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Division of Counselling Psychology

Working relationally with adults with an intellectual disability – A discussion



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This booklet is designed to inform and stimulate dialogue in the applied psychologies and sister disciplines. It is intended to offer an approach or perspective that highlights a relational focus. For some counselling psychologists this may be to enlarge their practice to include working with people with an intellectual disability in this way. For all psychologists working with people with an intellectual disability it offers an opportunity to think about working relationally.

This document is intended to complement the 'Relational Series' published by the Division of Counselling Psychology.

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The context for this paper

There are a number of documents produced by the Society in relation to working with individuals with an intellectual disability. The Faculty for People with Intellectual Disabilities has published informative and useful documents, particularly in relation to the assessment of people with intellectual disabilities and the adaptation of therapies.

Examples of these documents are:

- *Learning Disability: Definitions and Contexts* (2010).
- *Dementia and People with Learning Disabilities Guidance on the assessment, diagnosis, treatment and support of people with learning disabilities who develop dementia* (2010) in conjunction with The Royal College of Psychiatrists.
- *Guidance on Neuropsychological Testing with Individuals who have Intellectual Disabilities* (2015).
- NICE Guidelines.
- *Psychological Therapies and people who have intellectual disabilities* (2016).

This is an area in which there has been significant research and other valuable contributions to underpin specific psychological interventions with this client group. It demonstrates the role of psychologists as reflective scientist practitioners who deliver evidence-based practice.

There are a small but growing number of counselling psychologists working with people with an intellectual disability in specialist services. This discussion will focus on the skills that counselling psychologists intentionally and explicitly offer in working relationally with their clients. It will explore the philosophy that underpins counselling psychology practice and with the use of case studies, demonstrate the importance of working within a relational framework.

This discussion comes from the position of counselling psychology as a profession and also from that of counselling psychologists who, as a result of the 'journey' of training, develop their practice which most explicitly leads to a personal and professional identity that they bring to their practice in all areas. du Plock (2006) suggested that:

'through our adoption of the scientist practitioner and Human Science models of inquiry and our holistic perspective on what it means to be human allows us to engage with the notion of relationship in a new and distinctive manner' (p.22)

However, he acknowledged here a generated interest (or this may have always been present) with other applied psychologists. In the context of this discussion the 'relational framework' may be present but is not explicitly identified or discussed in relation to psychological therapies with people with an intellectual disability. Therefore, the idea of working relationally may be present but it is not identified as being at the centre of the work.

Working relationally is at the core of counselling psychology; it is explicit and intentional and is offered here as underpinning other ways of working. There is a dearth of research exploring these ideas.

When Jones and Donati (2009) undertook a literature review of working with individuals with learning disabilities, they concluded that although the literature base was increasing, research was limited in this area. Jones (2013) documented her own research and the value of the therapeutic relationship when working with people with a learning disability from the perspective of the therapist but of the limited published research, there is none which specifically addresses the issue of the value of the therapeutic relationship from the perspective of the client. Further research focusing on the possible value of this way of working from the client's point of view is one that requires further exploration.

Therefore, this means that the contributions to this discussion from counselling psychologists working with individuals with an intellectual disability currently are typically in the form of reflection on practice. Strawbridge and Wolfe (2003) refer to Schon (1987) suggesting that,

'...successful practitioners learn from experience. Reflection on action often with other practitioners and reflection in action, the monitoring of practice in process are crucial factors in this learning and keeping practitioners alive to the uniqueness and uncertainty of practice situations' (p.6)

Whilst acknowledging the importance of 'evidence' based practice, the reflections that counselling psychologists make and further reflect on both independently and in supervision could be described as 'practice' based evidence. For a discussion of practice-based evidence, see Blair (2010) and Barkham and Barker (2010).

Introduction

Counselling psychology

A reflection on the profession over the last 22 years is intended to help the reader understand the contemporary direction of practice. To name the core philosophy of counselling psychology is challenging, for a discussion see Orlans and Van Scoyoc (2009). The founding members of the profession in the UK laid down the original curriculum of the training programmes. However, as the profession grows, changes and adapts to the requirements of employers such as the health service it is acknowledged that the differences between psychologists with different adjectival titles is not always clear. Orlans and Van Scoyoc (2009) discuss their own journey that is likely to be the same for many others and describe it as *'to negotiate a tricky path that sought to maintain a sense of our own integrity, identifying a position that held on to an intelligent standard as well as satisfying a number of stakeholders.'* And further suggest that it *'requires a significant level of intellectual and emotional intelligence to wade through this quagmire of ideas and formulate something that presents with coherence'*. (p.37)

This is perhaps the tension when the narratives around practice in an area are so well documented and researched. It is then often difficult for dominant narratives to accommodate something different and this may be what working relationally offers.

Counselling psychology in the UK developed as a discipline that combined the practice of psychotherapy with psychology. It was formally recognised as a Section of the British Psychological Society (BPS) in 1982. The Division of Counselling Psychology was then formed in 1994 and has grown to become the third largest division within the Society with over 3500 members.

It is widely acknowledged that the philosophy and practice of counselling psychology is explicit in its value base, having its roots in humanism and therefore pays particular regard to role of the therapeutic relationship in achieving change. There is also an intentional use of self in the therapeutic process by sharing expertise but not taking the position of expert when working with clients.

'...counselling psychologists recognise the pivotal role of intersubjective experience and collaborative formulation between those participating in deriving understanding and approaches to people's psychological distress, which is often profound... This stance is embodied in the notion of the reflective practitioner, emphasising the joint creation of meaning within the therapeutic alliance. Counselling psychologists bring aspects of themselves to this shared enterprise, ...' (2014, p.4) Qualification in Counselling Psychology Candidate Handbook.

During training there is a particular focus on personal development to enable counselling psychologists to work relationally. This includes an ongoing reflection on practice and the requirement for at least 40 hours of individual personal therapy. The purpose of this is to know what it feels like to be a client but also, and perhaps more importantly:

'An understanding through therapy of your own life experience.

An ability for critical self-reflection on the use of self in therapeutic process.

Develop a personal philosophy to include responsibility and accountability in relation to your counselling psychology practice.

An understanding of the dynamics present in therapeutic and other relationships.

Creativity and artistry in the use of language and metaphor, in the service of empathic understanding.' (2014, p.15) Qualification in Counselling Psychology Candidate Handbook.

The practice of counselling psychology is influenced by and draws upon traditional scientific psychological knowledge, theory and empirical research, and the power of the psychotherapeutic relationship and process. An alignment with phenomenological models of practice and enquiry and the humanistic value base underpin this 'both, and' position. As psychologists, we approach the distress of our clients, the various responses or 'treatment' of this and the production of knowledge within the professional field in a particular way. Counselling psychologists give primacy to the subjective experience of the client, seeking to understand their context and unique frame of reference as valid in its own right, and to understand how this might impact on their experience of psychological distress and/or wellbeing. We seek to empower rather than control.

In addition to this, counselling psychology as a branch of applied psychology, values and upholds an overarching critical and pluralist philosophical perspective towards the construction of knowledge. Multiple sources of information are sought, without the automatic superiority of any. This means holding a 'both, and' perspective, which seeks to validate or find 'truth' in each position and these may, at times be dialectically opposed. Counselling psychology aims to validate or find 'truth' in the middle position, something that might include elements of both, and with the possibility that it may become something more than both. This is different to an 'either, or' position.

The therapeutic relationship

The relational focus of counselling psychology is further explored in Strawbridge, Dryden and Wolfe (2003) who draw attention to the emphasis counselling psychology places on the relationship and elements that may be regarded to be particularly relevant to working with an individual with a learning disability. These elements include:

'the empathic engagement of the psychologist with the world of the client'. This is a skill which requires the psychologist to 'be with' the client rather than to 'do to' and it requires the psychologist to enter into the world of the client with an intellectual disability on the basis of their understanding and experience it. Achieving this thereby demonstrates *'the acceptance of the subjective world of the client as meaningful and valid in its own terms, the need to negotiate between individual perceptions and world views without assuming an objectively discoverable "truth"'*. (p.8)

The elements that contribute to the growth of the therapeutic relationship enable the client with an intellectual disability to elucidate their own experience as valid and valuable. It enables the psychologist to support and formulate with the client and communicate this understanding to the wider system to enable non-judgemental understanding and acceptance. This approach is focused on promoting wellbeing, it avoids pathologising difficulties and regards the client as the expert on themselves. The counselling psychologist aims to 'be with' the client and offers expertise in facilitating the therapeutic process. This typically relies upon and is achieved by reflection and self-reflexivity, thereby enabling the development of one's own identity as a counselling psychologist and a position from which to practice.

Intellectual disability

The terms 'Learning /Intellectual Disability' are used interchangeably in this discussion. Older documents generally make reference to learning disability whereas the more up to date terminology being used by organisations including the British Psychological Society is 'Intellectual Disability'. A distinction is made between these terms and 'Learning Difficulties' which usually refer to specific difficulties such as dyslexia. A more detailed exploration is found in Emerson and Heslop (2010).

What is a learning/intellectual disability?

The term 'Learning/Intellectual Disability' is a socially constructed idea and term which defines a group of people often on the basis of difference and that which they are unable to do. It is important to note that the term is a construction that encapsulates a constellation of challenges for an individual but should be acknowledged as sitting alongside other descriptions relevant to the person such as family member or friend; 'A label describes an aspect of the person but does not capture the whole person' BILD (2011).

Valuing People (2001) defines learning disability as:

- Significant impairment of intellectual functioning;
- Significant impairment of adaptive/social functioning;
- Age of onset before adulthood.

In order for a person to be considered as having a learning disability all three conditions should be met.

This is also the definition cited by the BPS (2010) *Learning Disability Definitions and Contexts*, and Emerson and Heslop (2010).

Supporting clients through a neuropsychological understanding of intellectual disability

An understanding of a person's cognitive abilities can support the work and this is where specific assessment by a practitioner psychologist, often working with speech and language therapy and occupational therapy is useful to support an individual in the therapeutic process. This enables a person-centred approach. Rogers (1961) defines the '*Characteristics of a Helping Relationship*' as '*...a relationship in which at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other*' (p.40). In the case of a client with an intellectual disability it is often helpful to have an understanding of their particular difficulties and challenges to enable the psychologist to consider these during the therapeutic work and to support psychological growth.

Intellectual functioning is often assessed by psychologists using neuropsychological assessments. This is explored widely in the BPS (2015) *Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood*. Caution is advised on how this is reported to the client and consideration of the consequence of the findings. It may be that the findings are used to conclude on the eligibility of the person to receive a service and it is the responsibility of the psychologist to ensure that findings are reported with care and in

a way that supports the individual. It is the case however, that an in depth assessment of an individual's strengths and challenges can be helpful when understanding and supporting the individual alongside the nature and process of therapy and other interventions. In all cases, consent for the precise nature of the assessment and its purpose should be established.

Adaptive/social functioning is also often assessed through psychometric assessment which offers the opportunity for multidisciplinary assessment. Again, this may involve working with Occupational Therapy colleagues and an assessment of communication skills by a Speech and Language Therapist would add to an overall understanding of the person, thereby supporting psychological interventions.

There is ongoing debate about the value of the classification. Whilst it can be used to decide whether or not an individual meets the access criteria to services for people with a learning disability, it is also a classification that can be used to enable additional support.

What might cause an intellectual disability?

There are many explanations for an intellectual disability. The following is a summary of possible causes:

- Prenatal causes such as congenital or chromosomal abnormalities;
- Perinatal causes such as lack of oxygen during pregnancy, during or just after birth;
- Deprivation or neglect in early childhood.

It can be useful to understand the cause of the intellectual disability, this may have implications for other presenting health difficulties.

Change over time

The history and histories of people with an intellectual disability is complex and there exists a particular historical and cultural context out of which individuals with learning disabilities have grown (Bungener & McCormack, 1994). Throughout the first half of the twentieth century, individuals with learning disabilities were considered a threat to society and were subsequently detained under the Mental Deficiency Act (1913) in large institutions. The ideological movements of normalisation and empowerment significantly changed the lives of individuals with learning disabilities. With the establishment of the National Health Service (NHS) in 1948, the abolishment of the Mental Deficiency Act in 1959 and a government White Paper in 1971 'Better Services for the Mentally Handicapped', a massive increase in community services was advocated (Caine et al., 1998). The need for improvements to services continues to be highlighted. The White Paper 'Valuing People' (Department of Health, 2001) emphasises how people with learning disabilities are one of the most socially excluded and vulnerable groups in Britain. The paper, based upon four key principles; rights, independence, choice and inclusion sets out proposals to improve education, social services, health, employment, housing and support for people with learning disabilities and their families.

Individuals with learning disabilities receive assistance from a variety of services and

professionals throughout their lives, including multidisciplinary community teams, day services and residential or supported living projects. Staff turnover is a major problem within services which, in turn has serious consequences for service quality (Hatton et al., 2001). A number of empirical studies have researched factors that influence staff turnover in learning disability services, including Blumenthal et al. (1998), Hatton et al. (2001) and Mascha (2007). Factors include high job stress, low job satisfaction, inexperience and a lack of training. Professionals involved may include community nurses, psychologists, speech & language therapists, occupational therapists, psychiatrists, creative therapists (art & music), care managers, and residential support staff (Caine et al., 1998). The array of professionals involved in the lives of individuals with learning disabilities reflects an awareness of their complex and diverse needs.

Sadly, there continues to be inadequacies in the support of people with an intellectual disability. In 2007 Mencap published a report *Death by Indifference* documenting the lack of care for people with a learning disability in the hospital setting. In 2011, the Winterbourne View Hospital scandal uncovered cruel and inappropriate treatment of young people with an intellectual disability and mental health diagnoses. It is clear therefore, that whilst the support for people with an intellectual disability has improved, there continues to be pockets of abusive care for a very vulnerable group of people who are often unable to advocate for themselves.

Why might people with an intellectual disability be more likely to experience mental health difficulties?

Social factors may include:

- Early experience and understanding that experience may result in attachment difficulties. A discussion of this possibility is in Bowlby (1988, pp.33–38).
- A lack of opportunities or social inclusion which may lead to low self-esteem.
- Communication difficulties may result in difficulties understanding and expressing emotions or in initiating and/or maintaining social contact and meaningful relationships.
- Living with support may result in a lack of privacy and agency to conduct one's life as one wishes. People with learning disabilities should also be able to take risks and make unwise decisions. Health professionals and care staff are often unwilling or unable to accommodate this.
- Stress or feelings of loss may be more readily attributed to the learning disability itself (diagnostic overshadowing) rather than the actual cause and may therefore be overlooked.

The challenges of working with people with an intellectual disability and the possibilities for overcoming the challenge by working relationally

In the recent past, the difficulties of working psychotherapeutically with this group of people led to a situation where psychotherapy/psychological therapies were not

generally considered as appropriate for people with an intellectual disability. Bender (1993) challenged this position and since that time, opportunities for psychotherapy have increased.

The difficulties that may be relevant for some individuals which need to be addressed are:

Communication

Communication, whether verbal or non-verbal is an important element in the therapeutic relationship. Reflection on the nature of the communication between client and psychologist is essential when working relationally, including non-verbal interaction and that which is not articulated. It is always a shared enterprise.

Receptive and expressive communication may be difficult for the individual with an intellectual disability therefore it is necessary to check carefully that the person has understood. If they did not understand, then other methods could be explored such as drawing or pre-prepared symbols and images.

It is possible to work therapeutically with individuals whose communication is severely compromised. It is the development of a therapeutic relationship that places communication as a shared enterprise. An *approach* which is often described as 'Intensive Interaction' has its origins in a psychological approach originally termed 'Augmented Mothering' Samuel (2001) describes the approach:

'Intensive interaction was developed based on the dynamic social context of early human learning. In this circumstance, both infant and caregiver both initiate, maintain and respond contingently to each other's behaviour (for example, facial expressions, vocalisations and gestures) with joint attention turn taking and mutual enjoyment' (p.22)

Working in this way with people whose communication is particularly compromised, combined with the ongoing process of reflection and careful focus on the process of transference and countertransference promotes working relationally and offers possibilities for increasing communication in all its different forms. This is integral to working relationally and building the therapeutic relationship. Rogers (1961) makes reference to the importance of communication in the development of the relationship; *'... if a level of communication is reached so that the client can begin to perceive that the therapist understands the feelings that he is experiencing and accepts him at the full depth of that understanding then we may be sure that the process is initiated.'* (p.75)

Understanding

Language should be kept simple in order to promote understanding and this should be checked out several times. Often people with an intellectual disability develop strategies that produce a 'veil of competence' and it is easy to assume that someone has understood when they have not. Use of other forms of communication such as pictorial resources or objects can be used to support and aid understanding. Context can play an important role in understanding, therefore careful use of self and one's own experience can facilitate sharing and create an intersubjective space in which understanding can be supported through exploration and the sharing of ideas. Orlans and Van Scoyoc (2009) refer to the humanistic postulates as suggested by Bugental (1965) which include the *'uniquely human quality of seeking meaning, value and creativity'* (p.32). In the context of working relationally

the psychologist working to support and increase understanding may be creative and playful which is part of artistry of therapy.

Memory

It is not unusual for someone with an intellectual disability to have difficulty with memory skills. Therefore, it may be difficult to remember anything or the detail of previous sessions or discussion earlier in the session. It is important to work out with the individual how to overcome this by using simple language, perhaps with the support of cards of words or symbols. In terms of the relationship, it is important that this is co-created in order to empower the individual by 'playing to their strengths' and avoid making them feel patronised. Additionally, it may be that the client is unable to remember the time and day of appointments so this should be documented in a way that enables the person to remember.

Processing

Processing information may be difficult for a person with an intellectual disability. Whilst this will be different for every individual, it is often the case that giving more time for any question is useful for the client to reflect or to process the information. It is important to closely observe the process and mitigate against too much silence which can be confusing. Strategies to support this should be explored with each individual and again it is important that the strategies are co-created and can be 'playful' which contributes to development of a stronger therapeutic relationship.

Language and knowledge

When working with individuals with an intellectual disability, it is important to acknowledge that although understanding and accommodating the skills and difficulties of the individual, this is only one part of working relationally. Anderson (2012) cautions against '*theoretical scripts or standards of behaviour*' that lead to an assumption of '*artificial categories, types, and classes*' which restricts seeing and understanding the uniqueness of the client '*missing their specialness and limiting our and their possibilities*' (p.10). Anderson refers to the importance of the contextual, social and cultural role of language and knowledge and the importance of co-construction and creation in the therapeutic process.

Understanding the therapeutic relationship

It is unlikely that a person with an intellectual disability has experienced or had the opportunity to reflect on a psychotherapeutic relationship. Without this prior experience they are unlikely to have experienced creating a collaborative and equal relationship where all communication is valued and where particular attention is paid to the communication itself in all its different forms. People with an intellectual disability are often encouraged and supported to attend appointments and so it is difficult to choose not to attend. This is even more difficult when the health professional visits the client's home. This should be considered along with the referral itself because it is common for referrals to be made on an individual's behalf without consent being checked. Therefore, understanding and consent need to be explored explicitly and any emerging issues should be carefully addressed.

Subjectivity and inter-subjectivity

An individual who has not experienced a therapeutic relationship is unlikely to understand the process of the therapeutic relationship and may be used to being 'done to' rather than

someone 'being with' them. People generally work out how to 'be' in their world and their own strategies to manage their internal representational model. Bowlby (1988) discussed this idea and how the models are internalized and therefore operate in adulthood. Ditchfield, in Waitman and Conboy-Hill (1992) acknowledged the loss and difficulty in parenting a child with an intellectual disability (p.129). For the individual with an intellectual disability, representational models are updated on the basis of prior experience and understanding; for a person with an intellectual disability there may be interference as a consequence of the learning disability. Stokes and Sinason in Waitman and Conboy-Hill (1992) refer to 'Secondary Mental Handicap as a Defence'. This discussion suggests that the trauma of disability (to use contemporary language) is too painful to bear and so the presenting problem is the secondary difficulty. The therapeutic relationship enables the existence of that which is subjective and intersubjective to be talked about. A possible strategy for a person with an intellectual disability to get by is often to be a 'people pleaser', to always smile and say what is expected. Therefore, it is necessary to be alert for instances of this. Time and experience in therapy is helpful in addressing and enabling the individual to co-create the therapeutic process.

The contribution of working relationally with individuals with an intellectual disability: Some case studies

Individual work

Mark and I have worked together for six years. When we began meeting weekly he was visiting the community support team office daily. His Social Worker was unsure about how to deal with this and requested psychology intervention.

As we undertook the work together, our therapeutic relationship developed and he was able to tell me his story which included abuse, rejection, trauma and loss. This helped us to work out why he needed to check in with someone and why the need was so difficult to 'quench'. Our relationship grew and survived its own difficulties through ongoing projection onto me of the fear of rejection and likelihood of future rejection. This was particularly tested one day when I had mixed up my commitments and failed to attend a pre-planned appointment on time and was an hour late.

I felt awful and used supervision to discuss this, together with the possibilities for what had happened. We discussed the therapeutic relationship. The co-created therapeutic relationship may be represented by Bowlby's (1979) description:

'as a working model of an attachment figure who is conceived as accessible trustworthy and ready to help when called upon.' (p.117)

I also focused on the possibility that my feelings about his childhood were so intense and difficult to bear that I had internalised the feelings and shut them away – so far away that I overlooked the appointment.

When we met the following week, Mark was very angry, and I was sorry but told him that I had made a mistake – I am human. This was a landmark in our relationship and he began to view me as fallible as anyone else and understand that although I would ‘hold’ his distress, we needed to work out a way for him to do this for himself.

We undertook some CBT problem solving and case conceptualisation which helped Mark to understand his difficulties and why he needed to overeat when he felt bad. We agreed that this was not the worst thing he could do (many years ago he took an overdose of medication) and that a good day could follow a bad day. He learnt to be kind to himself and he began to show kindness to me. We talked about this as growth. Now he and I meet for 15 minutes once a month to ‘check in’ and he can reach me on the phone if he needs to, although he knows that I am very busy and if I do not answer quickly, this is the case and it is not a rejection.

Couples and family work

Teams supporting individuals with an intellectual disability have a responsibility to ensure the safety and the physical and emotional wellbeing of their service users. Relationships and consent to sexual activity are areas where concern is often expressed in relation to safeguarding. Intimate relationships by their nature require privacy and balancing this need with safeguarding often causes stress in organisations. This was the underlying reason for the referral.

Jeremy and Susan met at the day centre and told their friends and support staff that they have become engaged. Jeremy is 35-years-old and lives in a supported living house. Susan is 40-years-old and lives independently with some support. Jeremy spends his daytime weekends with Susan and as she is able to drive, taking Jeremy out during weekday evenings.

Jeremy’s social worker had spoken to him about relationships and she felt that Jeremy did not have previous experience of a close relationship and was worried that the relationship was progressing too quickly for Jeremy to understand. She has referred Jeremy to the psychology team for support.

I began by meeting Jeremy to talk about the referral and although he had consented to the referral, he was unsure about why I had come to see him. He was upset and worried that I had been ‘told to split us up’. I explained to Jeremy that this was not the case but that his social worker was worried about him and reassured him that we would like to help him and Susan to be sure that their relationship was how they wanted it to be. I offered him the opportunity to discuss this or alternatively not to meet again. Jeremy asked if Susan could come to sessions with him and we agreed that this would be a good idea if it helped him and also it would help me to get to know them better and so understand more about them and their relationship.

We met weekly in a room away from the day centre and team office where Jeremy and Susan could meet in private and be more comfortable, they also were able to have refreshments which helped them to be comfortable and Susan sometimes brought biscuits for us to share.

We met for ten weeks. At the beginning I listened to Jeremy and Susan talking about themselves, their families and their personal histories including how they met and became close. From this, I came to understand them as enjoying a relationship that might be regarded as culturally 'traditional', Jeremy and Susan talked about how much they loved one another and wanted to be married like others in their close families.

With Jeremy's and Susan's consent I spoke with Jeremy's social worker about my observations that Jeremy and Susan appeared to be genuinely affectionate and loving towards each other and Jeremy comforted Susan when she became upset about her father's death. As a result, I felt that the relationship offered Jeremy love and warmth and although he was less able than Susan it was a relationship of equality and reciprocity.

During session five Susan and Jeremy talked with me about the house that Susan lived in and how she really liked preparing meals for Jeremy and they enjoyed spending time together. Susan and Jeremy appeared to be comfortable talking with me and when we were discussing their intended home together I asked were they intending to sleep in separate rooms or share the main bedroom. They laughed and reported that they were intending to wait until they were married before they 'slept in the same bed' but that was the long-term plan.

I felt that I had a good enough therapeutic relationship to explicitly raise this issue with them without them becoming embarrassed and finding it too difficult to discuss. We agreed that we would all speak with Jeremy's social worker to tell her about the work we had done and the plans that Jeremy wished to make for his future.

I used supervision to reflect on the feelings of warmth that I experience when I was with this couple and reflected on the therapeutic relationship, I reflected on the possibility that I felt the warmth because I enjoyed the work? Or was this transference of the warmth of their relationship? I continued to monitor this and discussed it when I met my supervisor. The conversations I had with Jeremy and Susan gave me the opportunity to observe, support and make an assessment as to their ability to understand close relationships whilst also maintaining a respect for their privacy. We also discussed why Jeremy's social worker was worried. We were able to work on a narrative to deliver to the team supporting them including Jeremy's social worker to help them understand their wishes and demonstrate their understanding.

Assessment

Psychologists are often asked to provide assessments to support multidisciplinary work. This may be for others to increase understanding, as part of a clinical pathway or risk assessment. In addition to the assessment, a fuller understanding of the person and the situation will be part of any formulation. The process of assessment enables the psychologist to develop and is facilitated by a therapeutic relationship.

Concerns about dementia

Individuals with an intellectual disability are statistically more likely to develop dementia at a younger age. The epidemiology of this issue is discussed in *Dementia and People with Learning Disabilities*, BPS RCP (2009, p.8). This document also describes a pathway for an assessment and diagnosis of dementia.

Alongside appropriate assessment to establish the possible presence of dementia it is also necessary to consider alternative or co-existing explanations to support individuals with behaviour.

Mr Davies, a 73-year-old gentleman diagnosed with an intellectual disability, was referred to the psychology department as he was becoming more agitated on the hospital ward. The ward staff were concerned that he was developing dementia and requested a formal assessment.

Working relationally with Mr Davies was key in engaging in his narrative and life story. We worked collaboratively to identify some particular situations that seemed to trigger his anger and irritation at staff and other clients on the ward. The work that we did included educating staff about his own needs, wishes and values. For example, when staff would lock the cupboard where the tea bags were stored, Mr Davies worried that he would not be able to make himself a cup of tea. This then led to him hoarding tea bags when the cupboard was unlocked and being reprimanded by staff causing him to become angry and verbally abusive.

Supporting Mr Davies to tell his story and understanding how important his independence was for him, helped him come up with solutions on how he can express his needs better.

The team agreed to provide Mr Davies with his own tea making facilities in his room. By understanding his deprived background through the life and social story work we completed, staff were more able to carry out their roles in a more supportive and person-centred way with Mr Davies. The incidents of agitation reduced significantly, and he was able to relate better to the staff on duty by learning more appropriate ways of communicating his needs. Mr Davies and I worked on a variety of social stories over the years, supporting him in personal hygiene difficulties; establishing routines that he felt more comfortable with and formed a strong therapeutic relationship. I believe that without the relational element, Mr Davies would not have felt comfortable with some of the work that we did together, and this foundation supported him in forming further relationships with staff and friendships with clients on the ward.

Mental capacity and cognitive assessment

Assessments of the skills and difficulties of people with an intellectual disability are common in services. Working relationally occurs across all settings when it is at the core of practice.

Mary is a young woman in her early twenties who lived with her family until a breakdown in the relationship resulted in her moving in to supported accommodation. She had become angry towards her co-tenant when she returned home from a trip out with her mother. Mary shouted at her and broke some items of crockery in the kitchen. Since leaving her family home Mary has also been eating excessively. A referral was made to psychology to support her and the team working with her.

Mary and I met and talked about what had happened at home and she told me about how angry and jealous she felt about her co-tenant having a loving relationship with her mother when her own mother had rejected her. We talked about her low mood and belief that no one liked her. We then helped her think about all the positive things about herself when she notices herself having negative automatic thoughts.

We also thought about the things that she could do to improve the way she felt about herself. We talked about how things in the past make us think and feel as we do today. My formulation using the cognitive behavioral model was that her core belief about herself was that she was unworthy; she often behaved in ways that pushed people away including her family and this served to confirm her belief when people reacted negatively. We reflected on how missing her family contributed to her feelings of stress and triggered her negative thoughts.

Our therapeutic relationship enabled me to 'hold' her exploration and challenge of this belief and included her reconstructing her story with elements of how she wanted her life to be. Our work also included putting together a 'pack' of resources such as a diary in which to write her feelings, an aide memoire to help her with her deep breathing and some photographs of some of the things she enjoys.

Despite some success using these distractions, Mary continued to eat sugary foods when she was stressed and this continued to raise her blood sugar levels. This meant that the dietician and her social worker felt that a formal capacity assessment needed to be undertaken to address the question 'Does Mary understand the consequences to her health of continuing to eat excess sugar?'

I was asked to undertake a cognitive assessment to inform the capacity assessment as to her skills and areas in which she needs more support. I reflected on this and the effect this would have on the therapeutic work but as I knew her well by this time, I believed that feeling secure would enable her to perform to the best of her ability. I discussed this with her and she said that she would feel comfortable with this.

Had I not known her I would have spent time with her to enable her to feel comfortable with the assessment and me. This would include gathering background information to aid understanding of the person and to put them at ease. Mary agreed to undertake this assessment. I explained to her that this was to help her social worker and dietician to understand all the things that she was able to do so that they could do some work with her to see if she understood what would happen if she ate too much sugar. It would also help everyone working with her understand what she was able to do and when she needed more help.

WAIS IV assessment

My focus was on making the assessment a positive experience for Mary. I met her on two occasions to assess her cognitive abilities using the WAIS IV (2008).

Mary found the assessment challenging but with regular breaks and over two sessions she was able to complete all the necessary subtests. In line with the instructions in the WAIS manual, I did not interact with her during the subtests, but we had short breaks between the subtests and I allowed 'space' for her to express how annoying she found the assessment. She informed me during the assessment that it was 'doing her head in' and that 'I'm only doing this because it's you – you know'.

At the end of the assessment I congratulated her for sticking at it and the following week reflected with her that I thought that she had shown good verbal understanding. I had noticed this from how well she reads and writes but I thought that she got confused when people tell her things as they think she understands more than she does. She agreed and said that this also makes her angry.

I met with Mary's speech and language therapist to compare my assessment with a communication assessment and this enabled us to support the process of the Mental Capacity Act (MCA) (*Mental Capacity Act Code of Practice, 2007, p.34*). The conclusion of the MCA assessment was that she *appeared* to understand the information relating to the decision but that she found it particularly difficult to weigh the information and then communicate it back. The conclusion was that she did not have the capacity to understand the risk to her health of continuing to eat too much sugar.

The team working with Mary met to discuss making a best interest decision on her behalf and expressed concern about what the least restrictive option would be. To restrict her diet more rigorously without increasing her behaviour would be challenging and may affect the ability to support her in the community. We agreed that we would try to make a plan with Mary's agreement, that she buys her food daily and supported her to eat more healthily. I would continue to work with her to focus her thinking more positively about herself.

I was able to discuss Mary's situation with her and we tried exercise during our meetings. She moved to a self-contained apartment with 24-hour care in a suburban seaside town. We discussed the work I have done in the past where exercise in natural surroundings has helped to reduce low mood and increase psychological wellbeing (Mind, 2013). For several weeks we walked and talked. We discussed that eating a low sugar diet is important to maintain health. This also offered me an opportunity to 'be with' Mary rather than 'do to'. These interventions were intentional, and I was able to reflect with her on my own experience of feeling well when getting exercise and fresh air. She began to enjoy the surroundings and the companionship of walking and this enabled her to talk freely. We practiced mindfulness and I made a bespoke relaxation CD for her.

Slowly Mary lost some weight and eats much less sugar as she practices much better self-care.

Working with individuals whose behaviour challenges

Support for individuals with an intellectual disability whose behaviour is described as challenging is typically an integral part of a service for individuals with an intellectual disability. This is outlined in *Challenging behaviour a unified approach – update* (BPS RCP, 2016).

Sarah is 20-years-old and lives with her father and stepmother and their young family. Sarah has complex intellectual and physical disabilities and attends a day centre where she also receives some respite care at the weekends. She was referred to psychology and other members of the multidisciplinary team including the Specialist Behavioural team as a consequence of concerns expressed by staff about her self-injurious behaviour. This behaviour was typically head banging to the extent that she sometimes caused minor injury to her head which was difficult for staff working with her to witness. A full assessment was carried out by speech and language therapy, occupational therapy, physiotherapy and lead clinical nurse in relation to a Positive Behavioural Plan (PBS), agreed by the MDT. Psychology were requested to write the Positive Behavioural Support Plan supported by observations by the behavioural specialist.

The staff in the day centre were very worried about her behaviour, most of them were local to her home community and had known her family for many years. They felt connected to her and wanted the health team involved to give them the answers and means to stop her behaviour.

I began the intervention by being introduced to and observing her for a short period of time. I then met with her father who told me about Sarah and her family story.

Sarah is the only child born to her parents, she was born when they were just 18-years-old. When she was diagnosed with complex disabilities at six months, the local community fundraised to support physiotherapy interventions which were offered in Europe. She travelled to clinics with her mother and received intensive physiotherapy which her mother continued on their return with support from friends. At this time her father was working long hours to support the young family and sadly her parents separated, and Sarah and her mother went to live locally in a small flat. Sarah and her mother did not continue to travel for interventions and her father reported that Sarah's mother became very isolated and withdrawn and concerns were raised about her ability to continue to care for Sarah. When Sarah was six-years-old her mother was admitted to hospital with a serious and previously undiagnosed mental health condition and Sarah went to live with her father who had remarried.

Sarah continues to live with her new family, her mother died in hospital last year.

The team working with Sarah continued to complete communication and eating and drinking assessments and considered how these assessments would contribute to recommendations in the PBS plan. Observations confirmed that transitions from one place or activity to another would typically be followed by an episode of behaviour. The team began to formulate around this and recommended that objects of reference (an object that signify and represent the activity, e.g. coat when going out) must be given to Sarah two minutes before the transition.

I continued to meet with Sarah and to just spend time with her helping her to become more comfortable being her. The team occupational therapist had trained the team in Intensive Interaction (BILD, 2004) which she seemed to engage with well and she began to engage with me in this way also.

I met with Sarah late one afternoon in the respite service. She was having her tea when I arrived and I sat with her and her carer whilst she was finishing her food. Sarah reached out and touched my arm and so I mirrored this by touching her arm. We then sat in the sensory room where Sarah sat on the floor with me. Sarah continued to explore me by touching my arms and I gently reciprocated. Sarah's attention was focused on me and I was able to establish and maintain eye contact with her. This continued for approximately 30 minutes and I reflected on my feelings, I reflected that I felt calm and connected to Sarah. Sarah then held my arm and gently repetitively made contact with her head against my arm. As she did this, she vocalised 'Mm Mm'. I was moved by this connection, I felt sad but warm towards her. She continued for about five minutes and then sat back relaxed, we sat together for another five minutes and then I said goodbye.

The observations and assessments contributing to the PBS plan suggested that Sarah had the most difficulty when she is uncertain what is going to happen and her response to this is to bang her head to communicate this. Conversely, she gently made contact with my arm and her head whilst quietly vocalising. I wondered if she was expressing the need for connection and if this had occurred because through the therapeutic relationship, I had been able to 'hold' her uncertainty and enabled her to express herself. I was also curious about the vocalisation itself and whether she was remembering her early connection with her mother. Although at the end of their time together her mother had found it difficult to manage their life when she was younger, they were very physically connected through the physiotherapy.

The MDT assessments were vital to the understanding of Sarah's behaviour however, the relational work had enabled a deeper understanding and connection with Sarah which enhanced the understanding and formulation around her behaviour.

Assessment and psycho-educational interventions

It is possible with some assessments to support the understanding of the individual. When assessments are difficult or sensitive in nature, working relationally can be helpful.

John is 24-years-old and has a mild learning disability. His parents are divorced and John lives at home with his mother who works full time in a school. John used to spend some weekends with his father, but this stopped when his father got married again, it is reported that John is unhappy that he had to share his father's attention. John has excellent communication skills, he attends the local day centre during the week and he has a volunteering job at a local coffee shop where once a week he helps with cleaning and handing out refreshments. He also enjoys dancing, singing. He is popular and appears very outgoing but sometimes he is 'blamed' for any 'high spirits' at the day centre.

John recently met his social worker to discuss new activities and he talked to her about confusion about his sexual identity. She discussed a referral to psychology to help him to talk about this and John agreed that this might be helpful. John's social worker is however, worried that his family may see this as a way of 'fixing' the situation.

John was supported by his mother when he came to meet with me and we discussed some initial work to help us understand how much he knew about sex and sexuality.

The Assessment of Sexual Knowledge (ASK) (2004) is an assessment that aims to provide health professionals with a tool to assess the sexual knowledge and attitudes of individuals with an intellectual disability.

During the first two sessions John engaged well, communicating as openly as he could. I noticed that he apologised frequently for taking time to think and seemed embarrassed. As he had asked his mum to remain in the session she joined in our work. This also enabled me to observe and engage with the way he naturally and playfully engaged with communication and relationships. When he found things funny he became flamboyant which is the behaviour that is observed at the day centre and I felt I was able to understand this better.

John showed limited understanding in describing the changes that take place within the human body, but he was able to show a better understanding in terms of relationships and was able to identify the age appropriateness. I became aware that the explicit nature of some of the pictures and questions caused John to become embarrassed and distressed and his mother became concerned about how this was affecting him. It was agreed, that at this stage it would be more beneficial if the formal assessment stopped.

I continued with an informal assessment led by John and at his pace which used a different set of questions. I focused on an exploration of the personal meaning of his experience. It was clear that everything seemed uncertain to him and at the same time my feelings in relation to his experience made me think about the uncertainties of life and personal journeys for self-discovery. We discussed this using language that was familiar to him and this was supported by our developing therapeutic relationship.

The last meeting with him started with summarising in simple words some of the things that we talked about and John said that he would just like to know what is OK for him and how to find this answer. I reflected on this and shared that I also have moments when I am uncertain about things in my life and this is the same for many people. We agreed that it is important to know who he can talk to when he is unsure. We listed the people he could talk to in his family and he said he would like to spend more time with his dad to talk about this.

John asked if his mum could join us and talked about his worries being something that many people have when they are finding out about themselves and he would like to talk more with his family, especially his dad. His mother promised John that they would arrange this.

I discussed the sessions with John in supervision and reflected on how important it can be for people to be supported to find their own answers and also how during the sessions I reflected on my own uncertainty and this appeared to 'deepen' our relationship.

I was also able to meet with the team supporting John to ensure that when he was unsure he was most likely to behave in a way that was previously regarded as disruptive. He may seek support from them or he can meet with me again in the future. Also, when John disrupts the programme of activities, he can be reminded that whilst everyone enjoys this there will be an opportunity for singing and dancing later in the day. His contribution should be congratulated at appropriate times.

Working relationally with systems and teams

Working systemically is an approach that is often used when working with individuals with an intellectual disability and is well documented (Baum & Lynggaard, 2006). The value of the approach is that rather than focus on the difficulty being *within* the individual, the focus is on a symptom of a difficulty experienced by the system surrounding the individual and the relationship *between*. Although it is an approach often adopted by clinical psychology and the social work practitioner, the 'Systems Paradigm' which has its roots in family therapy is also described by Bor and Legg in Strawbridge, Dryden and Wolfe (2003). In documenting the 'basic tenets of the systems approach' (p.262), they refer to context, reciprocity, the relationship between, the importance of language collaboration and empathic understanding which perhaps demonstrates the similarity to a relational approach that fits with the philosophy of counselling psychology.

Systemic practice has developed and changed with time and for many practitioners, it now represents a 'post-modern' perspective as is the case for counselling psychology. Dallos and Draper (2005) refer to this idea in relation to developments in systemic family therapy and point to the relevance of the systemic approach,

'...post-modernist thinking eschews the notion of reality and truth and argues that instead there are competing ideas or narratives about the world including families and the role of their dynamics in relating to problems' (p.174)

De Haene (2010) describes family therapy as postmodern and emphasises the role *'of language practices in the intersubjective construction of reality'* (p.3). This idea is relevant to offering support working through the therapeutic relationship.

The role of the relationship in the systemic approach is beginning to be discussed beyond ideas about supporting the system by creating a space for the therapy to take place.

Anderson (2012) discusses collaborative relationships and notes that *'Narrating continually shapes and reshapes the person'* (p.12) and that *'Relationships and conversations are inseparable and influence each other'* (p.14) and refers to Sampson (2008, p.24) who suggests that *'human possibilities, which cannot be readily known in advance or outside the dialogue but emerges as a property of the ongoing dialogue itself'*.

These points seem relevant to the position of counselling psychology in that they refer to the necessity to negotiate between individual perceptions and world views in an intersubjective space. This is relevant in the context of this discussion in relation to negotiating between the ideas, beliefs and views of the person with an intellectual disability

and synthesising the view of the wider system of support and beyond, which may find difficulty in reflecting on the position where understanding or knowing are privileged. This negotiation can occur with an individual or couple between their views and those of the wider context but additionally this work can take place with a wider group or system. A systems approach is often used with families to explore relational difficulties but it also is used with teams of staff to understand situations and difficulties with individuals and or situations.

Jenkins and Parry (2006) describe an intervention informed by systemic theory called 'Network Training' which is an intervention that intentionally brings the system together to reflect on a *difficulty* or problem. The *problem* is named and the focus is on the system and their understanding and interpretation of the problem. The system is supported to take different positions including a person-centred position and a new narrative is generated that enables a richer understanding and offers possibilities for different ways of working. Although the individual is not always present during the meeting, consent is sought for the meeting to take place and they are always at the centre of the discussion.

Formulating with a team

Tom lives in a flat on his own and he was referred to psychology because his behaviour is difficult to manage at his day centre. Specifically, he had been angry with the staff who support him and he had shouted at his peers. When I met him, it seemed that he was really struggling on his own and was very lonely. I wondered if his previous social worker had overestimated his abilities and maybe living alone was not the best thing for him. The difficulty did not seem to be with him but with the situation. Whilst I continued to meet with him weekly and with Tom's consent, I contacted all the people in his support system which included his new social worker, advocate, mental health nurse, learning disability nurse, occupational therapist, and the manager of his day service.

Tom and I had previously discussed what he wanted to tell them about himself although he felt that he would be too stressed to attend. He wanted to tell everyone how lonely and sad he felt and that he was dreading spending another Christmas alone.

We began by introducing ourselves and speaking about our relationship with and to Tom. We then went on to share our knowledge of Tom and co-create an understanding of him and why he may be behaving in ways that his support staff find challenging.

By encouraging the team to tell Tom's story as they understood it and then reflect on the thoughts and feelings that Tom's story stimulated within the team, we were able to reflect on a deeper understanding of Tom. Flaska (1996) reflects on the value of the techniques of Milan therapy such as '*circular questioning and positive connotation both allow for and create a stronger therapeutic bond between the therapist and the family's experience*' (p.43) in this case the stronger bond is between the team, the facilitator and the client. Furthermore, Flaska (1996) suggests that in the systemic context;

'if engagement is understood as a process in therapy, not as an event, the analytic ideas of transference, counter-transference and projective identification may be helpful in a number of ways. They offer

recursive understandings of interactions in the engagement process; they offer a different kind of information about the relationship dilemmas of the client'. (p.45)

This proved to be a useful intervention for Tom. Taking into account his family history and current pattern of engagement with his family, the team thought about the difficulties he may face. Additionally, they took time and were given space to consider how isolated he was. Happily, this enabled more support and he moved into a supported living house.

Summary of document and reflections

The role of a psychologist working in a service supporting people with intellectual disability is varied and will include working with individuals, systems and contexts. Counselling psychologists bring their skills to all situations and contexts. Typically, counselling psychologists work closely with teams and professional colleagues such as occupational therapists, physiotherapists, dieticians, speech and language therapists and social workers to ensure the needs of clients are met. Working collaboratively, carrying out a comprehensive psychological assessment, often including psychometric testing and formulating a treatment plan for each client provides a clear and concise person-centred pathway to wellbeing and recovery. Counselling psychologists are well suited to providing useful and valuable in-house training on a variety of topics and through consultation are able to contribute to care plans. They are also skilled in providing individual and group supervision to psychology colleagues and other professions.

Working through a relational 'lens', counselling psychologists are skilled at recognising multiple sources of information in relation to understanding psychological experiencing, the therapeutic endeavour and relationships with their clients. Transparency, collaboration and dialogue guide counselling psychology practice. Counselling psychologists follow evidence-based therapeutic protocols (for example cognitive behavioural therapy) if the client or context demands it. This would however, be delivered in a particular way – with attention given to the relational aspects, with a critical perspective on how this 'knowledge' has been produced, and with an openness to the subjective and phenomenological experience of the client throughout the process. In this way, both 'doing to' and 'being with' the client are happening, as is something more.

In conversation with Dr Helen Nicholas, the 2015/2016 Chair of the Division of Counselling Psychology we reflected on the role of the counselling psychologist in a service for individuals with an intellectual disability. Whilst counselling psychologists are fewer in numbers in this area of practice, we recognised the contribution of counselling psychologists and counselling psychology practice to these services.

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