *"he/she"* used in the items was cumbersome and unnecessary. It was agreed among the expert participants that the items should be changed to "*them, they, or their"*. Item 10 was highlighted as irrelevant to some clients as it states "*your client was able to see the connection between some ways he/she reacts in the sessions and the difficulties that made them seek therapy".* Participants reported that frequently clients had not sought therapy themselves and that family or carers had made

the referral. The wording "…*difficulties that brought them to therapy"* was suggested by participants and it was agreed among the group that this should be changed.

When generating items for the *warded off* level of assimilation there was concern over the length of the measure. There were no fewer than four items for the other levels in the measure, but it was felt by the expert participants that including many more items would make it unmanageable for participants during the second stage of this study. As the items were being developed around cognitive, affective, and behavioural aspects, the groups agreed that an additional three items were sufficient. All participants agreed upon the following three items:

1. *"Your client is unaware that there is a problem or denies they have a problem"* (cognitive).
2. *"Your client shows no emotion when you talk about their problem"* (affective).
3. *"Your client talked about topics unrelated to their problem"* (behavioural).

The TAM was amended to include the three new items and the previously suggested alterations to existing items. This created a 47-item measure, which was labelled the Therapist Assimilation Measure - Plus (TAM+), in order to differentiate it from the original measure (Appendix F).

Phase Two: Piloting the TAM+

When revising an existing scale it is necessary to confirm that the scale uses clear and appropriate language with no errors or omissions (Johanson and Brooks, 2010). Johanson and Brooks (2010) recommend conducting a pilot study to address these issues and to investigate the feasibility of a measure. Participants completed the TAM+ after client therapy sessions for one month.

Clients' scores on the TAM+ were used to investigate the relationship between mean subscale scores and independent factors of level of intellectual disability, therapy mode, and phase of therapy. Where clients contributed more than one TAM+, only scores on the first TAM+ were included. Data is presented in descriptive format only. Statistical analysis was not possible due to the small sample size, unequal groups, and violations of assumptions of normality.

Demographic Data

A total of 42 TAM+ questionnaires were completed for 33 clients (five clients had two or more TAM+ completed for them). Clients' identity remained anonymous but demographic data were collected and study identification numbers were assigned to ensure anonymity of the data. The measure was completed in response to 14 male clients, and 19 female clients, aged between 18 and 62 years (M = 35.6, SD = 13.4). Seventeen clients were described as having mild ID, eight were described as having moderate ID, and one client was described as having severe ID. IQ scores (as measured by the Wechsler Adult Intelligence Scale – Fourth Edition, WAIS-IV; Wechsler, 2008) were provided for the remaining seven clients and ranged from 47 to 68. The most common comorbid diagnosis was Autistic Spectrum Disorder (n = 9). Two clients had a diagnosis of Personality Disorder, and one had Turner Syndrome. Comorbid diagnosis was either not present or not stated for 20 clients. Reasons for referral to therapy were: anxiety (n = 7); low mood (n = 10); challenging behaviour (n = 5); paranoia/psychosis (n = 2); bereavement (n = 3); anger (n = 3); and interpersonal difficulties (n = 3). Clients were receiving one of three therapy modes: psychodynamic (n = 18); cognitive behavioural therapy (CBT, n

= 8); or person-centred counselling (*n* = 6). As this study was based in routine clinical practice, clients had not been randomly assigned to therapy mode.

Results

Relationship of assimilation scores with level of intellectual disability, therapeutic approach, and phase of therapy. Mean TAM+ scores were plotted for all clients (*N* = 33). Figure 1 shows the majority of clients were working at the level of *vague awareness*, in which clients acknowledge the existence of the problematic experience but cannot formulate it clearly and they experience acute negative affect.

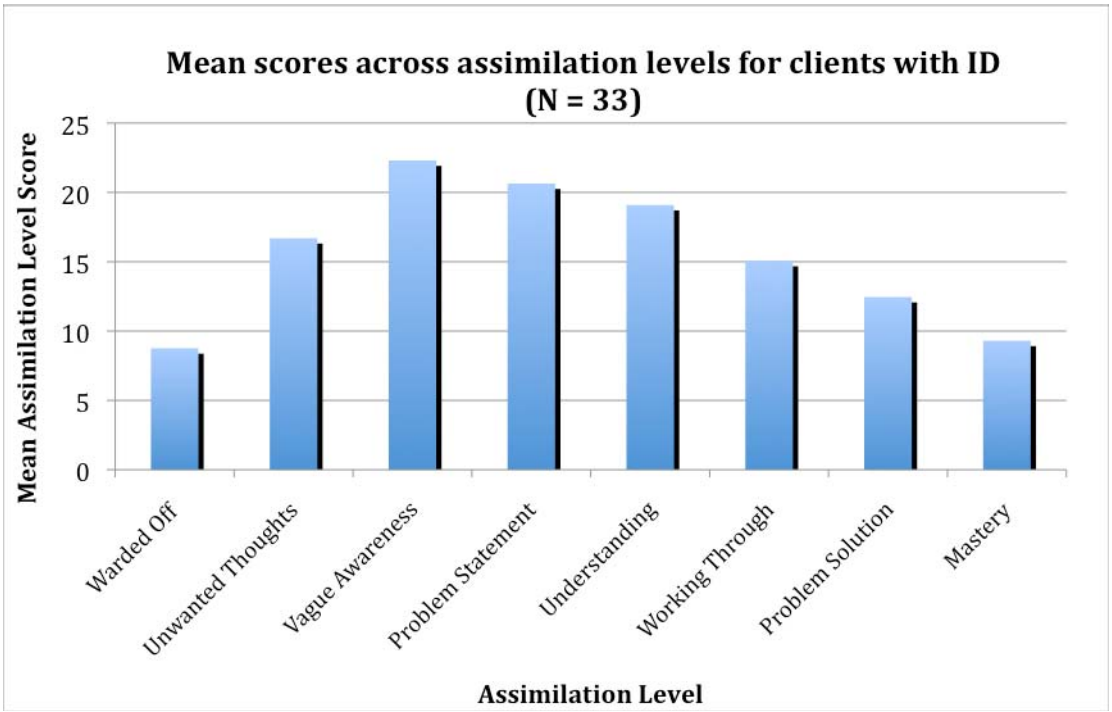

Figure 1. Clients' mean scores across assimilation levels.

Clients assimilation scores appeared to increase from *warded off* to *vague awareness* and gradually declined towards the higher levels of assimilation. The lowest mean scores were for *warded off* and *mastery*. Mean

scores indicate that clients scored slightly higher across the four lower levels of assimilation (*M* = 68.9), than the four higher levels of assimilation (*M* = 55.9).

The relationship between level of intellectual disability (mild, *n* = 19; moderate, *n* = 12; severe, *n* = 2) and mean score for each level of assimilation is shown in Figure 2. Clients whose actual IQ score had been reported were grouped as follows: mild = 60 - 70; moderate = 50 - 59; severe = 49 and below.

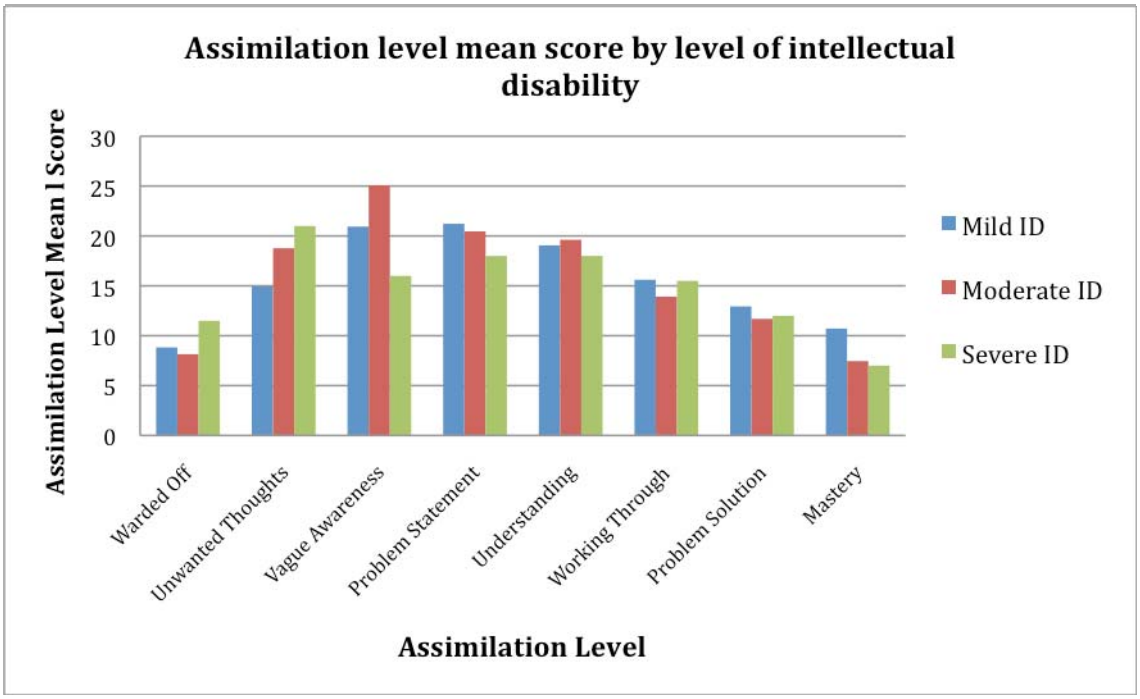

Figure 2. Clients' mean scores for assimilation level for mild, moderate, and severe intellectual disability.

Clients of all levels of intellectual disability worked across all levels of assimilation. Clients with mild and moderate ID appeared to follow a similar pattern, with a peak in scores around *vague awareness* and *problem statement*. Clients with severe ID were most commonly working at *unwanted thoughts*. Clients with a mild ID showed the highest scores in *mastery* compared to clients with moderate and severe IDs, whereas clients with severe ID showed higher scores at *warded off* compared to clients with a mild or moderate IDs.

The relationship between therapy mode (psychodynamic, *n* = 19, CBT, *n* = 8, or counselling, *n* = 6) and mean score for each level of assimilation is shown in Figure 3.

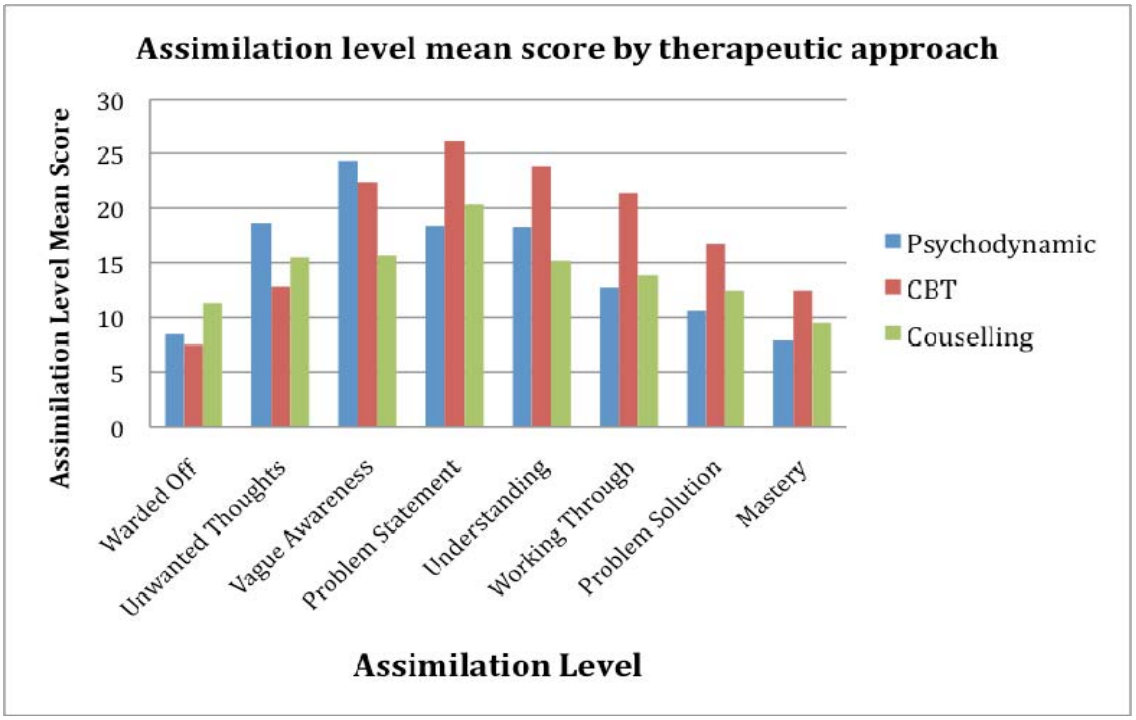

Figure 3. Clients' mean scores for assimilation level in psychodynamic psychotherapy, CBT, and person centred counselling.

Figure 3 shows that CBT and Counselling followed a similar pattern with lowest scores at *warded off* and *mastery*, and the majority of clients working at the level of *problem statement*. Clients in CBT were least likely to be working at the *warded off* and *unwanted thoughts* level. Clients utilising psychodynamic psychotherapy was shown to be more commonly working at the lower levels of *unwanted thoughts* and *vague awareness.*

The relationship between phase of therapy and mean score for each level of assimilation is shown in Figure 4. Session number determined phase of therapy. Sessions one to four were categorised as beginning (*n* = 19), session five to nine were categorised as middle (*n* = 8), and sessions 10 to 14 were categorised as end (*n* = 6).

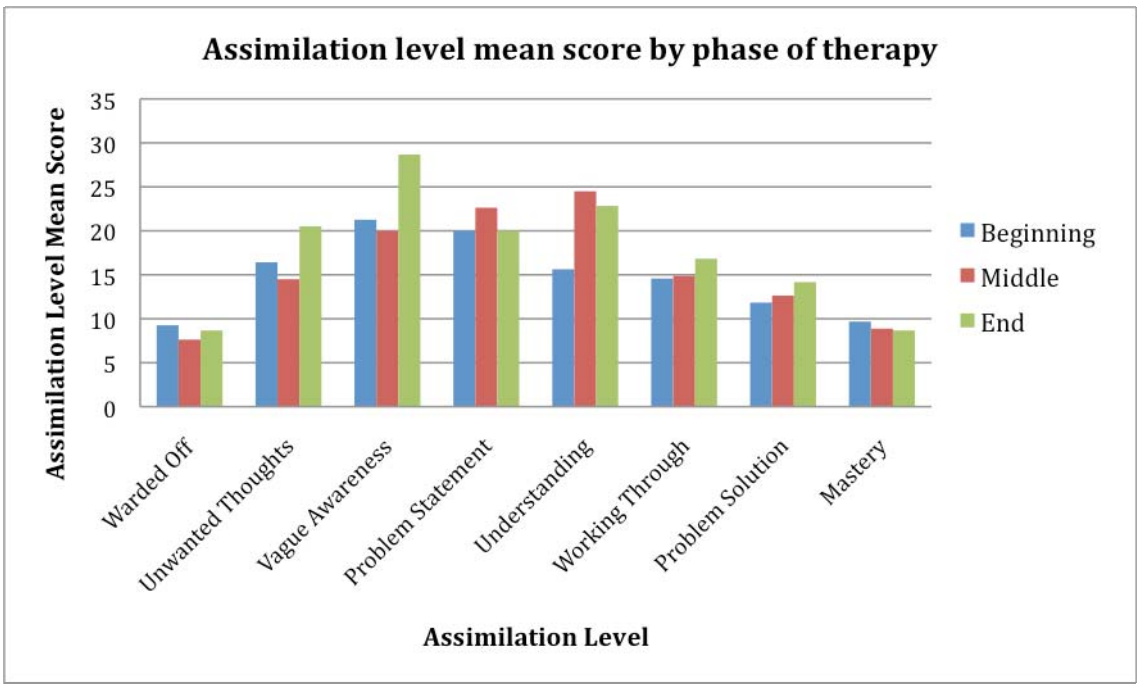

Figure 4. Clients' mean scores for assimilation level by phase of therapy.

Figure 4 shows that during the beginning of therapy, scores increase across the lower three levels of assimilation and decrease across the higher levels of assimilation. Clients' scores during the middle phase of therapy increased, peaking at the central levels, and then decreased in the higher levels. Clients in the end phase of therapy show a similar pattern to clients in the beginning phase, with a higher peak at *vague awareness*.

Therapist feedback from the pilot study. Meetings were held between the researcher and the therapists at both services to explore therapists' experience of completing the TAM+ and collect their views on the measure's feasibility, applicability, and utility in routine clinical practice. Therapists reported that the measure took between 5 and 15 minutes to complete, but took longer for those participants who were less familiar with the assimilation model. Completion was reported to be longer for new clients and clients who had limited communication. All participants said that the measure was too long, as it

was designed to be completed after every client session and there were some common concerns about the impact the measure would have on their workload. In order for it to be feasible for use in routine clinical practice, therapists requested it be shortened.

Whilst participants stated that they understood the measure and generally found it applicable to their clients, this was sometimes dependant upon model of therapy. Those therapists delivering CBT found that some of the items were not relevant, for example "*your client found it annoying to have to talk about their past…"* as CBT is often focused on the present rather than the past. The phraseology of some items was highlighted as a problem by the expert participants. A large number of the items are double barrelled, for example "*your client became more aware of how they really felt in certain relationships and was able to see how their past experiences affect how they feel right now."* Participants found that for some clients they would agree with one half (*they were aware of how they felt in certain relationships*) but not the second (*they had not made a connection with their past*). When this was the case participants were uncertain how to score the item and suggested that this was amended in the new version of the questionnaire.

Another difficulty participants reported related to items that asked what their client was thinking, *for example "your client thinks you expect them to get more upset over things that have happened to them than they do".* Participants felt it was important to know what a client was thinking and wanted to avoid making unfounded assumptions. One participant had completed the measure for a client with severe ID and limited communication and reflected that the measure was extremely difficult to fill out for this client. Items that used the terminology "your client stated" were particularly difficult to complete as the

client's limited communication made it unlikely they would be able to 'state' something. Participants also thought that the *"neutral"* centre point of the Likert scale was unspecific and there was common uncertainty among the participants about how to use it appropriately.

As participants had not been taught how to score the TAM+, the ability of the measure to provide clinically useful information was difficult to determine. Participants who had good knowledge of the assimilation model found that even without scoring, completing the TAM+ influenced how they approached the next session with the client. Overall, participants felt that the TAM+ would be a useful measure and would inform their clinical practice if they could score the measure. One participant suggested a computerised scoring programme that would graphically represent clients' scores across sessions. As well as being seen as a useful process and outcome measure, participants thought that the TAM+ could be used to inform commissioning and service delivery. An awareness of a client's level of assimilation when entering the service could be used to inform and justify model and length of therapy provided.

Phase Three: Developing the TAM+ for use in clinical practice

Procedure

One of the central features that emerged from participant feedback was that the TAM+ was too long to be used in routine clinical practice. Research on measure completion by clinicians supports this view. For instance, Brown, Dries, and Nace (1999) found that the majority of clinicians consider measures that take more than five minutes to complete as impractical. The first stage of adapting the measure was therefore to reduce the number of items. All eight levels of assimilation needed to be represented in the measure. Each level had

to contain a minimum of three items to ensure all levels of the adapted measure still contained cognitive, behavioural, and affective aspects of client activity. Therefore, the minimum length the measure could be was 24-items. Therapists considered this to be acceptable for use in clinical practice however; stated they would not support anything longer. Johanson and Brooks (2010) suggest that during the initial stages of the development or adaptation of a measure issues such as item difficulty, item discrimination, internal consistency, and response rates need to be investigated. In order to reduce the measure to 24 items, proportions of participants responding to particular options, item analyses, and estimates of internal consistency were used to ensure the retention of the most discriminatory, representative, and user-friendly items.

Analysis

Frequency distributions, item-total correlation, and inter-item correlation were used to investigate proportions of participants responding to particular options, item discrimination, and internal consistency. Priest, McColl, Thomas, and Bond (1995) state that high endorsement of a single response is problematic and items endorsed by more than 80% or less than 20% of respondents should be considered for removal. As the TAM+ measures presence or absence of level of assimilation, it is expected that some items would be highly endorsed, whilst others will not be endorsed at all. For example, if a client were at the *warded off* level, high endorsement of the warded off items and no endorsement of the *mastery* level would be seen. Therefore in order to investigate the proportion of participants responding to particular options frequency distribution was calculated. It has been found that neutral options in Likert scales result in respondents avoiding the extreme ends of the category

(Wakita, Ueshima, & Noguchi, 2012). Items that generate responses on either extreme of the scale provide the most useful information. The three middle response options of the TAM+ 7-point Likert scale (slightly agree, neutral, and slightly disagree) were considered to be the least discriminatory of the response options. Items that had the *slightly agree*, *neutral*, and *slightly disagree* options endorsed by more than 50% of participants were removed. Four items were removed based on this criterion, items 29 and 40 from *vague awareness*, and items 24 and 36 from *insight/understanding*.

Low item-total correlations suggest that the identified item is inconsistent with the averaged behaviour of the other items, and thus should be discarded (Field, 2005). High inter-item correlation suggests the items are asking the same question. Kline (2000) recommends removal of items with a corrected item-total correlation of < 0.3 and an inter-item correlation > 0.8. Applying the low item-total correlation criterion to the *a priori* scales resulted in removal of four items from *unwanted thoughts* and one item from *vague awareness*. Applying the high inter-item correlation criterion resulted in removal of one item from *problem solution*, one item from *problem statement*, and four items from *application/working through*. The decision as to which of the highly correlated items were retained was based on the phrasing of the statements; the item with the simplest and most succinct phrasing was retained.

Quantitative item analysis only reduced the TAM+ by 15 items. To reduce it to the previously agreed 24 items therapists reassessed the remaining items. P*roblem statement, insight/understanding, problem solution, and mastery* still contained more than the pre-determined three items so the remaining items were grouped in terms of cognition, behaviour and affect to ensure one item from each category remained. Therapists then removed items based on

language, terminology, appropriateness to client group and similarity. The most lengthy, complex items that were considered difficult to score were removed to ease completion. Items considered inappropriate to the client group were removed, for example *"your client was able to see a connection between some of the ways they react in the sessions, and the difficulties that made them seek therapy"*. Items that used the terminology "*stated*" were removed due to the difficulty in answering these for clients with limited verbal communication. Items with the phrase *"your client thinks"* were removed because of the assumptive nature of the statement. The final 24 items (Therapist Assimilation Measure – Intellectual Disability; TAM-ID) are shown in Table 2 with their original item number. Removed items and the reason for their removal can be found in Appendix G.

Table 2.

Therapist Assimilation Measure – Intellectual Disability

Level of Assimilation	Item No.	Statement
Warded Off	7	*Your client is unaware that there is a problem or denies they have a problem*
	16	*Your client shows no emotion when you talk about their problem*
	33	*Your client talked about topics unrelated to their problem*
Unwanted Thoughts	19	*Your client avoided thinking about painful topics*
	25	*Your client changed the conversation when certain topics arose*
	35	*Your client found themselves thinking of other things, rather than getting involved in therapy*
Vague Awareness	8	*During the sessions, your client found themselves having feelings (e.g. affection, anger, hurt, embarrassment) towards you that they couldn't explain*
	14	*While talking about some of their experiences, your client became quite emotional, but they were not sure why*
	46	*Your client found it very painful talking about things from their past that they thought they had got over*
Problem Statement	4	*Your client became clearer about their goals in therapy*
	13	*Your client was able to describe their problems more clearly*
	27	*Your client is more certain about what they need to change*
Understanding	17	*Your client saw a clear connection between problems in past relationships, and their problems now*
	32	*Your client became more aware of how they really felt in certain relationships and was able to see how past experiences affect how they feel now*
	45	*Your client told you about a new understanding they have of their problem*
Application/Working Through	6	*Your client feels good knowing they are beginning to use the understanding they have gained since coming to therapy.*
	18	*Together with you, your client worked out a clear approach to dealing with a problem that has bothered them for a long time*
	38	*Your client was able to use an understanding they have gained since coming to therapy to work on a specific problem*

Table 2. continued
Therapist Assimilation Measure – Intellectual Disability

Level of Assimilation	Item No.	Statement
Problem Solution	3	*Your client described how they solved a problem in their life that had seemed very difficult or impossible before*
	23	*Your client felt good discussing a problem they had successfully tackled*
	43	*Your client described being able to cope with a situation that they would have avoided in the past*
Mastery	9	*Your client feels ready to tackle any problems that may come up in the future*
	37	*Your client feels that a lot of their problems really are behind them now*
	42	*Your client no longer feels upset when discussing their former difficulties because they have overcome them*

Phase Four: Reliability of Therapist Assimilation Measure- Intellectual Disability

This phase of the study sought to determine the reliability of the TAM-ID (Appendix H). Therapists' ratings of two transcripts of client therapy sessions were analysed to assess the measure's internal consistency and inter-rater reliability.

Procedure

Of the clients currently receiving psychotherapy from the services, five were considered to have capacity to consent to having their therapy session recorded (capacity was predetermined by the service and the client's therapist). Clients were approached by their therapist and provided with an information sheet (Appendix I). Two clients agreed to participate and gave informed consent (Appendix J). As a result of technical issues, only one client session

could be transcribed (Appendix K). The client was a 30-year-old male, referred to the service for anxiety and depression. The recording was encrypted and anonymised. In accordance with the procedure for thematic analysis described by Braun and Clarke (2006) the transcript was checked against the original audio-recordings for accuracy by the researcher. As only one client session was transcribed, a second session was taken from a previously published paper (Beail, 1989; Appendix L).

The TAM is designed to track one problematic experience however; the assimilation model predicts that clients are likely to be working on more than one problematic experience during therapy. To ensure all therapists were rating the same problematic experience, the main problematic experience was defined. The client's problematic experience was defined using the criteria set out by Newman & Beail (2005):

i) The most dominant theme bought by the client to therapy.

ii) The most dominant theme as formulated by the therapist.

iii) The most dominant theme as stated by the referrer/referral letter.

TAM-IDs were completed on both transcripts by eight of the original twelve therapists. Two therapists had left the services and two were unable to complete the ratings due to high workload.

Results

Inter-rater reliability. Inter-rater reliability is the degree of agreement between raters and gives an indication of the homogeneity of the ratings given by different raters. Inter-rater reliability for all items and subscale scores were assessed using intraclass correlation coefficients (ICC), based on a two-way

random effects model. This model was chosen because raters were consistent across transcripts. Absolute agreement, not correlation, between scores was taken into account by the ICC calculation. This corresponds to *ICC*(2, *k*), where *k* = number of raters, according to Shrout and Fleiss (1979).

Figure 5 shows the mean scores of each assimilation level given by therapists for transcript one. The graph appears to show good consensus that the client was working around the lower to middle assimilation levels. *Unwanted thoughts,* appears to be the most consistently detected level by all therapists. There appeared to be consensus that the client was not working at the higher levels however, there was a lack of consensus regarding *mastery*. Analysis of rating agreement for individual items showed near perfect agreement as defined by Portney and Watkins (2000), *ICC*(2, 8) = .87, (95% CI .78 - .94). Analysis of the mean rating scores for each assimilation level also showed near perfect agreement, *ICC*(2, 8) = .90, (95% CI .75 - .98).

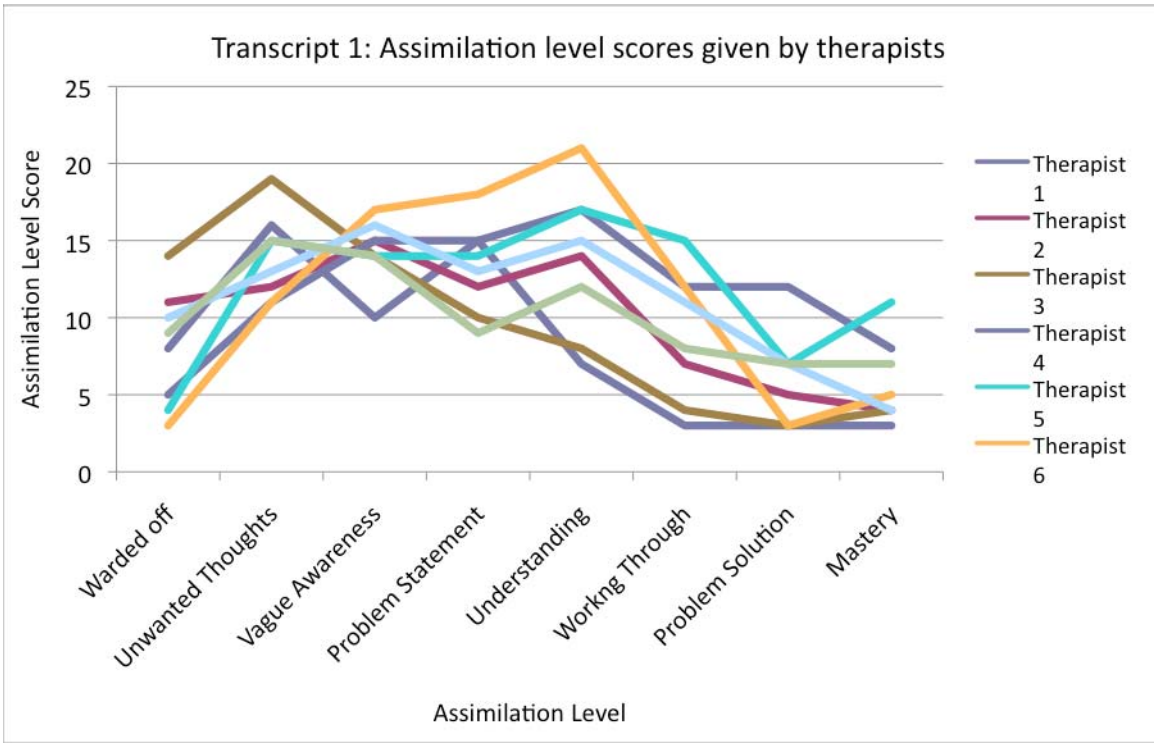

Figure 5. Assimilation level scores given to transcript 1 by therapists.

Figure 6 shows the mean scores for each assimilation level given by therapists for transcript two. There appears to be high consensus among participants that the client was not working at the higher assimilation levels. The medium assimilation levels appeared to be most frequently detected, suggesting the client was working around *problem statement* and the adjacent levels. There was less consensus regarding lower assimilation levels. Analysis of rating agreement for individual items showed near perfect agreement, *ICC*(2, 8) = .84, (95% CI .72 to 92). Analysis of the mean rating scores for each assimilation level also showed near perfect agreement, *ICC*(2, 8) = .88, (95% CI .70 - .97).

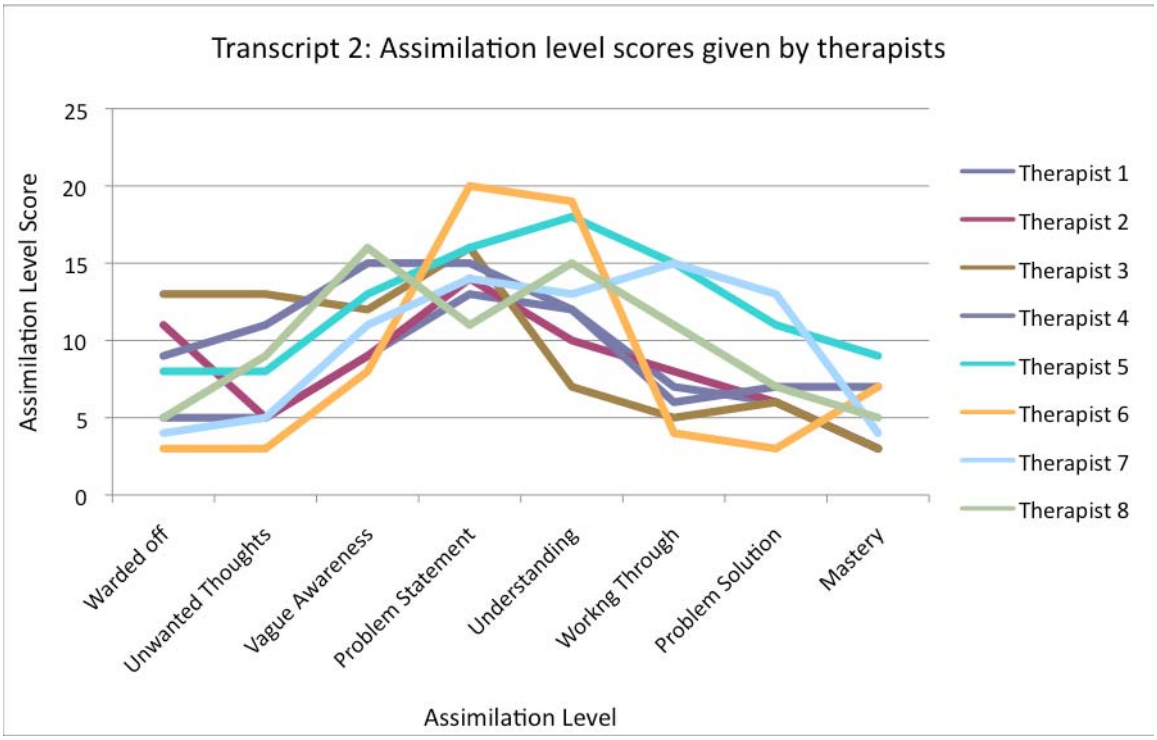

Figure 6. Mean assimilation level scores given to transcript 2 by therapists.

ICC for transcript one and two suggest that the TAM-ID has high inter-rater reliability. Confidence intervals show that 95% of all samples will have an ICC of between .70 and .98, suggesting good to high reliability (Fleiss, 1986).

Internal consistency. Internal consistency is the measure of the agreement between multiple items that are proposed to measure the same general construct. A correlation is generally used to measure the agreement and Cronbach's alpha coefficient is arguably the most commonly reported measure of internal consistency (Johanson & Brooks, 2010). Cronbach's alpha was therefore calculated for each level of assimilation (alpha values are shown in Table 3). The level of *application/working* through showed "*excellent"* internal reliability, *warded off* and *mastery* were found to have "*acceptable*" internal consistency, whilst the remaining levels had "*moderate*" internal reliability (distinctions based on definition by George & Mallery (2003): > 0.9 = excellent; > 0.8 = good; > 0.7 = moderate; > 0.5 = acceptable, < 0.5 = poor). Often a measure or subscale with an alpha of below 0.7, as was found for *warded off* and *mastery*, would be considered unreliable, however, Kline (2000) argues that alpha values below 0.7 can be expected when dealing with psychological constructs due to their diversity.

Table 3.

Cronbach's alpha coefficients for the assimilation levels in the TAM-ID

Scale	Items			Cronbach's alpha (α)	Level of internal consistency
Warded Off	7	16	33	.58	Acceptable
Unwanted Thoughts	19	25	47	.70	Moderate
Vague Awareness	8	14	46	.71	Moderate
Problem Statement	10	13	27	.87	Good
Insight/Understanding	17	32	45	.85	Good
Application/Working Through	5	18	38	.92	Excellent
Problem Solution	3	23	26	.81	Good
Mastery	9	37	42	.57	Acceptable

Discussion

The aim of this study was to evaluate the feasibility and acceptability of a general population measure of therapist assimilation (TAM) with people who have ID. This study consisted of four phases that assessed the feasibility and applicability of the measures use in routine clinical practice with clients with ID. The initial phase examined the appropriateness and applicability of the original measure to clients with ID. Therapists were recruited as expert participants to respond to the suitability of the TAM for patients with ID, suggest any necessary amendments to the TAM, and comment on the feasibility and applicability on an amended version of the TAM for use in clinical practice.

Therapists considered the measure applicable and suggested three new items to represent the lowest level of assimilation, which was not captured in the original TAM. In phase two therapists piloted the adapted measure (TAM+) and it was concluded that the TAM+ was applicable to their clients and would

be a useful measure that could inform clinical practice and service delivery. However, in order for the TAM+ to be feasible for use in routine clinical practice therapists requested it be shortened. Clients' TAM+ scores from phase two showed that all levels of assimilation were represented with clients of all levels of intellectual disability. There appeared to be a relationship between clients' scores and the therapeutic approach but the relationship between phase of therapy and assimilation level was unclear. Due to the unequal distribution and small size of the sample, statistical analysis could not be carried out to further investigate these relationships. In phase three the TAM+ was shortened to create a 24-item measure, the TAM-ID. The reliability of the TAM-ID was tested during phase four and the measure was found to have reasonable internal consistency and high inter-rater reliability.

Feasibility and Applicability

The TAM-ID was reported by therapists to be a useful measure, relevant to clients with ID, and feasible for use in routine clinical practice due to its brevity. It was found to be reliable across raters using ICC analysis, suggesting that the measure can be used consistently by different therapists without training. This differs from the Assimilation of Problematic Experiences Scales (APES), which requires tape recording, transcription and an understanding of context and clinical inference about the client (Stiles, 2005).

One aspect that affected participants' views of the amended questionnaires utility was their inability to score it. The measure did not produce an overall score but a profile of scores across the eight subscales. Graphical representation is the most useful and usable format for clients' profile of scores. To enable therapists to make use of TAM-ID scores and for them to inform their

clinical practice, a computerised scoring program that produces graphs, in order that a client's progress could be mapped, would need to be developed and made available to clinicians.

The TAM-ID provides a potential quantitative clinical and research tool that could be a suitable measure of progress through therapy for clients with ID. It could also be considered for use when individuals with ID enter a service to inform decisions on therapy type. Theoretically, clients entering the service at the lower levels of assimilation would have less well formulated problems, which would suggest the need for a more explorative therapy such as psychodynamic. For clients who are entering the service at the middle levels of assimilation, a more prescriptive approach such as CBT would be recommended (Stiles, 2002).

Application of the assimilation model

The data on assimilation levels within the client group is worth comment as this is only the second study to apply the assimilation model to clients with ID. When rating clients with ID the therapists in the present study used all levels of assimilation. The majority of results support Newman and Beail's (2005) findings that the assimilation structure proposed by Stiles et al. (1990) is the same for people who have ID. The model was found to be useable by all therapy modes, supporting the trans-theoretical nature of the model. However, differentiation could also be seen between scores within different therapy modes, suggesting the models acknowledgement that psychodynamic approaches emphasise the lower levels of assimilation, whilst cognitive approaches emphasise the higher levels of assimilation (Stiles et al., 1990).

The assimilation model's prediction, that client's progress up the levels during therapy, was partially supported in this study. Lower scores in the higher levels during the first phase of therapy were found however, higher scores in the *warded off* and *unwanted thoughts* would have been expected. The pattern of scores during the middle phase of therapy supports the model but the end phase of therapy did not show increasing scores in the higher levels. This is contradictory to the model, which would lead to the prediction of higher scores in the higher levels as clients have successfully assimilated their problematic experience (Stiles et al., 1990). However, this might be a result of the crude categorisation of phase of therapy. One limitation of this study is that there was no measure of the expected length of therapy, therefore clients categorised as 'end' might have had a significant amount of therapy remaining. Progression along the continuum of levels is considered to represent therapeutic progress (Honos-Webb et al., 1999). The scores evident in this study could therefore indicate a lack of therapeutic progression, or suggest an alternative progression for clients with ID.

Graphical data suggested that clients were most commonly working at the level of *vague awareness*. At this level the client is aware of their problematic experience but it is not clearly distinguished. It is associated with higher levels of acute negative affect that is not fully understood by the client. In other research the *vague awareness* subscale on the APES has been expanded and divided into three subscales (Teusch, Bohme, Finke, Gastpur, & Skerra, 2003). This extended version could be used to explore the clustering of clients around this level. The original TAM only measured seven of the eight levels of assimilation. However, the present study found that *warded off* was represented in the clients' scores, which appears to support Newman and

Beail's (2005) finding that therapists are able to recognise and rate *warded off*. However, following Newman & Beail's (2005) finding that the majority of clients with ID entered therapy at the *warded off* level, higher scores would have been expected for this level. Newman & Beail (2005) assessed level of assimilation between sessions one and eight. A number of clients in the present study had been attending therapy for more than eight sessions, so could not be considered to be entering therapy. This may account for the lower scores at *warded off*. The lower scores could also be related to the construction of the *warded off* scale as it showed questionable inter-item correlation and only acceptable internal consistency. As only three new items were generated for this subscale during the first phase of the study, little could be done to improve its internal consistency. The decision to create only three new items was based on therapists' views that the measure was already too long however, including more items for the pilot phase could have allowed for a more reliable scale to be produced. Further development of robust, reliable items to include in this subscale is recommended.

This is the first study to raise the concept of level of ID impacting upon the ability to assimilate problematic experiences. There were indications that clients of differing levels of ability were working across different levels. Due to higher assimilation requiring increasing metacognitive functioning, a negative relationship between level of assimilation and level of intellectual disability would be predicted. It was not within the scope of this study to investigate this hypothesis; however, it will be an important element to consider if the TAM-ID is to be routinely used with this client group.

Methodological considerations

The sample size in this study was small, which did not allow for statistical analysis to be carried out that would have established differences between groups of clients. The size of the sample may also have affected the calculation of Cronbach's alpha, leading to the removal of suitable items or the retention of inappropriate items. This was however, the earliest stage of development of a measure and small samples are common during this phase. Rattray and Jones (2005) state that measures should be piloted on small samples to help identify items that lack clarity or may not be appropriate for respondents. The sample size is also a function of the population being studied. This study took place in two services, which cover a large geographical area. It utilised all available therapists working psychotherapeutically with clients with ID. In order to increase the number of therapists and collect data on a larger number of clients, a national, multi-centre, longitudinal study would need to be undertaken.

Inter-rater reliability was shown to be high however the graphical data shows some area of inconsistency between raters. This discrepancy could be related to the fact that therapists had varying lengths of experience and familiarity with the assimilation model. The small sample could have masked these differences. Therapists who are familiar with the assimilation model may rate the measure differently to those who have limited knowledge of the model. Having a sample large enough to compare experienced and non-experienced raters could help to overcome this limitation. However, as this study sought to explore the feasibility of using the measure in routine clinical practice, receiving ratings from therapists with varied knowledge is more representative. If the measure was to be used across services its reliability and validity would need to be independent of knowledge of the assimilation model.

The retention and deletion of items to create the TAM-ID was largely based on the assessment of item correlation and internal consistency using Cronbach's α. Whilst Cronbach's α is the most commonly used method for evaluating reliability; there are many conditions under which it is not a valid estimator (Polit & Beck, 2008). Kopalle and Lehmann (1997) argue that deletion of items based on inter-item correlations can lead to an over-estimation of α and does not address the issue of items correlating highly with other scales. It is also the case that Cronbach's α is a function of test length (Kottner & Streiner, 2010). As number of items increases, α value increases. This could result in the low alphas of some of the subscales in the TAM-ID being attributed to the small number of items in the scale. Whilst this might be the case, this argument could mask the truly poor internal consistency. Cronbach's α is also based on the concept of unidimensionality. It assumes that items measure one underlying dimension, however many empirical problems are multidimensional (Vehkalahti, Putanen, & Tarkkonen, 2006). Assessing the TAM as subscales, rather than as a whole, may have protected against violating this assumption. However, the levels of assimilation may not be unidimensional in themselves. The structure of the assimilation model is that of stages which are sequentially related, therefore can be considered a one-dimensional structure. It has also been argued that each level of assimilation has within it levels of attention and affect, which would be viewed as a two-dimensional structure (Detert et al., 2006). The measure may therefore violate the assumption of unidimensionality resulting in the overestimation of the reliability. Factor analysis and cross validation in a separate sample is proposed to confirm the measures reliability (Kopalle & Lehmann, 1997).

Clinical Implications

This study aimed to help develop and provide support for the use of psychotherapy with clients with ID in order to improve patient outcomes. There has been much distain over the years about the practice of psychotherapy with this population. Recent reviews of the literature have shown that a variety of psychotherapies can be effective for individuals with ID (Nichol et al., 2009; Prout & Browning, 2001; Shepherd, 2015). However, Shepherd (2015) comment on the poor quality, lack of methodological rigour of the research and the need for reliable and valid outcome measures to enable the further development of the research base. Without this development, the evidence base for psychotherapy with clients with ID will be unable to grow, leading to restriction in funding and service development.

The TAM-ID is a promising measure for research purposes and a tool to support clinicians in their practice. It has the potential to be used as a sessional measure to support assessment and formulation and inform clinician's decisions around intervention. It could also be used as a time-point measure to track a client's progress through therapy. Krause and Lutz (2009) explain that therapists can use information about clients' progress through therapy to modify their approach in order to maximise outcome. Such use would provide a more in-depth understanding of the process of change in psychotherapy for clients with ID, as well as the possible impact of ID on the process of assimilation of problematic experiences. Stiles, Shapiro, and Harper (1994) argued that in order to better understand long-term outcome, a deeper understanding of the incremental changes that occur for clients in the process of therapy is needed. A measure, such as the TAM-ID, offers this versatility within the field of ID and

could be potentially useful to develop understanding of psychotherapy for clients with ID.

Recommendations for future research

Within the small sample of this study, the TAM-ID has been shown to have high inter-rater reliability and reasonable internal consistency. As it measures a transient concept that is expected to fluctuate over time, it would not be appropriate to assess its test-retest reliability. Future research should aim to improve the internal consistency *of warded off, unwanted thoughts* and *mastery* subscales.

Validity requires a measure to be reliable, but a measure can be reliable without being valid (Kimberlin & Winterstien, 2008). Whilst the acceptability approach of the present study assessed face validity and some aspects of content validity, further investigation is required to determine the validity of the TAM-ID. A factor analysis could be conducted to establish if the factor structure of the 24-items is consistent with the eight levels of assimilation. Halstead (1998) did not conduct an exploratory factor analysis on the basis that it assumes the scales are independent. The assimilation model predicts that the levels are related to each other in a systematic way. However, as the assimilation model predetermines a structure, confirmatory factor analysis could be more appropriate to test the hypothesised relationship between the levels.

Another approach to test validity would be to compare the concurrent validity between the original APES and the TAM-ID. This however could be problematic as the TAM was developed to overcome some of the limitations of the APES as a measure. An alternative would be to compare client levels of assimilation with scores on other outcome measures, such as the Brief

Symptom Inventory (BSI; Derogatis & Spencer, 1993) and the Clinical Outcomes in Routine Evaluation (CORE-OM; Evans et al., 2000). The model considers progression through the levels of assimilation a sign of improvement; therefore as a client's symptom score decreases, TAM-ID scores on the lower levels of assimilation would be expect to decrease whilst TAM-ID scores on the higher levels of assimilation would be expected to increase. However, this may only be the case if clients with ID follow the linear sequence proposed by the assimilation model. More recent research has shown that within the general population, clients show an irregular pattern of progression through the levels, advancing then falling back, which Stiles (2001) refers to as "*saw-tooth*" (Osatuke et al., 2005; Gabalda, 2005). Newman and Beail (2005) also found this pattern for clients with ID. The cross-sectional nature of the present study did not allow for the investigation of this pattern with clients with ID; however the TAM-ID could explore this in the future. Looking to the future, for the TAM-ID to be used in clinical practice it would be necessary for a manual and computerised scoring system to be developed so scores could be used in routine monitoring databases.

Conclusions

This study explored the feasibility and acceptability of a measure of assimilation in psychotherapy for clients with ID. An existing measure of assimilation developed for the general clinical population was piloted and adapted to create a therapist measure that can track progress through therapy for clients with ID (Therapist Assimilation Measure; TAM-ID). The findings suggest that the measure has high inter-rater reliability and reasonable internal consistency. The final 24-item TAM-ID was considered by therapists to be

applicable to clients with ID and feasible to use in routine clinical practice. This is the second study to apply the assimilation of problematic experiences model to clients with ID and has provided some evidence to suggest that the assimilation model is a useful framework for understanding the process of change in psychotherapy for clients with ID. Further development of the TAM-ID will be required to demonstrate its reliability and validity. If this can be achieved, it is recommended that multi-centre, longitudinal studies be conducted to further develop the TAM-ID and deepen our understanding of change during psychotherapy with clients with ID.

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Appendix A: Ethical Approval Letter

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

06/10/2013

Miss Caroline Shepherd
Trainee Clinical Psychologist
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Email address: helen.carter@swyt.nhs.uk
research@swyt.nhs.uk

Dear Miss Shepherd

Re: Process of assimilation in clients with an intellectual disability

REC ref: 13/YH/0272

Reda ID: 159

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Therapist Informed Consent Form	4	09 July 2013
Therapist Information Sheet	4	09 July 2013
Therapist Demographic Data	4	09 July 2013
Recording Confidentiality Statement	4	09 July 2013
Therapist Assimilation Measure		
Evidence of Insurance or indemnity		01 September 2013
Investigator CV		
Participant Information Sheet: Client	4	09 July 2013
Participant Consent Form: Client	4	09 July 2013
Protocol	4	09 July 2013

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive
- changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit[1].
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care[2](RGF). Failure to do this could lead to permission to carry out this research being withdrawn.

- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines

- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator**[3].
They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

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[2] Details from:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

[3] SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

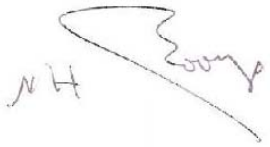
Appendix A *(continued)*

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely



Dr Nisreen Booya
Medical Director

cc: Professor Nigel Beail
Local Collaborator and University Supervisor

Appendix B: Therapist Information Sheet

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The University Of Sheffield.	**Department Of Psychology.** **Clinical Psychology Unit.** Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.
Clinical Psychology Unit **Department of Psychology** **University of Sheffield** **Western Bank** **Sheffield S10 2TN UK**	Telephone: 0114 2226650 Fax: 0114 2226610 Email: c.harrison@sheffield.ac.uk

Adaptation of a therapist measure of assimilation to be used with a learning disability population

Who is conducting the study?

Caroline Shepherd (Trainee Clinical Psychologist) and Professor Nigel Beail (Registered Clinical Psychologist) at Barnsley Learning Disability service.

What is the study about?

This study aims to adapt a measure of assimilation of problematic experience. It is hoped that this measure will enable therapists to track the process of change during psychotherapy for clients with a learning disability.

What will be involved if I take part?

If you choose to take part you will be involved in a focus group with other professionals from your service to adapt an existing measure to an intellectually disabled population. You will then be asked to use the measure to rate tape recordings of client sessions.

You will also be asked to provide details of your profession, number of years' experience as a psychotherapist, and the psychological model in which you work. This information will remain anonymous.

Do I need to have knowledge of the assimilation model?
No, you do not need any prior knowledge of the assimilation model. Training on the model and rating will be provided by the researcher.

Do I have to take part?
No, involvement with this research is voluntary. If you are a psychotherapist working individually with clients with an intellectual disability you will be asked to give your consent by signing the form below. You are free to withdraw at any time, without the need to give a reason. However, as your contributions to the focus groups and ratings will remain anonymous it will not be possible to withdraw input you have already given to the research.

What will happen to the results of the study?
The results of the study will be written up as part of the qualification in a Doctorate in Clinical Psychology. Participants will not be identified in any report or publication. A copy of the results will be made available to the participants on request.

Who has reviewed this study?
This study has been reviewed and ethically approved by Leeds and Bradford National Research Ethics Service

What if something goes wrong?
If you have any questions, concerns or wish to complain, please contact the principle researcher or Supervisor on the details below.

Researcher contact details:
Caroline Shepherd,
Trainee Clinical Psychologist

Clinical Psychology Unit
Department of Psychology
The University of Sheffield
Western Bank
Sheffield
S10 2TN

Email: pcp11cs@sheffield.ac.uk
Telephone: 0114 222 6650

Professor Nigel Beail
Clinical Psychology Unit

Department of Psychology
The University of Sheffield
Western Bank
Sheffield
S10 2TN

If you feel your complaint has not been handled to your satisfaction please contact the University Secretary on:

Clinical Psychology Unit
Department of Psychology
The University of Sheffield
Western Bank
Sheffield
S10 2TN

Appendix C: Therapist Informed Consent Form

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The University Of Sheffield.	Department Of Psychology. Clinical Psychology Unit. Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.
Clinical Psychology Unit **Department of Psychology** **University of Sheffield** **Western Bank** **Sheffield S10 2TN UK**	Telephone: 0114 2226650 Fax: 0114 2226610 Email: c.harrison@sheffield.ac.uk

Please read the following questions and circle your response as necessary.

1. I have read the research Information Sheet provided by the researcher

Yes No

2. I understand that I am free to withdraw from this study at any time and without any negative consequences

Yes No

3. I understand that the information I provide will be treated in strict confidence and be used for research purposes only.

Yes No

4. I agree to take part in this study

Yes No

Note that this sheet will be kept separate from any other identifiable data to ensure anonymity.

Signed …… Date ……

Appendix D: Demographic Data Sheet

South West Yorkshire Partnership NHS Foundation Trust

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

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

Telephone: 0114 2226650
Fax: 0114 2226610
Email: c.harrison@sheffield.ac.uk

Please state your professional role and main therapy you provide (e.g. clinical psychologist, psychodynamic).

Please state the length of experience you have working psychotherapeutically.

Please state the number of years experience you have working psychotherapeutically with clients with an intellectual disability.

Please indicate, by circling the most appropriate response, how well you understand the assimilation model.

Not at all A little Quite well Extremely well

Appendix E: Therapist Assimilation Measure

TAM-44

THERAPIST'S ASSIMILATION MEASURE

r initials _____ Your Client's ID _____ Date _____

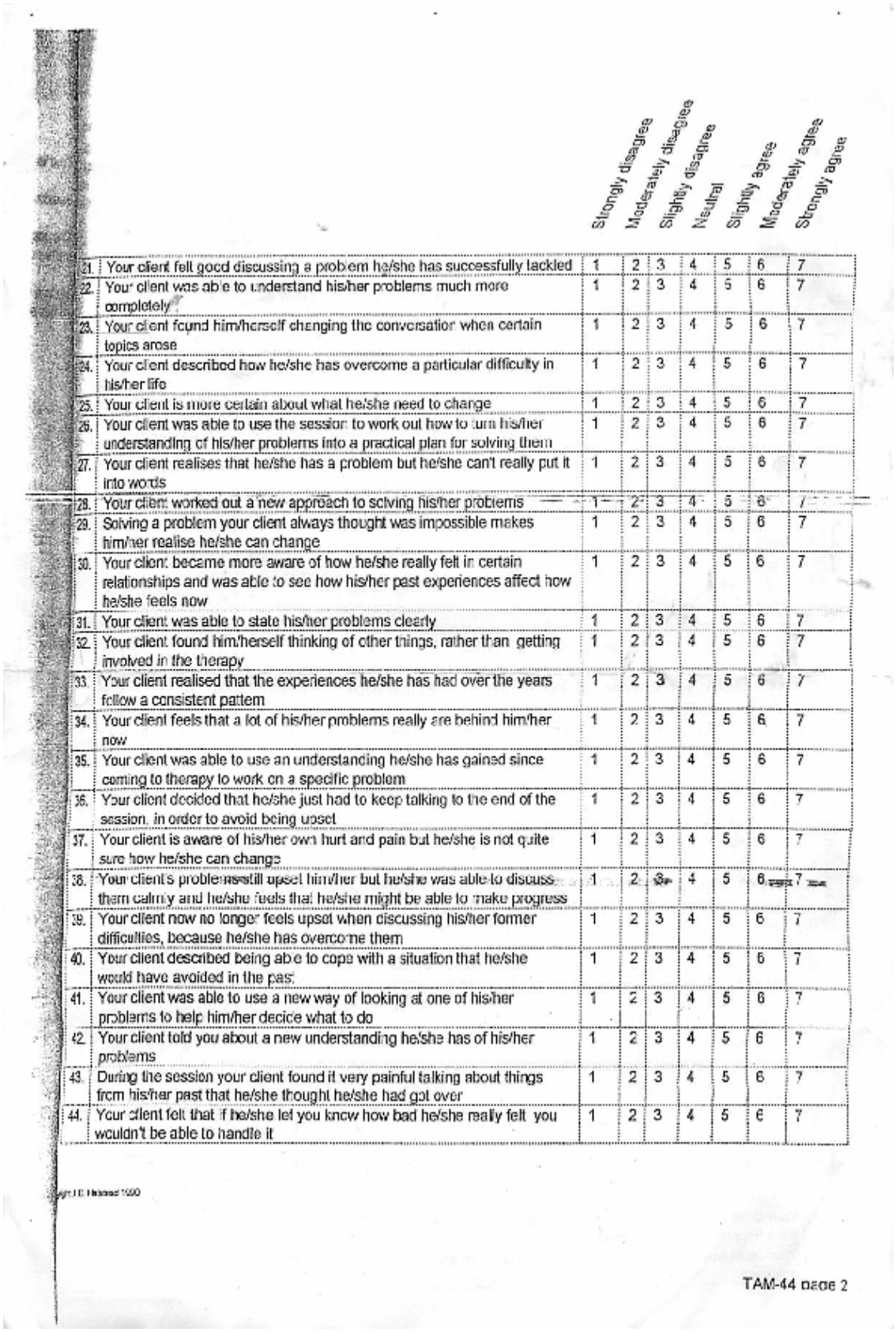
sion Number _____

statements below are about the things that may have happened, including things your client did, his/her thoughts and r feelings, in the therapy session you have just had.

se circle the number to the right of each statement, that indicates how much or how little you agree with it as a description s session. For example, if you agree strongly with a statement put a circle round 7.

		Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1	New thoughts and feelings are emerging about his/her difficulties but they are still unclear	1	2	3	4	5	6	7
2	Your client found it annoying to have to talk about things in his/her past, that he/she feels he/she has got over	1	2	3	4	5	6	7
3	Your client described how he/she has solved a problem in his/her life, that had seemed very difficult or impossible before	1	2	3	4	5	6	7
4	Your client became clearer about his/her goals in therapy	1	2	3	4	5	6	7
5	Your client looked at alternative ways of dealing with a particular problem	1	2	3	4	5	6	7
6	Your client feels good knowing that he/she is beginning to use the understanding he/she has gained since coming to therapy to work on his/her problems	1	2	3	4	5	6	7
7	During the session, your client found him/herself having feelings (e.g. affection, anger, hurt, embarrassment) towards you that he/she can't really explain	1	2	3	4	5	6	7
8	Your client feels ready to tackle any problems that may come up in the future	1	2	3	4	5	6	7
9	Your client discussed his/her problems with you and became more clear about what they are	1	2	3	4	5	6	7
10	Your client was able to see a connection between some of the ways he/she reacts in the sessions and the difficulties that made him/her seek therapy	1	2	3	4	5	6	7
11	Your client felt a sense of achievement describing how he/she has overcome a particular difficulty	1	2	3	4	5	6	7
12	Together with you your client was able to describe his/her problems more clearly	1	2	3	4	5	6	7
13	While talking about some of his/her experiences, your client became quite emotional, but he/she was not quite sure why	1	2	3	4	5	6	7
14	Your client thinks he/she is ready to cope with whatever difficulties may arise without the need to come for therapy	1	2	3	4	5	6	7
15	Your client saw a clear connection between problems in past relationships, and his/her problems now	1	2	3	4	5	6	7
16	Together with you your client worked out a clear approach to dealing with a problem that has bothered him/her for a long time	1	2	3	4	5	6	7
17	Your client avoided thinking about painful topics	1	2	3	4	5	6	7
18	Your client feels really confident that he/she can deal with problems as they arise	1	2	3	4	5	6	7
19	Your client thinks you expect him/her to get more upset over things that have happened to him/her than he/she does	1	2	3	4	5	6	7
20	Your client was able to focus on a particular problem and felt less confused	1	2	3	4	5	6	7

Appendix E: Therapist Assimilation Measure *(continued)*



		Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
21.	Your client felt good discussing a problem he/she has successfully tackled	1	2	3	4	5	6	7
22.	Your client was able to understand his/her problems much more completely	1	2	3	4	5	6	7
23.	Your client found him/herself changing the conversation when certain topics arose	1	2	3	4	5	6	7
24.	Your client described how he/she has overcome a particular difficulty in his/her life	1	2	3	4	5	6	7
25.	Your client is more certain about what he/she need to change	1	2	3	4	5	6	7
26.	Your client was able to use the session to work out how to turn his/her understanding of his/her problems into a practical plan for solving them	1	2	3	4	5	6	7
27.	Your client realises that he/she has a problem but he/she can't really put it into words	1	2	3	4	5	6	7
28.	Your client worked out a new approach to solving his/her problems	1	2	3	4	5	6	7
29.	Solving a problem your client always thought was impossible makes him/her realise he/she can change	1	2	3	4	5	6	7
30.	Your client became more aware of how he/she really felt in certain relationships and was able to see how his/her past experiences affect how he/she feels now	1	2	3	4	5	6	7
31.	Your client was able to state his/her problems clearly	1	2	3	4	5	6	7
32.	Your client found him/herself thinking of other things, rather than getting involved in the therapy	1	2	3	4	5	6	7
33.	Your client realised that the experiences he/she has had over the years follow a consistent pattern	1	2	3	4	5	6	7
34.	Your client feels that a lot of his/her problems really are behind him/her now	1	2	3	4	5	6	7
35.	Your client was able to use an understanding he/she has gained since coming to therapy to work on a specific problem	1	2	3	4	5	6	7
36.	Your client decided that he/she just had to keep talking to the end of the session, in order to avoid being upset	1	2	3	4	5	6	7
37.	Your client is aware of his/her own hurt and pain but he/she is not quite sure how he/she can change	1	2	3	4	5	6	7
38.	Your client's problems still upset him/her but he/she was able to discuss them calmly and he/she feels that he/she might be able to make progress	1	2	3	4	5	6	7
39.	Your client now no longer feels upset when discussing his/her former difficulties, because he/she has overcome them	1	2	3	4	5	6	7
40.	Your client described being able to cope with a situation that he/she would have avoided in the past	1	2	3	4	5	6	7
41.	Your client was able to use a new way of looking at one of his/her problems to help him/her decide what to do	1	2	3	4	5	6	7
42.	Your client told you about a new understanding he/she has of his/her problems	1	2	3	4	5	6	7
43.	During the session your client found it very painful talking about things from his/her past that he/she thought he/she had got over	1	2	3	4	5	6	7
44.	Your client felt that if he/she let you know how bad he/she really felt you wouldn't be able to handle it	1	2	3	4	5	6	7

TAM-44 page 2

Appendix F: Therapist Assimilation Measure – Plus (TAM+)

Therapist Assimilation Measure – Plus (TAM+)

Your Initials _____ Client's Initials _____ Date_____

The statements below are about the things that may have happened, what your client did, their thoughts and feelings, in the therapy sessions you have just had.

Please circle the number to the right of each statement that indicates how much or how little you agree with it as a description of the session you just had. For example, if you strongly agree with a statement put a circle round 7.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	New thoughts and feelings are emerging about their difficulties but they are still unclear	1	2	3	4	5	6	7
2	Your client found it annoying to have to talk about things in their past, that they feel they have got over	1	2	3	4	5	6	7
3	Your client described how they have solved a problem in their life, that had seemed very difficult or impossible before	1	2	3	4	5	6	7
4	Your client became clearer about their goals in therapy	1	2	3	4	5	6	7
5	Your client looked at alternative ways of dealing with a particular problem	1	2	3	4	5	6	7
6	Your client feels good knowing that they are beginning to use the understanding they have gained since coming to therapy to work on their problems	1	2	3	4	5	6	7
7	Your client is unaware that there is a problem, or denies they have a problem	1	2	3	4	5	6	7
8	During the session your client found themselves having feelings (e.g. affection. anger, hurt, embarrassment) towards you that they can't explain	1	2	3	4	5	6	7
9	Your client feels ready to tackle any problems that may come up in the future	1	2	3	4	5	6	7
10	Your client discussed their problems with you and became more clear about what they are	1	2	3	4	5	6	7
11	Your client was able to see a connection between some of the ways they react in the sessions and the difficulties that made them seek therapy	1	2	3	4	5	6	7
12	Your client felt a sense of achievement describing how they have overcame a particular difficulty	1	2	3	4	5	6	7
13	Together with you your client was able to describe their problems more clearly	1	2	3	4	5	6	7
14	While talking about some of their experiences, your client became quite emotional but they were not sure why	1	2	3	4	5	6	7
15	Your client thinks they are ready to cope with whatever difficulties may arise without the need to come to therapy	1	2	3	4	5	6	7
16	Your client shows no emotion when you talk about their problem	1	2	3	4	5	6	7
17	Your client saw a clear connection between problems in past relationships, and their problems now	1	2	3	4	5	6	7

1

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
18	Together with you, your client worked out a clear approach to dealing with a problem that has bothered them for too long	1	2	3	4	5	6	7
19	Your client avoided thinking about painful topics	1	2	3	4	5	6	7
20	Your client feels really confident that they can deal with problems as they arise	1	2	3	4	5	6	7
21	Your client thinks you expect them to get more upset over things that have happened to them than they do	1	2	3	4	5	6	7
22	Your client was able to focus on a particular problem and felt less confused	1	2	3	4	5	6	7
23	Your client felt good discussing a problem they have successfully tackled	1	2	3	4	5	6	7
24	Your client was able to understand their problems much more completely	1	2	3	4	5	6	7
25	Your client found themselves changing the conversation when certain topics arose	1	2	3	4	5	6	7
26	Your client described how they have overcome a particular difficulty in their life	1	2	3	4	5	6	7
27	Your client is more certain about what they need to change	1	2	3	4	5	6	7
28	Your client was able to use the session to work out how to turn their understanding of their problems into a practical plan for solving them	1	2	3	4	5	6	7
29	Your client realises that they have a problem but they cant really put it into words	1	2	3	4	5	6	7
30	Your client worked out a new approach to solving their problems	1	2	3	4	5	6	7
31	Solving a problem your client always thought was impossible makes them realise they can change	1	2	3	4	5	6	7
32	Your client became more aware of how they really felt in certain relationships and was able to see how their past experiences affect how they feel now	1	2	3	4	5	6	7
33	Your client talked about topics unrelated to their problem	1	2	3	4	5	6	7
34	Your client was able to state their problem clearly	1	2	3	4	5	6	7
35	Your client found themselves thinking of other things, rather than getting involved in the therapy	1	2	3	4	5	6	7
36	Your client realised that the experiences they have had over the years follow a consistent pattern	1	2	3	4	5	6	7
37	Your client feels that a lot of their problems really are behind them now	1	2	3	4	5	6	7
38	Your client was able to use an understanding they gained since coming to therapy to work on a specific problem	1	2	3	4	5	6	7
39	Your client decided that they just had to keep talking to the end of the session, in order to avoid being upset	1	2	3	4	5	6	7
40	Your client is aware of their own hurt and pain but they are not quite sure how they can change	1	2	3	4	5	6	7

Appendix G: Items removed from TAM+ and reason for removal

Item Number	Assimilation Level	Reason for removal
29	Vague Awareness	Over endorsement of neutral option
40	Vague Awareness	Over endorsement of neutral option
24	Insight/Understanding	Over endorsement of neutral option
36	Insight/Understanding	Over endorsement of neutral option
2	Unwanted Thoughts	Low item-total correlation
21	Unwanted Thoughts	Low item-total correlation
39	Unwanted Thoughts	Low item-total correlation
47	Unwanted Thoughts	Low item-total correlation
1	Vague awareness	Low item-total correlation
22	Problem Statement	High inter-item correlation
5	Application/Working Through	High inter-item correlation
28	Application/Working Through	High inter-item correlation
30	Application/Working Through	High inter-item correlation
18	Application/Working Through	High inter-item correlation
31	Problem Solution	High inter-item correlation
10	Problem statement	Terminology
34	Problem statement	Terminology
41	Problem statement	Phrasing
11	Insight/Understanding	Application to clients with ID
23	Problem Solution	High inter-item correlation
26	Problem Solution	High inter-item correlation
15	Mastery	Terminology
9	Mastery	High inter-item correlation

Appendix H: Therapist Assimilation Measure – Intellectual Disability (TAM-ID)

Therapist Assimilation Measure – Intellectual Disability

Your Initials _____ Client's Initials _____ Session no. _____ Date_____

The statements below are about things that may have happened (what your client did, their thoughts and feelings) in the therapy sessions **you have just had**.

Please circle the number to the right of each statement that indicates how much or how little you agree with it as a description of the session **you just had**. For example, if you strongly agree with a statement put a circle round 4.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	Your client described how they have solved a problem in their life, that had seemed very difficult or impossible before	1	2	3	4	5	6	7
2	Your client became clearer about their goals in therapy	1	2	3	4	5	6	7
3	Your client feels good knowing they are beginning to use the understanding they have gained since coming to therapy.	1	2	3	4	5	6	7
4	Your client is unaware that there is a problem or denies they have a problem	1	2	3	4	5	6	7
5	During the sessions, your client found themselves having feelings (e.g. affection, anger, hurt, embarrassment) towards you that they couldn't explain	1	2	3	4	5	6	7
6	Your client feels ready to tackle any problems that may come up in the future	1	2	3	4	5	6	7
7	Your client was able to describe their problems more clearly	1	2	3	4	5	6	7
8	While talking about some of their experiences, your client became quite emotional, but they were not sure why	1	2	3	4	5	6	7
9	Your client shows no emotion when you talk about their problem	1	2	3	4	5	6	7
10	Your client saw a clear connection between problems in past relationships, and their problems now	1	2	3	4	5	6	7
11	Together with you your client worked out a clear approach to dealing with a problem that has bothered them for a long time	1	2	3	4	5	6	7
12	Your client avoided thinking about painful topics	1	2	3	4	5	6	7
13	Your client felt good discussing a problem they had successfully tackled	1	2	3	4	5	6	7
14	Your client changed the conversation when certain topics arose	1	2	3	4	5	6	7
15	Your client is more certain about what they need to change	1	2	3	4	5	6	7
16	Your client became more aware of how they really felt in certain relationships and was able to see how past experiences affect how they feel now	1	2	3	4	5	6	7
17	Your client talked about topics unrelated to their problem	1	2	3	4	5	6	7
18	Your client found themselves thinking of other things, rather than getting involved in therapy	1	2	3	4	5	6	7
19	Your client feels that a lot of their problems really are behind them now	1	2	3	4	5	6	7
20	Your client was able to use an understanding they have gained since coming to therapy to work on a specific problem	1	2	3	4	5	6	7
21	Your client no longer feels upset when discussing their former difficulties because they has overcome them	1	2	3	4	5	6	7
22	Your client described being able to cope with a situation that they would have avoided in the past	1	2	3	4	5	6	7
23	Your client told you about a new understanding they have of their problem	1	2	3	4	5	6	7
24	Your client found it very painful talking about things from their past that they thought they had got over	1	2	3	4	5	6	7

Appendix I: Client Information Sheet

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The University Of Sheffield.	Department Of Psychology. Clinical Psychology Unit. Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.
Clinical Psychology Unit **Department of Psychology** **University of Sheffield** **Western Bank** **Sheffield S10 2TN UK**	Telephone: 0114 2226650 Fax: 0114 2226610 Email: c.harrison@sheffield.ac.uk

Looking at change in therapy

If you would like help reading this please ask your therapist.

Who is doing the study?

Caroline Shepherd a trainee clinical psychologist.

Professor Nigel Beail a clinical psychologist who works at Barnsley Learning Disability service.

What is the study about?

It is about how people with a learning disability change in therapy.

What will I have to do?

Nothing BUT we would like to tape record some of your therapy sessions.

Who will listen to the tapes?

Other therapists will listen to the tapes.

Do I have to take part?

No.

It is ok to say no.

Will people know who I am?

No. No one will know who you are.

What will happen to the tapes?

They will be kept in a locked cupboard at Barnsley Disability Service.

If I say yes now can I change my mind?

Yes.

You can say no any time. We will stop tape recording and no one will listen to them.

What will be good about taking part?

You will help us understand therapy for people with a learning disability.

This study has been checked to make sure you are kept safe.

What might be bad about taking part?

It might be scary being tape recorded.
Staff I don't know will listen to the tapes.

I want more information or I wish to complain...

Talk to:

Caroline Shepherd, Professor
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield
S10 2TN
Telephone: 0114 222 6650

Nigel Beail
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield
S10 2TN
Telephone: 0114 222 6650

Thank you for reading this.

Appendix J: Client Informed Consent Form

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The University Of Sheffield.	**Department Of Psychology.** **Clinical Psychology Unit.** Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.
Clinical Psychology Unit **Department of Psychology** **University of Sheffield** **Western Bank** **Sheffield S10 2TN UK**	Telephone: 0114 2226650 Fax: 0114 2226610 Email: c.harrison@sheffield.ac.uk

If you would like to take part please fill this in.

1. I have read the information sheet

✓ Yes ✗ No

2. I understand I don't have to take part if I don't want to

✓ Yes ✗ No

3. I understand my tapes will be kept safe

✓ Yes ✗ No

4. I am happy for staff to listen to my tapes

✓ Yes ✗ No

5. I want to take part in this study

✓ Yes ✗ No

Appendix K: Transcript 1

This is a transcript of a therapy session. The problematic experience being worked on in therapy is: disruptive behaviour at home – hitting his mother, staying up all night, talking all the time/repetitive questioning. He was admitted to hospital to give his parents a break.

Please read the transcript and complete a Therapist Assimilation Measure – ID for this session. Thank you.

John: I had a nightmare. I dreamt about going back into hospital. Started with an ambulance arriving at my house. They wanted Murdoch but they took me instead. They put me in there. There is a nurse there, and two nude men were getting ready to go to bed – unattractive men – like other patients at the hospital who are a bit mad. Nurse said: "What are you two ding with no clothes on? Get to bed". Then it was the next day and they took me by ambulance to our old house and they let me out because they hadn't got Murdoch. Then a car came. It was like true to life. They came in the house and went off again.

T: How were you feeling when they brought you into the hospital?

John: All right – there must be some reason for bringing me to hospital.

T: You said it was a nightmare, but that it was alright.

John: It was a shock to me.

T: You fear being admitted to hospital again.

John: Yeah.

T: You don't feel as well as you think you should.

John: In what way?

T: You feel you are going mad.

John: No. I've not gone mad, but I have got a different sense of humour – we have all got a different sense of humour.

T: You are not feeling very safe at the moment.

John: That's true.

T: You feel your Mum wants rid of you.

John: That's true – it's her anniversary today with stepfather.

T: He wants rid of you too.

John: It's all right at the moment. We are trying to cope with each other – OK?

T: These feelings that your mum wants rid of you – that must be very painful.

John: Yeah. What were those two nude men? Not getting dressed. What does that mean.

T: Is that something you have seen before?

John: Yeah.

T: On a ward?

John: No, with Andrew and David [*two boys who had sex with John when he was a child].*

T: So Andrew and David are popping into your dreams?

John: Yeah – as different people in different positions.

T: When you came on to the ward and saw them did you think they were Andrew and David?

John: They didn't look like them.

T: They made you think of Andrew and David.

John: Yeah – their nudeness.

T: You felt sexually attracted towards them.

John: Might have done.

T: So you say that they were unattractive but had some sexual feelings towards there.

John: They reminded me of Andrew and David in the nude.

T: Andrew and David still make you feel excited but at the same time you feel guilt and shame.

John: Yeah. It's 10.30 now.

T: You want to end

John: No, we've got something else now. [Speech becomes very rushed]. I've still got sexual feelings and have dreams about having it off with men and boys. Will it go away?!

T: You want it to go away?

John: If you can get rid of it.

T: You think that I have the power to get rid of it?

John: No, not really. I have two sexual feelings, one to men and one to women. You make the decision of which one to have.

T: You feel you can't have both.

John: No, I have to have one or the other. I feel I might make the wrong choice.

T: You must feel very confused,.

John: Yeah.

T: Lonely.

John: Yes, lonely. No sexual partner.

T: You want a partner

John: I have tried many ways of getting a partner, I go to a club, church, to see if I can get a girlfriend.

T: So you want a girlfriend.

John: Yeah.

T: but you also like boys.

John: I look at boys and wish I was younger.

T: You wish you were still mummy's little boy.

John: I wish I wasn't ageing so much.

T: You would like to feel that your mum still wanted you at home.

John: [Angry] I wish I had a better education and life. I wish I was born in the future and all this being me wouldn't have happened. This is not the right tie period for me. There is nothing for me on this planet.

T: You feel you don't belong.

John: I am far ahead of everybody.
We'd better stop now. Can I go and get a cup of coffee?

T: You want to stop.

John: Yeah. When's my next appointment?

Appendix L: Transcript 2

This is a transcript of a therapy session. The presenting issues are anxiety and depression with a history of anger management difficulties. The problematic experience being worked on is how the client is coping with his current responsibilities/relationships (e.g. management of finances, care of step children) after the death of his mother and in connection to his disability.
Please read the transcript and complete a Therapist Assimilation Measure – ID. Thank you.

123

T = Therapist
C = Client

T Yeah so where did you want to start with talking about what was on your mind?

C Yesterday I suppose (SIGH) I just want to, I just got a bit, I don't know depressed I suppose err, I get uptight about and I don't know, I don't know what happened, I were all reyt erm only yesterday morning we went shopping and that err and then I come home and I just (SIGH) just flipped out.

T You just flipped out?

C I just flipped out, I went off on one a bit, not, not err, not too much I just **..**

T So you went off on one a bit?

C I just lost, I just lost it, I just I felt like I were like flipping you know in air when you flip, you like flip off on summat and I just (SIGH). I dunno I just flipped, I flipped out totally, I don't know cos somebody got angry but...
T Can you maybe say a bit more about what made you angry?

C I did a car boot on Sunday.

T Right

C And house were a bit of err, I don't know a bit of a mess so all I wanted to do is like tidy it up a little bit you know erm but I don't know, I just, it, it felt, (SIGH) I don't know, and then there's (NAME), he's sat in front room, sat in room, just sat on his bum not doing owt, anything, just, just sat down then he got up, he's got all stuff out for car boot on't floor like and were like trying to get past and like and his mum said to him "oh, put it away" and then he put it away and then, then I went in kitchen and then I like, I just, I don't know (SIGH), I just (SIGH), I just don't know.

T Yeah.

C I just banged door with my hand a bit, I dint damage it or owt I just, I don't know I just, I don't know and I just, I said to her "I'm going out for a bit" otherwise if I dint go out you know me I just (SIGH) I don't know, then I

say's "I'm going out" err then I went for a walk just round block and then my hearts still (SIGH), me hearts still pumping going ten to dozen.

T So you're heart was racing?

C Ten to dozen.

T Pumping.

C Err and then I had them ring me back from Vodaphone because you know wanting payments or they are gonna cut my phone off and this, I says cos that's what were stressing me out and because..

T So is that what was stressing you out before you went shopping, did you have that on your mind?

C They rang me on, they rang me on Wednesday about it and I were, and I were just oh I don't know, and I said to my missis "I've got to get it sorted out", I says "I've got to get my phone back on" because it, because before with my old phone they let me have some lee way you know what I mean they let me have you know cos, you know in case I had an accident or anything and I, and then I can't be in touch with anybody then, then I'm stuck and if, if I'm out and about anywhere then I'm...

T Yeah so you've got, so you've got the fact that you're phone is really..

C Important, it is

T Important to you and you need to have it?

C It is but I just, but I just can't afford it at this minute to put it, to err switch it back on because erm I'm going to, I'm going to have to try and see if they'll let, see if they'll give me some lee way and switch it back on because I've got erm, I've got me holiday to pay for, I'm going on holiday soon.

T Yes

C So that, that's another, that's another expense but (INAUDIBLE) but you know.

T Yeah I noticed that you've actually got quite a lot of things that you are worried about and that sort of are wind

C So I won't tell anybody because I, but I want to tell someone to get it off me chest like, its but I just keep it bottled up, I just, I just ..

T So you keep it bottled up?

C Umm

T And you don't tell other people about the money worries? Is that what you don't tell them?

C Yeah I mean (SIGH) everybody's got money worries, there hundreds, its but I like in shop yesterday, in't supermarket when I'd gone shopping yesterday and I were just like staring in, I don't know just, me wife says "what's up with you, what's up" "oh I says stop worrying, stop worrying cos I were worried but you know I were still worried about things like and I says "oh things will, things will calm down and things will get sorted out like but it, it's like, with me it's easier said than done.

T Okay

C But you know..

T So that's interesting that you say that (NAME), just sort of take a moment maybe to think about why that is maybe and think about the fact that maybe you know that things need to be sorted out but that that's easier said than done and I wonder maybe what's stopping you or what's difficult about getting things sorted out at the moment. Have you got an idea about what's difficult about sorting things out.

C (SIGH) its err (SIGH) it one of them money things in't it and to pay, you know to (SIGH) it's just, it, it sometimes it like it seems so hard money, I just, I try, I have it at the back of my mind and I try to figure about it, I just... I don't know.

T So sometime you have it at the back of your mind?

C Yeah and I then I just forget about it.

T And, and what's that like? How's that work?

C It, (SIGH) it's scary.

T Right

C It frightens me because err (SIGH).

T What having it at the back of your mind sort of not thinking about it, is scary, is that what you mean?

C Umm (SIGH)

T Yeah?

C Its, sometimes because of my disability I find it difficult sometimes to, to cope sometimes and I think you know but, its but I'm, I'm supposed to (SIGH) I don't know provide for my wife now and money its but, its (SIGH) we like work things out together erm I mean we have, we have arguments like but nowt ....

T So you're supposed to work things out together, is that, is that what's happening or?

C We are, we are working things out together like.

T Okay

C Err, (SIGH)

T But something seems..

C Things are, things are, things are good err so like yesterday I, I didn't feel the same yesterday erm I were coming back from shop, I were alreyt yesterday morning, I were all reyt, spot on, I were like you know chilled out and I had to go yesterday shopping and as soon as I come back I just, I just flipped out again.

T Yeah it sounds like it, it happened quite suddenly?

C Yeah it were like I thought I were gonna have like an heart attack or summat or a panic attack or I sat, erm I leant against the wall just for a breather and this bloke off road says to me "are you all right like" and I were leant over and it were still beating, going fast like but err (SIGH) then I, I went back home and I were alright like when I've gone in and I were all reyt and then I just (SIGH) err broke down into tears, I were like just sat down and then I were just, that dint feel like me, I just..

T What felt different?

C (SIGH) I don't know I just, I just felt err that person on that settee weren't me do you know what I mean it felt like I were a different person and feeling like that I just...

T Is that because you were, what were you doing then is that when you were upset?

C Yes

T And you were crying maybe?

C Yeah I were just (PAUSE)

T Was that okay for you getting upset and other people kind of seeing how upset you were or did you not like that?

C I don't know like I thought when to stop do you know what I mean, I thought I'm, I'm not gonna stop it err I feel like and things like this err and stuff

T So you're saying that you thought it's not going to stop here or you thought it was going to stop?

C I don't know I just (SIGH).

T I wonder maybe so you got so upset maybe that it was hard to turn that down

C Yeah it were like

T Umm it sounds like it must have been really hard?

C Me brother were round yesterday err and he says to me "are you all reyt", I says "yeah I'm all reyt" "but what you been up to" I says "nowt much really", I dint tell him erm.

T So is that you bottling things up maybe a bit?

C Umm

T Did it kind of take you by surprise what happened yesterday?

C Yeah I've never been like that before, well I've been temper like that in me hearts not been like it were going (SIGH) it were.

T It seems like it's almost hard to put into words it was that, that powerful a reaction really?

C (PAUSE) then been alreyt rest of week.

T Yeah how was the rest of the week for you, was it?

C Okay

T Okay?

C Good (SIGH). Yeah I've been alreyt rest of week it were just yesterday (10 second pause)

T It kind of seems like you're almost kind of letting go of some of that pressure or some of that tension now so just and you're just getting to calm down and think about what happened yesterday maybe?

C I did have headaches yesterday, so I knew when I were getting stressed I had headaches headaches across here a bit here and my nose and head (SIGH)

T And is that how you felt yesterday, did you?

C Yeah

T Right

C Cos when I told you before if I'm a bit stressed I get headache.

T Yeah you did and I wonder if you...

C Because my nose here from here and all my head.

T And I remember you saying that you've had headaches at a time when you've been really stressed before like at difficult times in your life, when were you having bad headaches before, can you remember?

C I think it were like last year like err cos I used to get stressed all the time and I get stressed, stressed a lot, I used to get really stressed all time, I couldn't sleep, I mean I couldn't sleep, I couldn't hardly sleep but every time I shut my eyes I wanted to, to sleep if you know what I mean.

T Yeah and what was going on for you at that time?

C I were thinking about (SIGH) everything all, I were thinking about my mum, my dad (SIGH), all (SIGH), how I'd cope without my mum and that, I were saying "oh I will be alreyt" and everything you know more you know, and then I had our (NAME) at the time like and me brother err and I used to cry in front of him a few times but I just like I were saying I kept things again bottled up in, inside.

T Yeah

C I used to, I used to hate it sometimes, I used to sometimes I like I used to hate myself and I just sometimes I think, I don't know I din't want to be here sometimes, me head were like all over place when like it was..

T Was this when you were *** after you lost your mum?

C Erm (SIGH) I think it were a bit after I lost my mum I used to stay out a lot and I used to (SIGH) go to pub with my mates and I used to stay out a lot cos I couldn't err face going home and I used to like sit outside on wall of the house and I just, I used to sit there for hours.

T And it kind of, I guess it, it just makes me think of you being by the wall yesterday outside and having to get out of the house.

C Umm

T Yeah

C Probably yeah (20 second pause), sometimes I think (SIGH) sometimes I think I'm, I'm not coping sometimes.

T Right, yes.

C I think, I think I'm (SIGH) not coping.

T And when you say that (NAME - **P**) do you know what you're not coping with, can you say what is difficult for you to cope with in your life at the moment? What is it that's difficult for you to cope with right now?

C (SIGH) I don't know, that's only thing, I don't know.

T You don't know?

C No

T What's difficult to cope with or you don't know if you should be struggling or not it seems sometimes?

C I don't know, that's why I think I can't answer.

T So you don't know what's difficult for you at the moment for you to manage, that seemshard to think about why you're not coping maybe?

C Sometimes I (SIGH) when I scream and shout.

T Umm And what would you scream and shout if you could?

C I would scream at top of my voice when I feel something, just let it all out and then I would feel better I suppose, if you know what I mean.

T Yeah, you're kind of in a field where there's no one around?

C Yeah

T How was it sort of letting everything out and getting upset yesterday in front of everyone else, was that. was that difficult for you or was it alright?

C Yeah

T Yeah I wonder maybe because you might think you should be coping better and that it's not okay to struggle for you?

C (SIGH)

T How does it feel talking about this now, sort of what happened yesterday, how does that feel talking about it now?

C I feel better.

T Right okay.

C Because I, that's me I keep things in hidden

T That you?

C That's me

T What do you mean?

C Always (SIGH) I don't know I keep things close to my chest, I keep things bottled up, up and then I feel like I want to explode but erm its (SIGH)

just not, not me I suppose, it feels here I'm talking to you, like I can like unload all my problems off that I, I don't know, that I've bottled up all week, come here, lay it all out and its makes it better erm, erm what I want to think about in my head.

T So having someone to talk to does sometimes make it better?

C Umm

T Yeah. Can you think of any other times where you're able to talk to people in a similar way when you're not here.

C I talk to my wife like obviously I mean but (SIGH) I just (SIGH) I just don't want to like bother her because she's got some, like, I don't know like too much on her plate as well but

T Right okay

C I mean I know with marrying her and things like that but it's just, it's not difficult to talk to my wife about things that's (SIGH) been going on in my, in my past but I'll never (SIGH) I've never said anything about in my past but I know that, I know that I should do, I had an happy childhood, when I were a kid, normal childhood, I went to a normal school and I went to a normal college, you know I did what I wanted to do erm

T So you had a happy childhood?

C I had a happy childhood, I've (SIGH) been all over.

T And you did things you wanted to do?

C Yeah you know.

T So are you saying (NAME - P) that there is some things that are difficult for you to talk about with your wife?

C Yeah but I know, I know that err that I shunt but I do but I sometimes want to let it all out, all my skeletons

T Your skeletons you say?

C Yeah

T Yeah. So if you laid your skeletons out what, what would you be talking about, what would you be explaining about yourself, what would you want to share?

C (SIGH) about my past and what I've done and..

T What you've done yeah?

C What I've (SIGH) I used to like it like weren't my fault that my dad died, it weren't my fault and then I was just (SIGH) I went off rails a little tiny bit when my dad died, err (SIGH) but one night I (SIGH) I went off even more like even worse, even worse err one day I were feeling I were gonna be alreyt and everything's gonna be okay and then you're going to cope.

T And how do you feel that you went off the rails, what do you think about sort of flipping out?

C I were grieving but I shunt have done what I've done and I regret what I've done, I never used to regret what I'd done err I just used to sleep and get up one morning and I used to think what I've done and I used to (SIGH) all go round in my head what I'd done.

T Yeah

C And..

T So you worried a lot about having flipped out and maybe, maybe having lost a bit of control?

C Yeah. Yeah it were like I couldn't sleep, I weren't eating reyt, I erm I had to go to Doctors and he put me on some tables cos I couldn't sleep very well, I were getting angry all time (SIGH) just I used to flip off , flip off at like a simple thing, it might sound daft to you but..

T Yeah I think, I think that's really interesting that you might think that it sounds daft to me cos I think you're quite aware of maybe what other people think when you do get upset, maybe its difficult to give yourself a break sometimes, things are just really hard, yeah and its difficult to cope. Mmm. Kind of what you're telling me today about what happened yesterday, I wonder if that's got you thinking about when you used to flip out in the past and ...

C Probably yeah

T Do you think, I don't know if I'm right I might be wrong.

C I don't know. Maybe, maybe it is (SIGH).

T And do you think maybe people need to see that you need support?

C Yeah I think, I think so, I think I'm coping okay on my own (SIGH), sometimes I don't think I am, I just think...

T And I guess it's about recognising when you're not coping and when you need that support and getting that support from others making sure that you get it which is hard sometimes you know, yeah and then that you mentioned earlier just about you know having your disability does make life harder and that if life's harder you do need some extra support sometimes. How do you feel about that?

C I don't know, I just, I don't know it's like, its, I felt like it, cos I used to think all time with my wife I were going to let her down, I think I were going to (SIGH) I don't know its err break down I think I'm just, I don't know just, I don't know.

T Mmm and is that what all the worrying and all the stress and maybe that there's something that you can't cope with at all?

C Think so.

T I guess it's really hard, I, I'm kind of picking up that it is really hard (NAME - P) for you to maybe know what you're coping with well and when you're really not coping very well and you need help or you need support

C Sometimes I think, I think I'm too ashamed to ask for it over years, I don't know why anybody..

T Ashamed?

C Yeah

T Its a really powerful word isn't it I mean like that.

C I am, I'm a grown up but I've got a disability but it dun't make me (SIGH)...

T What were you going to say?

C It dunt make me daft I suppose but..

T Yeah and you don't want other people to think that you're daft just because you've got a disability and maybe that sometimes makes it difficult for you to ask for help

C But now I don't care, if people don't like who I am its, it's their problem but now I don't care I'm not bothered now I just take it with a pinch of salt, it used to bother me, it used to like bother me all time, people used to stare, people, I had loads of friends and that but friends I dint know would stare, "oh look at him" and that, and that were (PAUSE) it were shameful but I proved everybody wrong and I achieved what I wanted to achieve and that were, I could do what I want to do but I, I've done what I've wanted but not as a.., not I suppose it could be (INAUDIBLE) but you know. Some people are worse off than me and things, a lot worse off than me and so it..

T I guess you just try and justify in your mind how much you are struggling or how much you might need help. I guess, I guess you know erm sort of struggling on your own and not asking for help you've proved some people wrong haven't you that you can achieve stuff?

C Yeah if you put your mind to it, that's what my mum said to me all't time, if you put your mind to it you know some people might find it err wrong way about it more, I always found it a good way to think, err a good way to think about it you know.

T And what would that be, what's that way of thinking about it do you mean like?

C I don't know just see.

T So trying hard?

C Umm

T To make things happen, if you try hard enough you'll get there?

C Yeah

T Do you think that's true all of the time or?

C (SIGH) it, it is if you're, if you want summat really bad else you get your.. (SIGH), you can like achieve your goals or if your, and then in effect I work in a garage you know I never thought, thought I'd be driving I thought I'd never you know but it's just (SIGH), its way, it's the way it is but some people can't do what I do, something wrong you know but I can't do what some other people can do but it dunt make me any different you know it.., I'm still same person as, as I've always been, I know that me mum used to spoil me but you know I've always been like that but you know me mum used to spoil me a lot but it's what she's done being spoilt but I, you know I.., (SIGH) it were like owt else but it were, it's just the way it is.

T I'm just thinking back to when you did have support, support, support of your mum and maybe how life was easier?

C Umm

T Maybe coming to terms now with perhaps why things are hard and when you might need to ask for help and whether that's okay to do.

C I used to go out with (NAME) on a weekend and that and we used to like talk about stuff and things and whatever (SIGH) I still *** and we used to talk about it and say "what's up with you" and I'd say "nowts up with me" and he's say "oh best way to talk about it, what's up with you", cos I used to get stressed about work and that.

T Is this with your brother?

C No this is someone I work with cos I used to <u>get stressed</u>

T <u>Saying through work?</u>

C Yeah cos I used to stressed at work all time and that and I just ...

T So he's not there for you to have a chat about things?

C I just sometimes I just want to go out and I just wanna like talk to someone or talk to one of my mates about stuff.

T Yeah. Is there a chance that you can still do that or is that difficult?

C Err it, it is because he knows he's at work rest of week but he's off on one, he works Saturdays as well sometimes so only, only times that if I do see him you know a Sunday so I don't (SIGH), I do see him though but you know he's always at work and that and stuff so I just, yeah I go out a lot like during day and things but ...

T I guess there's something, maybe also about knowing what you're problems are and maybe what you need to do about them I suppose, maybe once you're sharing a bit about how you feel?

C Umm

T Shall we leave it there (NAME) just for this and then we can have a chat afterwards and thinking that erm, sorry I should have said that the time has gone on hasn't it.

END OF SESSION

Appendix M: Transcribing Confidentiality

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The University Of Sheffield.	Department Of Psychology. Clinical Psychology Unit. Doctor of Clinical Psychology (DClin Psy) Programme Clinical supervision training and NHS research training & consultancy.
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