# Telephone-delivered compassion-focused therapy for adults with intellectual disabilities: A case series

**Practice Paper**

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Abstract word count: 225
Text word count: 3409
Number of tables: 4
Number of figures: 3

**Funding -** This project was not funded.

**Conflict of interest -** The authors have none to declare

**Acknowledgements -** We wish to thank the clients and their caregivers for allowing us to learn from their experiences.

## Abstract

**Purpose:** Services are increasingly exploring the use of remote conferencing to deliver psychological interventions. These approaches have become particularly important given the COVID-19 pandemic and subsequent infection control guidelines. However, no evidence exists demonstrating the use of remote therapies in people with intellectual disabilities (ID).

**Design:** As part of routine practice within an adult ID community health service, we developed a six-session programme based on Compassion Focused Therapy (CFT), and delivered it to six clients. Clients completed the Psychological Therapy Outcome Scale for Intellectual Disabilities 2nd Edition, at assessment, pre- and post-therapy, as well as a Feasibility and Acceptability measure.

**Findings:** Six clients engaged in telephone-therapy; four clients individually, while the remaining two were supported by their caregiver. Most clients found the intervention helpful, enjoyable and were pleased that they received telephone-delivered psychological therapy. A reduction was observed at post-therapy in distress ($g$=0.33) and risk ($g$=0.69). No difference was reported in psychological wellbeing. Five clients were subsequently discharged from psychological therapy.

**Originality:** To our knowledge, this is the first study examining the use of telephone-therapy (including CFT) for individuals with ID. Findings add to the growing evidence suggesting individuals with ID can benefit from receiving adapted psychological therapies. Research is required to further explore the effectiveness of remote-therapies, who would most likely benefit from this approach and how remote-treatments could be utilised within existing pathways.


Keywords: Learning Disability; Psychological Therapy; Telehealth; CFT; Teletherapy

## Introduction

The COVID-19 pandemic has resulted in mental health services adapting their routine practice in efforts to reduce the spread of the virus, and help keep patients and staff safe (Moreno *et al.*, 2020). While at the same time, these services are essential and have a duty to continue providing accessible and effective interventions for those seeking support for their mental health needs (British Psychological Society, 2020).

Many services have been exploring the acceptability, feasibility and effectiveness of delivering psychological therapies (and assessments) via telephone and videoconference (British Association for Counselling & Psychotherapy, 2020). Whilst evidence exists supporting the use of tele-health in the general population (Dent *et al.*, 2018), there is no data that we are aware of examining the effectiveness of remote therapies for individuals with an intellectual disability (ID). This lack of data could further contribute to healthcare inequalities in people who have ID, reported prior to (Beail, 2016a) and during the pandemic (Iacobucci, 2021). Moreover, the available evidence suggests that less than one-third of people with ID referred to adult ID community health service (N=22) were accepting of remote psychological therapies during the pandemic, with the majority not interested or unable to receive therapy via videoconference due to technology accessibility issues (Rawlings *et al.*, 2021). The Division of Clinical Psychology, Faculty for People with ID published guidance in May 2020, during the pandemic, on how to meet the psychological needs of people with ID (British Psychological Society, 2020). While therapeutic contact via telephone or video was recommended, the potential barriers were discussed including the client experiencing difficulties in communicating with or understanding the professional, and given that carers may need to help clients engage with remote contact, the possible consent and confidentiality concerns.

Within the general population, evidence is increasing supporting the effectiveness of Compassion-Focused Therapy (CFT) for a range of mental health difficulties (Leaviss & Uttley, 2015, Craig, Hiskey & Spector, 2020) – including anxiety and uncertainty associated with the COVID-19 pandemic (Whalley & Kaur, 2020). CFT is a skills-based approach integrating theories from Buddhism, evolution, neuroscience, and social and developmental psychology (Gilbert, 2009, 2014). This therapeutic modality was developed following evidence suggesting people with psychological problems often experience high levels of shame and self-criticism (Gilbert, 2014).

CFT is viewed as a transdiagnostic approach aiming to help individuals develop compassion for themselves (i.e. self-compassion) and others (i.e. giving compassion and receiving compassion). This is also known as the flows of compassion in the CFT literature (Gilbert, 2014). The overall goal of CFT is to help clients improve their wellbeing and reduce psychological distress (Leaviss & Uttley, 2015, Craig, Hiskey & Spector, 2020). In therapy, clients are introduced to a simplified evolutionary model of motivational regulation (referred to in CFT as the Three Circles model; Gilbert, 2014), conceptualised as the Threat, Drive and Soothing systems. A key part of CFT is that clients are encouraged to practice a range of compassion-focused strategies (called Compassionate Mind Training) aimed at developing their compassion(ate) motivation and facilitating related capacities for self-soothing and courage-stimulation (Lucre & Clapton, 2020), thus creating a greater balance between these systems (Irons & Beaumont, 2017).

Studies adapting and applying CFT to individuals with ID presenting to services with mental health needs is growing. In fact, compassion-based approaches may be particularly suited to individuals with ID (Cowles *et al.,* 2018). For example, reflecting on the flows of compassion, this group have reported to be at a greater risk of experiencing self-criticism, abuse and hostility from others, and enmeshed in unhelpful relationships (Clapton, Williams

& Jones, 2018, Davies *et al.,* 2020, Marriott *et al.,* 2020). There are also suggestions that CFT relies less on cognitive abilities than other psychological therapies (Cooper & Frearson, 2017) – possibly due to its focus on behavioural and practical skills. Whilst CFT is a motivational multimodal process-based psychotherapy, some of its therapeutic processes and interventions are consistent with those targeted by, and found in, third-wave Cognitive Behavioural Therapy (CBT) approaches (Patterson, Williams & Jones, 2019). CBT has a (relative) extensive research base in ID (Jahoda *et al.,* 2017) and is recommended by the National Institute for Health and Care Excellence for mental health difficulties in people who have ID (National Institute for Health and Care Excellence [NICE], 2016). Finally, in the context of the COVID-19 pandemic specifically, CFT may be particularly relevant to people with ID given its focus on fostering feelings of social safeness and connectedness (Kelly, Zuroff, Leybman & Gilbert, 2012, Gilbert, 2020, Armstrong, Nitschke, Bilash & Zuroff, 2021). Indeed, high levels of social isolation and loneliness have been reported by individuals with ID as a result of the pandemic, with the majority of their carers feeling people with ID are not getting the support and care they need (Scottish Commission for Learning Disability, 2020).

CFT has been shown to be helpful when delivered on a one-to-one basis for clients with ID presenting with anxiety (Hardiman *et al.,* 2017), low mood, overeating (Cooper & Frearson, 2017) and difficulties associated with trauma (Cowles *et al.,* 2018). This therapeutic approach has also been shown to be clinically useful and acceptable when delivered in a group format (Goad & Parker, 2020). Clapton, Williams, Griffith and Jones (2018) developed and tested a six-session CFT group for intellectual disabilities (CFT-ID) named ‘Growing Kind Minds’. Six clients with depression and/or anxiety were treated using the programme. The majority of participants found aspects of the intervention enjoyable (97.1%), helpful (91.2%) and easy to engage with (76.5%). Moreover, outcome measures

suggested a significant reduction in self-criticism and social comparisons - although no significant difference was observed in psychological distress ($p$=0.34); however this should be interpreted in light of the study being underpowered.

As part of routine practice and in response to the infection control guidelines associated with the COVID-19 pandemic, we developed a six-session CFT programme that was telephone-delivered to six clients with ID while under the care of a community health service. The primary aim of this report was to examine the feasibility and acceptability of delivering psychological therapy to individuals with ID remotely, with a secondary aim to explore the preliminary effectiveness of this approach. Given the limited research base in ID, practice-based case studies have a valuable role in effectiveness research (Beail, 2016b). To our knowledge, this is the first report investigating the implementation of a psychological therapy (including CFT) delivered remotely for individuals with ID.

## Method

### Service Evaluation Design

The current report is a retrospective service evaluation of routine data collected from six clients between June and September 2020. Clients had been referred for psychological therapy at an adult ID community health service in a Metropolitan Borough in the north of England with a population of 245,200. For more information on the service see Jackson & Beail, (2016). Clients had received one face-to-face triage appointment prior to the UK lockdown (March 2020), which prevented patients from attending the service in person for routine appointments.

An opportunity sampling method was used. All clients waiting for psychological therapy within the service were rated in May 2020 by a Consultant Clinical Psychologist using the Red/Amber/Green (RAG) system considering potential suitability for

remote/indirect service provision (see Rawlings *et al.,* (2021) for further information). This assessment considered cognitive ability, risk and presenting problem. Overall, 22 clients and were suitable, six of whom agreed to have remote therapy (opposed to waiting for face-to-face therapy in the future) and were allocated to a second-year trainee clinical psychologist (the first author, referred to here as the "therapist") while on placement at the service from April – September 2020. The therapist had already completed his CFT competencies as part of his doctoral training in clinical psychology. The therapist received weekly supervision from a Consultant Clinical Psychologist. Reasons for clients not being suitable for remote therapy included, preferring to wait for face-to-face therapy, not being able to talk over the phone for the clinician to complete an assessment, and the client could not be contacted (Rawlings *et al.,* 2021).

All clients involved in the current evaluation were given the option of receiving therapy via telephone or videoconference (please see Rawlings *et al.,* (2021) for additional information). Five of the clients opted for telephone-therapy, while one client requested for video-therapy using her carer's phone. Unfortunately and despite several attempts, the carer's phone could not connect to the link and so the client agreed to receive telephone-therapy.

At the post-therapy stage, all clients were informed of the service evaluation and provided written and/or verbal consent for their data to be used for the purpose of this report. Their consent and responses were recorded in an Excel database. The two-stage test was used to obtain consent; the first author confirmed clients understood and retained the information, and communicated and expanded on their decision (Department of Health, 2005). All clients provided consent to receive psychological treatment; the two clients supported by their caregiver also gave consent for their caregiver to be included in therapy.

The service evaluation was commissioned and approved by the head of psychological services. It was registered with the Quality Improvement and Assurance Team of the Trust

and reviewed by the Clinical Psychology Unit, University of Sheffield. As this study was a service evaluation, ethical consent was not required and therefore not sought. All identifying information has been removed and measures taken to ensure clients' anonymity.

## Measures

### *Psychological Therapy Outcome Scale for Intellectual Disabilities (PTOS-ID II)*

As part of routine practice at the service, all clients were asked to complete the Psychological Therapy Outcome Scale for Intellectual Disabilities – 2nd Edition (PTOS-ID II) (Jackson *et al.,* 2017; Vlissides *et al.,* 2017). This measure examines: (i) psychological distress; exploring depression, anxiety and anger (16-items); positive wellbeing (11-items) and risk (5-items).

Clients are asked to report "*over the past week*" how often they have experienced each of the items by endorsing the following categories: "*Not at all*", "*A little bit*", "*Sometimes*" and "*A lot"*. Scores on the distress measure range from 0–48, wellbeing 0–33 and risk 0-15. A greater score on distress and risk suggests worse functioning, whereas a higher sore on wellbeing is indicative of better health.

Psychological distress and positive wellbeing indexes have good internal consistency ($\alpha$=0.85 and $\alpha$=0.81 respectively). A score of 16 or above on psychological distress indicates the clinical level and the respondent may require professional care.

Clients completed the PTOS-ID II with the therapist during the initial assessment (T1), first (T2) and final therapy session (T3). Time between T1 and T2 varied between 2-4 weeks (median = 3 weeks).

*CFT-ID Feasibility and Acceptability Measure (revised)*

At the final session, clients were asked to complete an adapted version of the CFT-ID feasibility and acceptability measure developed by Clapton *et al.,* (2018). This measure consisted of eight questions asking: how much of the session did clients understand, were the sessions focusing on compassion helpful, how helpful was the homework, how easy/hard was the homework, were the sessions enjoyable, how easy/hard was having therapy over the telephone, were they pleased to have telephone-therapy opposed to waiting for face-to-face therapy, and would clients recommend CFT to a friend (see Table 3 for more information).

Unbeknown to the authors until after the intervention, one client journaled her experience of engaging in the CFT programme. Written permission from the client (and verbal consent form the clients' mother) were obtained to transcribe her entries and use the content for the purpose of this report. Such data provides unique insights into the acceptability of this approach, including how CFT concepts and skills can be incorporated into everyday life (Fig 2-3). A mixed-methods approach is consistent with a previous study investigating the use of CFT in people with ID (Hardiman, Willmoth & Walsh, 2017).

**Intervention**

The intervention was developed and delivered by the therapist. The programme was designed to consist of six-weekly sessions lasting 30-50 minutes. The intervention was guided by the CFT-ID protocol of the 'Growing Kind Minds' intervention discussed previously (Clapton *et al.,* 2018). The programme was revised due to the remote method of delivery, and based on qualitative and quantitative evidence examining CFT with people who have ID (Clapton *et al.,* 2018; Cowles *et al.,* 2018). For example, in Clapton et al's study, participants found it difficult to comprehend evolutionary concepts of CFT and apply it to their day-to-day life. Therefore, this was not discussed here and instead, the focus of that

session was to help clients better understand the three systems by conceptualising it in their daily activities (see Table 1).

Table 1 Summary of CFT ID individual programme

| Session | Content | Homework (exercise) |
|---|---|---|
| 1 | Introduction and explore concept of compassion, experiences of compassion, advantages and disadvantages of compassion. | Develop a self-soothe box to begin practicing self-compassionate (Fig 2). |
| 2 | Introduction to three systems model – threat, drive and soothe. Discussion around feelings, thoughts and experiences associated with each system. | Practice calm-breathing to start activating soothe system. |
| 3 | Continuation of the three systems developing a mini formulation based on the size/activation of each system for each client. Discuss the goal of CFT to make the three systems equal and link to compassion. | Practice compassionate activities/behaviours to continue to activate the soothe system and cope with overactive threat/drive systems. |
| 4 | Discuss flows of compassion focusing on self-compassion. Explore differences between self-compassion and self-criticism, and consequences. | Practice compassionate self by saying compassionate statements, including compassionate mirror task. |
| 5 | Continuation of flows of compassion focusing on compassion towards others. Explore the importance of being kind to others and the impact on self and others. | Practice compassionate acts to others. |
| 6 | Review concepts and skills developed, reflect on changes made, complete outcome and acceptability measure (see below) and discuss next steps (i.e. discharge, referral). | Continue exercises from previous weeks (Fig 3). |

CFT = Compassion Focused Therapy

Prior to the first sessions, clients received via post, a CFT ID programme booklet developed by the therapist (Figure 1). Clients were asked to have this booklet with them in preparation for each session. The booklet was used to help clients visualise and refer to aspects of CFT. If clients did not have their booklet, the therapist assessed whether the client

could engage in the next session as planned, or whether to use the appointment to build on the knowledge and skills the client had already developed.

Session duration was dependent on the client's ability to stay engaged. This was assessed by the therapist on a session-by-session basis. The therapist arranged appointments with clients at the end of each session considering client's availability. This is congruent with evidence advocating therapists to offer greater flexibility regarding days and times of appointments for people with ID to help improve with adherence (Lewis, Lewis & Davies, 2016). If the client did not answer the phone at the agreed time of the session, they were tried two more times within the space of ten minutes. If clients did not attend, they were sent a letter stating a date and time that the therapist would contact them at to arrange their next session.

Clients worked systematically through the programme receiving each session, even if they failed to attend a session when it was originally scheduled. As the therapist finished the placement at the service in September 2020, all clients concluded the intervention by receiving session six at that time; regardless of whether they had completed the full programme.

>insert figure 1<

Figure 1 Pages from the CFT ID programme booklet. Journal entry: "*I wasn't sure about phone therapy because I struggle to understand* [people on the phone] *because of my autism, but I decided to try because I was feeling bad and lonely and needed help. [The therapist] phoned me and gave me a day to start a therapy. I am happy to start therapy and it will be a lot more easier with* [sic] *talk to people like my mum and all support workers. [Therapist] sent me a booklet in the post for when we started."*

## Data analysis

Descriptive statistics were used to present client's demographic, clinical information and data collected using the feasibility and acceptability measure. One client did not complete the PTOS-ID II measure during the assessment stage as their first session started the week after. Due to the small sample size (n=6), *p* values were not described as the investigation was underpowered. Instead, effect sizes using Hedges' *g* have been reported using 95% confidence intervals – this analysis is more reliable for smaller sample sizes (n<20) (Lakens, 2013). Statistical analyses were conducted using an online effect size calculator (Uanhoro, 2017). The following were used to interpret effect sizes: ≤0.2 small, ≤0.5 medium and ≥0.8 large (Cohen, 1977). SPSS25 (IBM, 2017) was used for inferential statistics (i.e. determining correlation coefficients to calculate *g)*. Clinical and non-clinical norms are unavailable for the PTOS-ID II and so reliable change indexes could not be calculated (Vlissides et al., 2017). However, the cut off score of 16 was used to help explore change (Jackson et al., 2017).

# Results

## Demographics

The average age of clients was 34.2 years (SD=12.6). The entire sample was female. Five of the six clients classified as White British. Clients' demographical information, reason for referral, and number of sessions completed are shown in Table 2.

Table 2 Client's demographics and clinical information

| ID | Age | Gender | Reason for referral | No. of CFT sessions completed | No. of sessions in total |
|---|---|---|---|---|---|
| 1 | 20s | Female | Anger | 2 (session 1 & 6) | 4 |
| 2 | 30s | Female | Anxiety | 6 | 6 |
| 3 | 40s | Female | Anxiety, depression, health-anxiety | 6 | 6 |
| 4 | 20s | Female | Anxiety, depression, self-harm | 6 | 6 |
| 5 | 50s | Female | Anxiety, depression, loss | 5 (missed session 5) | 6 |
| 6 | 20s | Female | Anxiety, depression | 6 | 6 |

CFT = Compassion Focused Therapy

**Feasibility**

Four of the clients were able to engage in the programme individually, whereas two clients were supported by their carer. Carers helped to expand on what the therapist and client were discussing, and assisted the client in using CFT skills outside of sessions.

Four clients received all six CFT sessions between July and September 2020. One client received five CFT sessions (one of the sessions was replaced to discuss risk associated with the client's living situation). The final client received the first and last CFT session as she kept forgetting her CFT booklet and the therapist did not want to introduce the three systems without visual aids. This client had already received eight sessions of psychotherapy ending in March 2020. During the four therapy sessions, the therapist and client used compassion to help further develop and consolidate her existing psychological skills. In session four, the therapist and client mutually agreed for the client to be discharged from psychological therapy (Table 2).

**Acceptability**

All six clients reported finding the programme "helpful" and enjoyed focusing on compassion. All but one would recommend CFT to a friend if they were experiencing

problems with their own mental health; one was not sure (this client however only received two sessions). Five clients found the homework "easy" and were "pleased" they had telephone-therapy, although half did find this approach "a bit hard". Four clients found the homework helpful. While the context of sessions was tailored to the client's ability, four clients only understood "some" of the information discussed (Table 3).

Table 3 Adapted feasibility and acceptability questionnaire

| Question | Response |
|---|---|
| How much of the session did you understand? | All 33.3%<br>Some 66.6%<br>None 0% |
| Did you find the sessions focusing on compassion helpful? | Yes 100%<br>No 0%<br>Not sure 0% |
| How helpful did you find the homework focusing on compassion? | Very 66.%<br>A bit 33.3%<br>Not helpful 0% |
| How easy/hard was the homework? | Easy 83.3%<br>A bit hard 17.6%<br>Very hard 0% |
| Did you enjoy focusing on compassion? | Yes 100%<br>Not 0%<br>Not sure 0% |
| How easy/hard was having therapy over the phone? | Easy 50%<br>A bit hard 50%<br>Very hard 0% |
| Are you pleased you had telephone therapy opposed to waiting for waiting for face-to-face? | Yes 83.3%<br>Not sure 17.6%<br>No 0% |
| Would you recommend CFT to a friend? | Yes 93.3%<br>Not sure 17.6%<br>No 0% |

CFT = Compassion Focused Therapy

>insert figure 2<

Figure 2 Photo of client's soothe box. Journal entry: "*We* [therapist and client] *talked about what is compassion like being listened to, be cared, and loved, respected to others and kind to each other and to be supported* [sic]. *We also talk* [sic] *about what is not compassion like not being kind to others, with judging and bullying and making me feel scared. He* [therapist] *gave me homework to make a soothe box to keep all the nice things together. I've really enjoyed making this, so I went shopping and bought a box to decorate with things that I like. I really like my soothe box, I use it a lot when I'm so sad.*

>insert figure 3<

Figure 3 Example of incorporating CFT skills in everyday practices: Journal entry: "*Mum has put my work on my board to remind me to practice everyday* [sic] *so me and my support workers can see how my feelings are and help me to feel better by using a soothe box and breathing. I use my board when I* [sic] *don't feel like talking and everyone can see the board and help me. I have learnt to get my* [self-soothe] *box and do my breathing by myself before I get too cross* [frustrated, angry] *and fed up. I can calm myself down instead of saying "shut up"".*

**Preliminary effectiveness and outcome**

Table 4 provides a summary of self-reported changes on the PTOS-ID II measure between assessment, pre-therapy and post-therapy. Overall, improvements were observed between assessment and post-therapy ($g$=0.27*)*, and pre- and post-therapy ($g$=0.33*)* in psychological distress demonstrating a small effect size. A small reduction in positive wellbeing was observed between the assessment and post-therapy ($g$=0.24*)*, however no significant effect was reported between pre-therapy and post-therapy ($g$=≤0.2*)*. A small improvement was reported in risk between assessment and post-therapy ($g$=0.4*)*, which had increased to a medium effect between pre- and post-therapy ($g$=0.69*)*. Five clients were above the clinical cut off on distress pre-therapy, which reduced to three post-therapy.

Following treatment, five of the clients were discharged from psychological therapy. One client was accepted for face-to-face therapy due to her level of distress. Additional health needs were identified in two clients and were subsequently referred to other pathways

within the service (behavioural pathway and occupational therapy). None of the clients deteriorated in terms of risk.

Table 4 PTOS-ID II results; means (SD); Effect sizes Hedges' *g*, [CI 95%]

| Measure | | Assessment | Pre-therapy | Post-therapy | Effect sizes | | |
|---|---|---|---|---|---|---|---|
| | | | | | Assessment vs pre-therapy | Assessment vs post-therapy | Pre-therapy vs post-therapy |
| PTOS-ID II | Psychological distress | 21.4 (14.5) | 22 (13.7) | 16.8 (13) | 0 [-0.64, 0.56] | 0.27 [-0.33, 0.97] | 0.33 [-0.02. 0.77] |
| | Positive wellbeing | 22.8 (4) | 22 (5.2) | 21.3 (5.7) | 0.14 [-0.8,1.1] | 0.24 [-1.12, 1.7] | 0.1 [-0.9, 1.16] |
| | Risk | 1.2 (1.6) | 2 (2.3) | 0.5 (1.2) | -0.3 [-0.88,0.1] | 0.4 [-0.39, 1.33] | 0.69 [-0.12, 1.7] |

PTOS-ID II = Psychological Therapy Outcome Scale for Intellectual Disabilities 2nd edition

## Discussion

This is the first report that the authors are aware of examining the use of telephone delivered psychological therapy for adults with ID. The findings are novel in that regard and have important clinical implications, which are particularly relevant given the current climate as services for people who have ID are adapting their practice to meet the care needs and safety requirements of a COVID-19 world.

Notwithstanding the modest sample size and the fact effectiveness was not the primary aim of this evaluation, findings add to the growing evidence suggesting individuals with ID can benefit from adapted psychological therapies (Beail, 2016b). More specifically, CFT delivered within a routine clinical practice appears safe and can help a sub-group of individuals with ID manage their psychological distress. The methodological design further supports the practice of gaining feedback from clients with ID regarding their level of care to further develop service pathways (MacDonald *et al.,* 2003).

All clients self-reported the programme as helpful and enjoyable. Of those who attended more than two sessions, all would recommend CFT to a friend. High rates of attendance (83%) were also observed across the group – indeed, rates of adherence in remote therapies are often greater than attritions rates reported in face-to-face treatments (Mohr *et al.,* 2013). Such findings appear consistent with the previous study investigating the acceptability of a protocol-driven CFT programme for individuals with ID (Clapton *et al.,* 2018). However, given that Clapton *et al's.,* programme was delivered within a group setting, the authors questioned what role (if any) group effects had on client's level of satisfaction. Our study suggests clients report similar benefits when CFT is delivered individually, further supporting the acceptability of this approach in this population. Finally, extrapolated from the client's journal entries, the findings show that CFT principles delivered by drawing on key concepts of the 'Compassionate Kitbag' (Lucre & Clapton, 2020) can become tangible,

concrete and accessible for some people with ID, as the client was able to transfer theoretical and abstract ideas to her everyday life.

Results indicate after treatment on the group level; clients reported an improvement using the PTOS-ID II in psychological distress measuring a small effect size ($g$=0.33) and a reduction in risk at the medium level ($g$=0.69). However, no significant difference (≤0.2) was observed in positive wellbeing following treatment. None of the clients experienced a deteriorated in levels of risk. Five clients were subsequently discharged from psychological therapy, while the remaining client was assessed as needing face-to-face therapy given her presenting problem. Moreover, additional needs were identified in two clients who were in a position to receive treatment following the intervention.

In order to have greater confidence in the findings, future research is now needed to explore remote psychological therapies in people with ID using a sufficiently powered and controlled methodological design examining clinical and cost-effectiveness. Indeed, while the sample size largely reflected the number of clients suitable for this approach within an adult ID community health service, it was only modest affecting the reliability of the findings. However, before this step, pilot research studies collating qualitative and quantitative evidence examining the acceptability and feasibility of delivered treatments could be used to help improve on different aspects of remote interventions, such as identifying active (and inactive) behavioural change techniques associated with tele-therapies in ID. For example, while the intervention was adapted based on the available evidence base, two-thirds only understood “some” of the information that was discussed. At this stage, it is unclear whether this was a result of the content per se, remote method of delivery posing additional challenges on client’s level of comprehension, or both. Nevertheless, it further highlights the need for psychological therapies to be tailored to the client’s ability.

The largest reduction was observed in risk to self and others. CFT has been suggested to help clients manage motives underpinning self-harm; for instance, helping individuals to regulate their emotional states; promote self-compassion allowing clients to challenge triggers of self-punishment; and facilitate in more helpful ways of relating to others (Vliet & Kalnins, 2011). Future research is required to explore the link between compassion and risk-related behaviours, as well as other psychological correlates, in those with ID. This approach could be used to help supplement and guide other therapeutic modalities for clients presenting with risk. For example, studies investigating clinical samples without ID have begun exploring the correlation between self-compassion and health-related outcomes such as anxiety, depression, quality of life and coping, to help inform the role of therapies focusing on the development of compassion (Clegg, Sirois & Reuber, 2019).

This evaluation supports the need for future research to explore how remote therapy could supplement existing pathways for people with ID. Evidence from the general population suggests face-to-face therapies tend to be more effective than over-the-telephone for severe symptoms (Hammond *et al.*, 2012); therefore, a stepped care approach for people with ID may be more suitable, as Jackson and Beail (2016) suggest. Combined with our finding that only six from 22 clients were suitable to receive remote therapy, possibly a blended-stepped care model offering clients the option of face-to-face or remote-delivered services could also help to improve acceptability, while not at the expense of overall effectiveness (Wentzel et al., 2016). Stepped care pathways are recommended for adults and children without an ID, for depression and anxiety disorders (NICE, 2009, 2014, 2019). Indeed, stepped care can help to increase the accessibility of psychological therapies, reduce waiting times and provide people with an appropriate level of care, while at the same time providing cost-effective and helpful treatments (Ho *et al.*, 2016). Indeed, people with ID examined elsewhere have raised the issue of having to wait a long time before seeing a

psychologist (Lewis *et al.,* 2016). In this context, remote-delivered CFT could be offered to suitable clients with ID presenting with mild to moderate psychological difficulties in the first instance, before stepping up (or down) care to more intensive approaches (if necessary). However, as not all clients were suitable for remote therapy, an important first stage is to explore acceptability rates in a larger ID population helping to determine which clients would most benefit from this approach. This should also consider client's motivation to engage in remote-therapy. While the therapist set homework after each session, as reflected in the journal entries, clients were required to take some degree of ownership of their treatment and become self-directed in applying their skills. Motivation to engage has also been discussed by patients with ID when reflecting on their experience of receiving psychological therapy, demonstrating the importance of clients wanting to make changes (Lewis *et al.*, 2016), as oppose to acquiescing or changes being imposed by others.

*Limitations*

The findings should be viewed in light of the following limitations:

Qualitative data was not purposively collected as a method to further examine acceptability of the intervention. As demonstrated the by client's journal entries reported here and not withstanding any potential biases given how this data was collected, such evidence could have provided greater insight into clients' experiences, and help to consider how best to develop the programme and integrate it within existing care pathways for people with ID. For example, it has been recognised that there is a need to develop creative ways to apply and adapt CFT principles drawing together a 'Compassionate Kitbag' for clients, taking into consideration their need, ability and presenting difficulty (Lucre & Clapton, 2020). No follow-up data was collected post-therapy – this was largely due to the therapist leaving the service as the placement ended. Clients could have been contacted at a later date to explore

whether any therapeutic effects were maintained over time. Although clients were systematically screened for suitability, no conclusions can be made regarding possible selection biases in this process. Moreover, figures of how many clients were originally screened and excluded (and why) were not available. As one therapist delivered the treatment to all clients, we cannot explore the possible impact of therapist effects nor the validity of the results. This is particularly pertinent given that the therapist completed all measures with the client and therefore, results could be influenced by demand characteristics. Finally, no specific CFT-related measure was used. This could have helped to investigate factors assumed to underpin this therapeutic approach such as, social compassion or reduction in self-criticism. For example, the Adapted Self-Compassion Scale or Adapted Social Compassion Scale – as was used in the study by Clapton *et al.,* (2018) – could have been utilised here. However, it is important to recognise that such measures have not been validated in those with ID and previous research has suggested this population require considerable support when completing such questionnaires (Hardiman *et al.,* 2017). Future research is required to reliably examine key concepts of CFT, in people with ID.

*Conclusions*

The findings add to the growing evidence suggesting individuals with ID can benefit from receiving psychological therapies, including CFT, when adapted to their need and ability. Initial results of remote therapy in those with ID with mild to moderate mental health difficulties seem promising and warrant further research.

## References


Armstrong III, B. F., Nitschke, J. P., Bilash, U., & Zuroff, D. C. (2021), An affect in its own right: investigating the relationship of social safeness with positive and negative affect, *Personality and Individual Differences*, Vol. 168, pp. 109670.

Beail, N. (2016a), "Innovation, adaptation and reasonable adjustments to ensure equality of access to psychological therapies", in N. Beail (Ed.), *Psychological therapies and people who have intellectual disabilities,* Leicester, UK: British Psychological Society, pp. 140-141

Beail, N. (2016b), *Psychological therapies and people who have intellectual disabilities.* Leicester, UK: British Psychological Society.

British Association for Counselling & Psychotherapy (2020), "*Competences for telephone and e-counselling",* available at: https://www.bacp.co.uk/media/8113/bacp-competences-for-telephone-ecounselling-apr20.pdf

British Psychological Society (2020), "*Guidance for psychological professionals during the Covid-19 pandemic"*, available at: https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20for%20psychological%20professionals%20during%20Covid-19.pdf

British Psychological Society (2020), "*Covid-19: Meeting the psychological needs of people with learning/intellectual disabilities, and their families and staff"*, available at: https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Meeting%20the%20psychological%20needs%20of%20people%20with%20learning%20or%20intellectual%20disabilities%2C%20and%20their%20families%20and%20staff.pdf

Cohen, J. (1977), *Statistical power analysis for the behavioral sciences*, New York: Routledge.

Clapton, N. E., Williams, J., Griffith, G. M., & Jones, R. S. P. (2018), ' Finding the person you really are … on the inside': Compassion focused therapy for adults with intellectual disabilities, *Journal of Intellectual Disabilities,* Vol. 22 No. 2, pp.135-153. doi:10.1177/1744629516688581

Clapton, N. E., Williams, J., & Jones, R. S. (2018), The role of shame in the development and maintenance of psychological distress in adults with intellectual disabilities: a narrative review and synthesis, *Journal of Applied Research in Intellectual Disabilities*, Vol. 31 No. 3, pp. 343-359.

Clegg, S., Sirois, F., Reuber, M. (2019), Self-compassion and adjustment in epilepsy and psychogenic nonepileptic seizures, *Epilepsy and Behaviours*, Vol. 100, No. Part A, pp. 106490.

Cooper, R., & Frearson, J. (2017). Adapting compassion focused therapy for an adult with a learning disability—A case study, *British Journal of Learning Disabilities,* Vol. 45 No. 2, pp.142-150. doi:10.1111/bld.12187

Cowles, M., Randle-Phillips, C., & Medley, A. (2018). Compassion- focused therapy for trauma in people with intellectual disabilities: A conceptual review, *Journal of Intellectial Disabililties,* Vol. 24 No. 2, pp. 212-232.

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: a systematic review of its effectiveness and acceptability in clinical populations. *Expert Review of Neurotherapeutics*, Vol. 20 No. 4, pp. 385-400.

Davies, L., Randle-Phillips, C., Russell, A., & Delaney, C. (2020), The relationship between adverse interpersonal experiences and self-esteem in people with intellectual disabilities: The role of shame, self-compassion and social support, *Journal of*

*Applied Research in Intellectual Disabilities, Online ahead of print,* doi: 10.1111/jar.12844

Dent, L., Peters, A., Kerr, P. L., Mochari-Greenberger, H., & Pande, R. L. (2018). Using Tele health to Implement Cognitive- Behavioral Therapy, *Psychiatric Servives,* Vol. 69, No. 4, pp. 370-373. doi:10.1176/appi.ps.201700477

Department of Health (2005), *Mental Capacity Act*, London: HMSO.

Gilbert, P. (2009), Introducing compassion- focused therapy, *Advances in Psychiatric Treatment,* Vol. 15, No. 3, pp.199-208. doi:10.1192/apt.bp.107.005264

Gilbert, P. (2014), The origins and nature of compassion focused therapy, *British Journal of Clinical Psychology,* Vol. 53, No. 1, pp. 6-41. doi:10.1111/bjc.12043

Gilbert, P. (2020). Compassion: From its evolution to a psychotherapy, *Frontiers in Psychology*, Vol. 11, pp. 3123.

Goad, E. J., & Parker, K. (2020), Compassion-focused therapy groups for people with intellectual disabilities: An extended pilot study, *Journal of Intellectual Disabilities*, Ahead of print, 10.1177/1744629520925953

Hammond, G. C., Croudace, T. J., Radhakrishnan, M., Lafortune, L., Watson, A., McMillan-Shields, F., & Jones, P. B. (2012), Comparative Effectiveness of Cognitive Therapies Delivered Face-to-Face or over the Telephone: An Observational Study Using Propensity Methods, *PLoS One,* Vol. *7* No. 9, e42916. doi:10.1371/journal.pone.0042916

Hardiman, M., Willmoth, C., & Walsh, J.J. (2017), CFT & people with intellectual disabilities, *Advances in Mental Health and Intellectual Disabilities,* Vol. 12 No. 1, pp. 44-56.

Ho, F. Y., Yeung, W., Ng, T. H., & Chan, C.S. (2016), The efficacy and cost-effectiveness of stepped care prevention and treatment for depressive and/or anxiety disorders: A

systematic review and meta-analysis, *Scientific Reports*, Vol. 6, 29281. Doi: 10.1038/srep29281

Iacobucci, G. (2021), Covid-19: GPs opt to prioritise all patients with learning disabilities for vaccination, *BMJ*, Vol. 372, pp. n510.

IBM Corp. (Released 2017), IBM SPSS Statistics for Windows [Computer software], Version 25.0. Armonk, New York: IBM Corp.

Irons, C. & Beaumont, E. (2017), *The compassionate mind workbook: A step-by-step guide to developing your compassionate self*, London UK: Robinson.

Jackson ,T. & Beail, N. (2016), "Delivering psychological therapies: Managing referrals, pathways and stepped care", in N. Beail, N (Ed.) *Psychological therapies and people who have intellectual disabilities*, Leicester, UK: British Psychological Society, pp.11-19

Jackson T., Beail, N., & Vlissides, N. (2017), *Psychological therapies outcome scale for people who have intellectual disabilities (PTOS-ID) manual*, Unpublished manual

Jahoda, A., Kroese, B. S., & Pert, C. (2017), *Cognitive behaviour therapy for people with intellectual disabilities: Thinking creatively*, London, UK: Palgrave Macmillan.

Kelly, A. C., Zuroff, D. C., Leybman, M. J., & Gilbert, P. (2012), Social safeness, received social support, and maladjustment: Testing a tripartite model of affect regulation, *Cognitive Therapy and Research*, Vol. 36 No. 6, pp. 815-826.

Lakens, D. (2013), Calculating and reporting effect sizes to facilitate cumulative science: a practical primer for t- tests and ANOVAs, *Frontiers in Psychology*, Vol. 4, 863 doi:10.3389/fpsyg.2013.00863

Leaviss, J., & Uttley, L. (2015), Psychotherapeutic benefits of compassion- focused therapy: an early systematic review. *Psychological Medicine*, Vol. 45 No. 5, pp. 927-945. doi:10.1017/S0033291714002141

Lewis, N., Lewis, K., & Davies, B. (2016), 'I don't feel trapped anymore… I feel like a bird': People with learning disabilities' experience of psychological therapy, *Journal of Applied Research in Intellectual Disabilities,* Vol. 29 No. 5, pp. 445-454.

Lucre, K., & Clapton, N. (2020), The compassionate kitbag: A creative and intergrative appraoch to compassion-focused therapy, *Psychology and Psychotherapy: Theory, Research and Practice,* Early View, e12291.

MacDonald, J., Sinason, V., & Hollins, S. (2003), An interview study of people with learning disabilities' experience of, and satisfaction with, group analytic therapy, *Psychology and Psychotherapy: Theory, Research and Practice,* Vol. 76 No. 4, pp. 433-453.

Marriott, C., Parish, C., Griffiths, C., & Fish, R. (2020), Experiences of shame and intellectual disabilities: Two case studies, *Journal of Intellectual Disabilities,* Vol. 24, No. 4, pp. 489-502.

Mohr, D. C., Ho, J., Duffecy, J., Reifler, D., Sokol, L., Burns, M. N., . . . Siddique, J. (2012), Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients: A Randomized Trial, *JAMA,* Vol. 307 No. 21, pp. 2278-2285. doi:10.1001/jama.2012.5588

Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., . . . Arango, C. (2020), How mental health care should change as a consequence of the COVID- 19 pandemic, *The Lancet. Psychiatry,* Vol. 7 No. 9, pp 813-824. doi:10.1016/S2215-0366(20)30307-2

National Institute for Health and Care Excellence. (2009), "*Depression in adults: recognition and management* (Nice Quality Standard No. CG90)", available at: https://www.nice.org.uk/guidance/cg90/resources/depression-in-adults-recognition-and-management-pdf-975742636741

National Institute for Health and Care Excellence. (2014), "*Anxiety disorders"* (Nice Quality Standard No. QS54), available at: https://www.nice.org.uk/guidance/qs53/resources/anxiety-disorders-pdf-2098725496261

National Institute for Health and Care Excellence. (2016), "*Mental health problems in people with learning disabilities: prevention, assessment and management"* (NICE Quality Standard No. NG54). Retrieved from (NICE Quality Standard No. 39), available at: https://www.nice.org.uk/guidance/ng54/resources/mental-health-problems-in-people-with-learning-disabilities-prevention-assessment-and-management-pdf-1837513295557

National Institute for Health and Care Excellence. (2019), "*Depression in children and young people: identification and management"* (Nice Quality Standard No. NH134), available at: https://www.nice.org.uk/guidance/ng134

Patterson, C. W., Williams, J., & Jones, R. (2019), Third-wave therapies and adults with intellectual disabilities: A systematic review, *Journal of Applied Research in Intellectual Disabilities*, Vol. 32 No. 6, pp. 1295-1309.

Rawlings, G. H., Gaskell, C., Rolling, K. & Beail, N. (2021), Exploring how to deliver videoconference-mediated psychological therapy to adults with an intellectual disability during the coronavirus pandemic, *Advances in Mental Health and Intellectual Disabilities*, Vol. 15, No. 1, pp. 20-32.

Scottish Commission for Learning Disability, (2020), "*The impact of coronavirus on people with learning disabilities and their parents, carers and supporters",* available at: https://www.scld.org.uk/wp-content/uploads/2020/06/SCLD-Coronavirus-Report-FINAL.pdf

Uanhoro, J. O. (2017), Effect size calculators [Computer software], available at: *https://effect-size-calculator.herokuapp.com/*

Vilet, K. J. V., & Kalnins, G. R. C. (2011), A compassion-focused approach to nonsuicidal self-injury, *Journal of Mental Health Counselling,* Vol. 33 No. 4, pp. 295-311

Vlissides, N., Beail, N., Jackson, T., Williams, K., & Golding, L. (2017), Development and psychometric properties of the Psychological Therapies Outcome Scale – Intellectual Disabilities ( PTOS- ID), *Journal of Intellectual Disabilities Research,* Vol. 61, No. 6, pp. 549-559. doi:10.1111/jir.12361

Walley, M., & Kaur, H. (2020), "*Living with worry and anxiety amidst global uncertainty",* available at: https://www.psychologytools.com/resource/living-with-worry-and-anxiety-amidst-global-uncertainty.

Wentzel, J., van der Vaart, R., Bohlmeijer, E. T., & van Gemert-Pijnen, J. E. (2016), Mixing online and face-to-face therapy: how to benefit from blended care in mental health care, *JMIR Mental Health*, Vol. 3 No. 1, pp. e9.