Therapeutic support for young people with learning difficulties: what enables effective practice?

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Abstract: Supporting children and young people’s mental health is a central aim of the UK government policy, with those with learning difficulties a particularly vulnerable group. This systematic review of research uses published literature to explore how access and participation in therapy might be facilitated for young people with learning difficulties. Twelve studies published 2000-2019 were identified, which described the experiences of access to, and participation in therapy for people with learning difficulties, although notably most of these involved adults. Findings indicated eight themes: pre-therapy, careful contracting, therapy is hard, idiosyncratic needs, therapeutic relationship, group therapy, reviewing therapy and it changed my life. These were organized into three chronological stages: setting up of therapy; therapeutic processes; and therapeutic outcomes. A number of strategies that can promote access and participation are suggested for professionals working therapeutically with young people with learning difficulties, around contracting, clear communication, the therapeutic alliance and the ending of therapy.

Introduction

The mental health of children and young people with learning difficulties

It has been a long-standing political imperative to promote mental health and well-being for children and young people in the United Kingdom. The value and importance of preventative and early intervention to support children’s and young people’s mental health have been consistently emphasized (Department of Health [DoH] and Department for Education [DfE], 2017). A survey by Green, McGinnity, Meltzer et al. (2005) suggested the prevalence of mental health difficulties was one in 10 amongst, 5- to 15-year-olds, although data from a smaller, more recent survey suggest the figure is now one in nine (National Health Service [NHS], (Sadler et al., 2018).

The National Institute for Health and Care Excellence (NICE) (2016) estimated that 36% of children and young people with learning disabilities experience mental health problems at any point in time, raising to 40% for adults. The Children and Young People’s Mental Health Coalition (2019) reported that 5- to 15-year-olds with recognized special education needs were more likely to have a mental health problem (36%) compared with their peers (6%); and that one in seven young people with a mental health problem in the United Kingdom also had a learning difficulty. Although literature surrounding therapeutic provision for children and young people with learning difficulties is minimal, within the Feeling Down Report (Foundation for People with Learning Disabilities, 2014) families reported that psychological support received was invaluable. NICE (2016) identified psychological interventions as the most evidenced provision for promoting the mental health for people with learning difficulties, recommending these are adapted to meet the needs and preferences of the client. Structured therapies that work for the general population should be expected to work for people with learning difficulties, unless proven otherwise (Foundation for People with Learning Disabilities, 2015). Reasonable adjustments are a legal requirement for all service providers to avoid putting a disabled person at a disadvantage, as outlined in the Equality Act (Her Majesty the Queen’s Government, 2010).

There is minimal research conducted with purely children and young people with learning difficulties around their experience of therapeutic support. In one of the few published studies, Mishna (1996) obtained the views of 13- to 17-year-old Canadian students, who had attended a psychodynamic group therapy using a qualitative approach. Participants reported benefits, such as enhanced self-esteem and a better understanding of self and ability to relate to peers, and findings suggested that the psychodynamic group therapy was beneficial.

There is more research involving adults from this population, and therefore, it may be possible to use this to draw...
tentative conclusions how best to support the therapeutic needs in relation to access and participation for young people up to 25 years (DfE and DoH, 2015). Despite this, Brown et al. (2011) concluded from a literature review that research investigating the effectiveness of therapy for people with learning difficulties was generally sparse, although a small number of quantitative studies has investigated the effectiveness of adapted interventions. For example, Prout and Nowak-Drabik (2003) found evidence of good outcomes and concluded that psychotherapy could be effective and valuable for people with learning difficulties, whereas a meta-analysis by Vereenoooghe and Langdon (2013) found that psychological treatment had an overall moderate effect for treating mental health difficulties for this population.

Although quantitative studies tend to focus on outcomes and a reduction in symptoms, qualitative research might illuminate how to facilitate access and participation of therapy. Evans and Randle-Phillips’s (2018) meta-ethnography explored people with learning difficulties’ experiences of psychological therapy and identified five concepts: adapting to therapy, the therapeutic environment, group dynamics, the therapeutic relationship and the impact of therapy on life. The research highlighted the need for further consideration around power differentials within the therapeutic relationship and further adaptations to ensure accessibility of therapy.

By understanding how psychological therapies are experienced by people with learning difficulties, practitioners can be better equipped to develop appropriate and effective therapeutic services. This is in line with the Preparing for Adulthood (2013) framework, which is about giving disabled young people the right to choice and control over their lives to achieve their potential and live the life they choose. Alongside this, the green paper Transforming Children and Young People’s Mental Health Provision (DoH and DfE, 2017) seeks to improve the identification and provision of early help in education settings through proposals such as mental health support teams and a designated senior leader for mental health in schools. Children and young people with learning difficulties will potentially benefit from these initiatives, but there is a need to ensure that policy and practice are cognisant of their specific needs and experiences in order to be most effective.

Rationale and aims of the current study
The dearth of research relating to the therapeutic experiences of young people with learning difficulties makes it difficult to draw conclusions about effective practice. In an attempt to try and provide practitioners working therapeutically with young people with some tentative guidance, this literature review intends to explore how people with learning difficulties across a wider age range experience therapy, prioritizing the voices of younger participants aged 25 and under (DfE and DoH, 2015). In doing so, it aims to address the following research question:

What does the literature tell us about how access and participation in therapy might be facilitated for young people with learning difficulties?

Methodology

Search strategy
This study was focussed on a single country (UK), as it was envisaged that it would be difficult to draw conclusions from different countries, because of international variation of the conceptualization of mental health and learning difficulties and the way in which treatment is offered and delivered. A systematic search of the following electronic databases was conducted: PsychINFO, Education Research Information Centre, PubMed, SAGE, Web of Science and a review of British Library of Electronic Theses Online Service. Key search terms were as follows: learning disability, learning difficulty, intellectual disability, mental handicapped, mental retardation, therapy, therapeutic intervention, perspective, opinion, views, experience, service user, client and patient. Searches were conducted for published papers between 2000 and 2019. Inclusions parameters were developed which included:

- Qualitative paper which aimed to capture people with learning disabilities’ experiences of therapy;
- Involved interviews with participants;
- Direct quotes from participants were included;
- Included at least one participant who was aged 11-25 years. Notably, only one located study (Boyden, Muniz and Laxton-Kane, 2013) included participants who were all in the 11-25 age range;
- Research conducted in the United Kingdom;
- Written in English.

Outcomes of systemic search
There was an initial screen of 365 articles, and from reading the abstracts, 26 articles remained relevant. From the systematic search, 12 papers met the inclusionary criteria, of which three were theses. A descriptive overview of the studies can be found in Table 1.

Figure 1 shows the data screening process, documenting how the 12 studies were selected. The current review adopted a systematic search strategy that was guided by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

Quality assurance
The quality of the studies was reviewed using the Critical Appraisal Skills Programme (CASP, 2018) Qualitative Checklist, to check for potential, not to include or exclude studies but to provide a guide as to the quality and methodological rigour of the studies for the reader. The author(s) used the following judgements to indicate appropriate methodology: yes, partial, cannot tell and no.
Table 1: Overview of the included studies

| Author/Year          | Paper                                                                 | Sample (Number, age range) | Research design | Therapy received (type, durations, format) | Data analysis | Main themes identified                                                                 |
|---------------------|------------------------------------------------------------------------|-----------------------------|-----------------|---------------------------------------------|--------------|----------------------------------------------------------------------------------------|
| 1. Anslow (2014)    | Systemic family therapy using the reflecting team: the experiences of adults with learning disabilities | 5 participants (4 female: 1 male) Aged: 18 to 44 years | Semi-structured interviews | Attending regular systemic family therapy with one or more family members at the time of research. | IPA          | Therapists’ focus on strengths and difficulties Differences in metacognition Finding a voice in therapy Frustration with outcomes of therapy Managing an unusual experience |
| 2. Arkless (2004)*  | Talking to People with Learning Disabilities and their Families about the Experience of Systemic Therapy | 6 participants with learning difficulty. 3 female: 3 male. Aged: 19 to 47 years | Semi-structured interviews | Attended systemic family therapy for a minimum of three sessions no more than 3 years ago. | IPA          | Relationship to help Value of therapy Having a voice vs being silenced |
| 3. Bexley (2017)*   | Improving access to psychological therapy (IAPT) for people with learning disabilities from service users’ and clinicians’ perspectives: An action research approach | 7 participants (5 female: 2 male) (12 clinicians) Aged: 18 to 54 years | Semi-structured interviews | IAPT therapy based on CBT. Participants had received between 6-15, 50-minute sessions. | Thematic analysis (only analysed qualitative data from phase one: service user perspectives) | Helpful clinicians Inclusive service How clinicians could improve How the service could improve |
| 4. Boyden, Muniz and Laxton-Kane (2013) | Listening to the views of children with learning disabilities: An evaluation of a learning disability CAMHS service | 7 participants (2 female: 5 male) Aged: 11 to 17 years | Semi-structured interviews | All received input from service around mental health issues within the past 3 months | Thematic analysis | Experiences of the services Communication Impact of work carried out Difficulties encountered |
| 5. Currie, McKenzie and Noone, (2019) | The Experiences of People with an Intellectual Disability of a Mindfulness-Based Program | 6 participants (2 female: 4 males) Aged: 18 to 53 years | Semi-structured interviews | Voluntary participation in 11 sessions of a group Mindfulness-Based Programme with adaptations. Interviews | IPA          | Impact of mindfulness Mechanisms of the group |
Table 1: (Continued)

| Author/Year       | Paper                                                                 | Sample (Number, age range) | Research design | Therapy received (type, durations, format) | Data analysis | Main themes identified |
|-------------------|------------------------------------------------------------------------|----------------------------|-----------------|--------------------------------------------|--------------|------------------------|
| 6. Knight et al.  | ‘Getting into it’: People with intellectual disabilities’ experiences and views of Behavioural Activation and Guided Self-Help for depression | 25 participants (17 female: 8 male) aged: 21 to 66 years | Semi-structured interviews | Explored the experiences of individualized psychological interventions for depression: Behavioural Activation or Guided Self-Help. Interviews took place within 8 weeks of last session | Framework analysis | Before therapy, Therapy process, Relationships in therapy, Ending and after therapy, Impact of therapy, Participants’ views on the therapy overall |
| 7. Lewis, Lewis and Davies (2016) | ‘I don’t feel trapped anymore. I feel like a bird’: People with Learning Disabilities’ Experience of Psychological Therapy | 6 participants (5 female: 1 male) aged: 20 to 43 years | Semi-structured interviews | Accessed direct psychological therapy from a clinical psychologist and had ended no longer than 6 months prior to the interview | IPA | Setting up of therapy, Content and process of therapy, Other positive aspects of therapy |
| 8. MacMahon et al. (2015) | ‘It’s made all of us bond since that course…’ – a qualitative study of service users’ experiences of a CBT anger management group intervention | 11 participants (3 female: 8 male) aged: 22 to 44 years | Semi-structured interviews | Attended a 12 session Group CBT intervention for anger management. Interviews took place up to 2 weeks after the last session | IPA | The importance of relationships, A new me, New and improved relationships, Presenting myself in a positive light, What the group did not change, Expectations, Dependence alliance, Therapy as private, Reluctance to engage |
| 9. Merriman and Beail (2009) | Service user views of long-term individual psychodynamic psychotherapy | 6 males aged: 22 to 45 years | Semi-structured interviews | In receipt of long-term individual psychotherapy for at least two years or more | IPA | (Continued) |
| Author/Year       | Paper                                                                 | Sample (Number, age range) | Research design        | Therapy received (type, durations, format)                                                                 | Data analysis | Main themes identified                        |
|------------------|-----------------------------------------------------------------------|----------------------------|------------------------|------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|
| 10. Morgan (2011)* | Reflections of individuals with learning disabilities and their experience of receiving psychotherapy services: An exploration using IPA | 7 participants, (6 female: 1 male) Aged: 20 to 55 years | Semi-structured interviews | Accessing psychotherapeutic intervention with together NHS Foundation Trust. They had undergone at least 10 sessions and currently engaged in the services | IPA           | Positive change                               |
|                  |                                                                      |                            |                        |                                                                                                             |               | Relationship factors                          |
| 11. Ramsden et al. (2016) | Perceived barriers and facilitators to positive therapeutic change for people with intellectual disabilities: Client, carer and clinical psychologist perspectives | 3 cases: 1 clin psych and 2 dyads of a client. 6 clients, all males Aged: 19 to 43 years | Semi-structured interviews | Completed individual therapy from specialist intellectual disability psychology service with length of therapy varying from 1 to 3 years | Thematic Analysis | What the client brings                         |
|                  |                                                                      |                            |                        |                                                                                                             |               | Wider system                                  |
|                  |                                                                      |                            |                        |                                                                                                             |               | Therapy factors Therapists                    |
|                  |                                                                      |                            |                        |                                                                                                             |               | ‘Mental health General Practitioner’          |
|                  |                                                                      |                            |                        |                                                                                                             |               | Systemic dependency                           |
| 12. Roscoe et al. (2016) | Dialectical behaviour therapy (DBT) in an inpatient unit for women with a learning disability: Service users' perspectives | 10 female participants Aged: 19 to 57 years | Semi-structured interviews | Female inpatients of private mental hospitals and received adapted dialectical behaviour therapy | IPA           | Understanding DBT                               |
|                  |                                                                      |                            |                        |                                                                                                             |               | DBT as helpful ad beneficial                  |
|                  |                                                                      |                            |                        |                                                                                                             |               | Engagement with the DBT process               |

Notes: Abbreviations defined: IPA: Interpretative phenomenological analysis; IAPT: Improving Access to Psychological Therapies; DBT: Dialectical Behaviour Therapy. *Theses.
The judgements were then assigned a score (yes = 1; partial = 0.5; cannot tell and no = 0) (see Table 2).

Study information
This research was conducted from a critical realist perspective, which focussed on the explicit meanings of the dataset. Sections of the papers labelled as ‘results’ or ‘findings’ were analysed inductively, without a prior attempt to fit the data into a theory, using the six-step thematic analysis approach by Braun and Clarke (2006) using NVIVO software (QSR, 2020). One hundred and seven nodes were initially identified, before these were refined to 63 nodes, which later equated to eight themes and 29 subthemes through discussion and constant re-checking of the data. These can be located in Table 3.

Results

Study designs
The 12 studies were all exploratory, qualitative research designs involving semi-structured interviews. Nine of the studies used interpretative phenomenological analysis, although alternative methods were thematic analysis (Bexley, 2017; Boyden et al., 2013) and framework analysis (Knight et al., 2019).

Sample
Studies involved five to 25 participants aged 11-66 years, with precise ages specified in five studies (Arkless, 2004; Bexley, 2017; Currie et al., 2019; Morgan, 2011; Ramsden et al., 2016).

Focus
All papers involved the participants having participated in a therapeutic intervention, including attending a set amount of sessions, group or family intervention, or receiving intervention over a longer period of time. Only in Currie et al.’s (2019) paper did participants volunteer to participate in a therapeutic intervention.

Findings
Based on the analysis of the existing literature, Table 3 identifies the themes and subthemes. The themes (hereafter highlighted in bold italics) and sub-themes (highlighted in italics) will be explored in relation to the chronological processes of setting up therapy, therapeutic processes and therapeutic outcomes. Exemplar quotes are included, with those from participants aged 11-25 prioritized and indicated.

In relation to pre-therapy, the referral process was discussed, with only those in Currie et al.’s (2019) paper working with volunteers. Elsewhere, participants were referred to services by other professionals and carers. Participants were not always sure who had referred them, but most were able to describe why they thought they had been referred (Merriman and Beail, 2009). One of Morgan’s (2011) participants preferred to seek familial support, perhaps linking to feelings about the stigma of therapy, centred around embarrassment at others knowing they were attending therapy (Morgan, 2011; Ramsden et al., 2016).

Aspects of careful contracting included hope and expectations of therapy for participants. These included expectations prior to therapy (Lewis et al., 2016); expectations relating to end goals (Roscoe et al., 2016); and of desired outcomes such as improving mood (Morgan, 2011) and reducing worry (Merriman and Beail, 2009). For some participants, issues around length and frequency of sessions were expressed (Knight et al., 2019; Lewis et al., 2016), which might have been mitigated if addressed throughout the sessions. Morgan (2011) highlighted how previous experiences of therapeutic support could have a lasting impression.

Confidentiality was referred to by participants. Although there was recognition of the need for support (Boyden et al., 2013; Morgan, 2011), there were also concerns about sharing information with parents (Lewis et al.,
### Table 2: Quality assurance overview using CASP (CASP, 2018)

| Paper | Was there a clear statement of the aims of research? | Is a qualitative methodology appropriate? | Was the research design appropriate to address aims of the research? | Was the data collected in a way that addressed the research issue? | Has the relationship between researcher and participants been adequately considered? | Have ethical issues been taken into consideration? | Was the data analysis sufficiently rigorous? | Is there a clear statement of findings? | Is the research valuable? | Score (max score = 10) | Includes quotes from 11- to 25-year-olds |
|-------|---------------------------------------------------|------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------|------------------------------------------|------------------------------------------|-----------------------------------------|------------------------------------------|
| 1     | 1                                                 | 1                                        | 1                                                             | 1                                                             | 0.5                                                                              | 1                                            | 0.5                                               | 1                                        | 0.5                                      | 1                                         | 8.5                                      | No                                      |
| 2     | 1                                                 | 1                                        | 1                                                             | 1                                                             | 1                                                                                | 1                                            | 1                                                  | 1                                        | 1                                        | 1                                         | 10                                       | Yes                                     |
| 3     | 1                                                 | 1                                        | 0.5                                                           | 1                                                             | 1                                                                                | 0.5                                          | 1                                                  | 0.5                                      | 1                                        | 0.5                                      | 8.5                                      | Yes                                     |
| 4     | 1                                                 | 1                                        | 1                                                             | 1                                                             | 0.5                                                                              | 1                                            | 0.5                                               | 1                                         | 1                                        | 1                                         | 9                                        | No                                      |
| 5     | 1                                                 | 1                                        | 1                                                             | 1                                                             | 0.5                                                                              | 1                                            | 1                                                  | 1                                        | 1                                        | 1                                         | 9.5                                      | Yes                                     |
| 6     | 1                                                 | 0.5                                      | 0.5                                                           | 0.5                                                           | 0                                                                                | 0.5                                          | 1                                                  | 1                                        | 0.5                                      | 1                                         | 7                                        | No                                      |
| 7     | 1                                                 | 1                                        | 1                                                             | 0.5                                                           | 0.5                                                                              | 1                                            | 0.5                                               | 0.5                                      | 0.5                                      | 0.5                                      | 7.5                                      | No                                      |
| 8     | 1                                                 | 1                                        | 1                                                             | 0.5                                                           | 1                                                                                | 0                                            | 0.5                                               | 0.5                                      | 0.5                                      | 0.5                                      | 7                                        | No                                      |
| 9     | 1                                                 | 1                                        | 1                                                             | 0.5                                                           | 0.5                                                                              | 0                                            | 0                                                  | 0.5                                      | 1                                        | 0.5                                      | 6                                        | No                                      |
| 10    | 1                                                 | 1                                        | 1                                                             | 1                                                             | 1                                                                                | 1                                            | 1                                                  | 1                                        | 1                                        | 1                                         | 10                                       | Yes                                     |
| 11    | 1                                                 | 1                                        | 1                                                             | 1                                                             | 1                                                                                | 1                                            | 1                                                  | 1                                        | 1                                        | 1                                         | 10                                       | Yes                                     |
| 12    | 1                                                 | 1                                        | 1                                                             | 1                                                             | 1                                                                                | 1                                            | 1                                                  | 1                                        | 1                                        | 0.5                                      | 9.5                                      | No                                      |

**Notes:** Number of paper corresponds to Table 2. Score 1 = Yes, 0.5 = Partially, 0 = No or Cannot tell (shaded).
Table 3: Key themes and subthemes identified

| Stage of therapy | Theme                      | Sub-themes                                      |
|------------------|----------------------------|------------------------------------------------|
| Setting up of therapy | Pre-therapy | Referral process                             |                                            |
|                   |                | Stigma of therapy                           |                                            |
|                   | Careful        | Hope and expectations of therapy            |                                            |
|                   | contracting    | Confidentiality                             |                                            |
|                   |                | Nerves at the start                          |                                            |
| Therapeutic processes | Therapy is hard | Therapy is hard                             | Communication difficulties                |
|                   |                | Practical activities in therapy              | Support preferences                       |
|                   | Idiosyncratic  | Client’s cognitive skills                    |                                            |
|                   | needs          | Client’s motivation to engage               |                                            |
|                   | Therapeutic    | Role of the therapist                       | Relationship with the therapist           |
|                   | relationship   | Function of talking                         |                                            |
|                   | Group therapy  | Experiences of group therapy                |                                            |
| Therapeutic outcomes | Reviewing    | Ending is difficult                         |                                            |
|                   | therapy        | Therapeutic outcomes                        |                                            |
|                   |                | It changed my life                          | Practical and behavioural changes         |
|                   | life           | It changed my life                          | Emotional changes                         |

2016). One of Morgan’s (2011) participants was unsure whether the therapy was private or not:

*I felt a bit nervous because again I thought if I say all the things I feel, they might say I’ll repeat them to someone because every now and again, years ago when I was a lot younger I text saying about my feelings to someone and they repeated it and that is why I felt a bit nervous.* (p. 71)

Participants made reference to *nerves at the start* of therapy, linked to uncertainty (Knight et al., 2019), meeting the therapist (Boyden et al., 2013; Lewis et al., 2016) and talking about their fears (Morgan, 2011).

Some participants thought *therapy is hard* as it evoked difficult feelings, with some considering it a risk to disclose sensitive information to their therapist (Arkless, 2004; Morgan, 2011). Roscoe et al. (2016) acknowledged that participants had difficulty understanding the programme, with MacMahon et al. (2015) suggesting that for some, understanding takes a little longer. Currie et al. (2019) suggested complete understanding of their mindfulness-based programme was not essential for it to be beneficial.

Some participants reported that *communication difficulties* impacted on therapeutic work (Ramsden et al., 2016). Specifically, Anslow’s (2014) participants reported a sense of powerlessness in finding an effective way of communicating, with one recalling not understanding the “long words” (p. 42) used by the therapist in their initial session. Participants in Boyden et al.’s (2013) study valued creative and interactive tools such as books, pictures, Play-Doh and drawings to support communication, with one participant sharing that they preferred to talk and draw. In some studies, the presence of a family member appeared to facilitate communication: ‘My mum put it into sentence that I do understand’ (Arkless, 2004, p. 105).

**Practical activities in therapy** were mentioned with one participant sharing ‘some of the things we haven’t really done, we’ve just talked about—they haven’t really been improved’ (Anslow, 2014, p. 242); others referred to the practical work completed with the psychologist (Lewis et al., 2016). One participant shared how the use of imagery and metaphors helped with understanding feelings (Boyden et al., 2013). MacMahon et al.’s (2015) participants used role-play activities, which were a source of laughter, although the aim was unclear.

In terms of *support preferences*, Morgan’s (2011) participants could choose whether they wanted a supporter present, although only one participant opted in and linked to themes around confidentiality, as having another adult in the room was not always perceived as helpful (Arkless, 2004). By contrast, one 21-year-old participant (Arkless, 2004) made his own decision to have a parent present:

*I was with [psychologist] and she was saying would you like to do one to one, or have someone come with you, and I thought, my mum. I thought it was my idea, all on my own. I thought of that.* (p. 100)

In one study, participants commented on ensuring activities were age appropriate, for example:

*See the pictures, that is [sic] something like when I used to go to school. I don’t like that I am not a child and I just mean that I don’t need to draw daft pictures of wee people. Just because I have problems I don’t need daft wee pictures with loads of colours to make me feel, I don’t need that.* (Knight, et al., 2019, p. 827)

In addition, Ramsden et al. (2016) found participants struggled to develop a support network and make friendships, which was deemed to be a facilitator for positive therapeutic change and overall psychological well-being.

*Idiosyncratic needs* related to difficulties encountered due to clients’ cognitive skills, limiting their ability to reflect and appreciate different perspectives (Anslow, 2014), complete activities (Knight et al., 2019) or understand an in-session task (Roscoe et al., 2016). A client’s
motivation to engage impacted on the therapeutic process (Roscoe et al., 2016).

An important factor in the therapeutic relationship was the role of the therapist with valued aspects including discussing things they wanted to talk about (Morgan, 2011), adapting practice to meet their needs (Bexley, 2017) and identifying support to address their problems (Ramsden et al., 2016). Within family therapy, there was acknowledgement that participants valued the therapist speaking up for them (Anslow, 2014). By contrast, another participant felt able to not answer questions, promoting their sense of autonomy (Arkless, 2004). The relationship with the therapist was reflected upon by participants, with one 21-year-old stating ‘when you get along so well you can work on anything’ (Bexley, 2017, p. 65). Helpful features included the therapist’s ability to convey ease, understanding, and a unique sense of trust (Lewis et al., 2016; Morgan, 2011) with some participants feeling that the relationship was key to making life changes (Bexley, 2017; Morgan, 2011). In three papers, participants considered the therapist to be a ‘friend’, for example: ‘[therapist] just comes and is a friend. We talk to each other about all sorts of things, it’s good’ (Morgan, 2011, p. 92), although a participant in Knight et al.’s (2019) study acknowledged rules about becoming friends with a therapist. The function of talking provided an opportunity to share and offload problems and worries (Boyden et al., 2013; Merriman and Beail, 2009; Morgan, 2011). By contrast, some participants found talking difficult, with one finding it hard to think about the past (Lewis et al., 2016). Others felt talking was intrusive, especially questions about their family or difficult events (Morgan, 2011).

Three papers involved group therapy with notable differences in the experiences of group therapy for participants. A positive aspect noted was the relationships developed from the shared social experience: ‘I worked out that if you’re swapping stories, it helps each other out’ (MacMahon et al., 2015, p. 347). Currie et al.’s (2019) mindfulness-based programme improved participants’ confidence, demonstrated by their increased participation in the sessions. However, some participants recalled negative aspects of group therapy, including feelings of anxiety about speaking in front of the group (Roscoe et al., 2016).

Upon reviewing therapy, some participants found the ending of therapy difficult, one referring to it as experiencing a sense of loss: ‘I said to mum, do you think [the therapist] will come to the house? Just do a wee visit to see how I’m getting on, not to stay... So she said, I don’t think she’ll come back’ (Knight et al., 2019, p. 826). Others were worried about slipping back without support (Merriman and Beail, 2009). Perceived benefits of therapeutic outcomes were mixed. In some studies, all participants noticed positive outcomes (Roscoe et al., 2016), some referring to the experience as enjoyable (Lewis et al., 2016) and ‘fun and interesting’ (MacMahon et al., 2015, p.346). Some participants talked positively about brighter futures (Currie et al., 2019; Lewis et al., 2016) and therapy helping to overcome the past: ‘I don’t feel trapped anymore because the past is out of my head. I feel like a bird’ (Lewis et al., 2016, p. 451). Some participants felt no benefit from therapy (Merriman and Beail, 2009), although others reported still experiencing anger post-intervention (MacMahon et al., 2015). In Anslow’s (2014) study, some participants acknowledged progress, although others felt a ‘continued need for help’ (p. 241). MacMahon et al.’s (2015) participants noted no negative aspects of therapy in their spontaneous evaluation of their CBT group, perhaps due to a reluctance to criticize therapy they felt dependent on. Merriman and Beail (2009) wondered if their participants were reluctant to talk negatively for fear of losing the service.

In reference to outcomes from therapy, some participants reflect positively that it changed my life (Bexley, 2017; Knight et al., 2019; Lewis et al., 2016). Practical and behavioural changes were acknowledged, such as development of practical skills (Lewis et al., 2016), forming better relationships (Arkless, 2004), improved communication and negotiation skills (Roscoe et al., 2016) and changes to behaviour: ‘I’m a different person now, I used to be all boisterous but I’m not no more, I’ve calmed right down’ (MacMahon et al., 2015, p. 347).

Some participants acknowledged they had to put strategies into practice to experience the benefits of therapy, including those attending Currie et al.’s (2019) mindfulness-based programme, who discussed incorporating the techniques into everyday life. Some of Knight et al.’s (2019) participants continued to use session booklets to remind them of helpful strategies.

Emotional benefits were reported including improved confidence and development of skills to help with heightened emotions: ‘I was really down at the beginning. I was bottling everything up and couldn’t cope with it. It’s different now... Everything was going wrong. That’s all changed now’ (Merriman and Beail, 2009, p. 45). Others reported improved self-identity and self-compassion and were less concerned about the judgement of others (Currie et al., 2019).

Discussion
Within this section, it is not possible to explore all the themes and sub-themes identified in the findings section. Instead, the themes that are most relevant to practice with young people will be discussed in more detail.

Contracting
With regard to the referral process, apart from Currie et al.’s (2019) study where participants volunteered to participate, there was no mention of self-referral.
Although participants were all informed of the referral, there were few examples of adults initiating and sharing this decision with them (Arkless, 2004; Morgan, 2011). Being involved promotes a sense of agency and is advocated within Preparing for Adulthood (2013) documentation, for young people with SEND. As stated in the United Nations Convention on the Rights of the Child [UNCRC] (1989), Article 12.1 states ‘Parties should assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the view of the child being given due within accordance with the age and maturity of the child’ (p. 5). In addition, the Mental Capacity Act (DoH, 2005) empowering people to make decisions wherever possible and protecting those who lack capacity by providing a flexible framework that places individuals at the centre of the process. This act applies to people aged 16 and over. This is further highlighting the need for young people to be included in the decision-making process around taking part in therapy. In the majority of the papers, participants were able to convey why they were attending therapy, suggesting that involving them as active partners throughout the whole process is achievable and could have promoted a sense of empowerment. Dunsmuir and Hardy (2016) suggest a procedure for acceptance for therapy, which entails a self-referral or a request for help from a responsible adult, which may lead to signposting to alternative services such as a counsellor, specialist bereavement support or access to resources such as housing or activities that promote social inclusion, or acceptance for therapy. At this point, a contract is agreed. However, the views of the child or young person do not feature explicitly in Dunsmuir and Hardy’s (2016) procedure. Given that the British Psychology Society (2017) proposed that it is good practice to hear the voices of children and young people in relation to understanding what works, this should perhaps be considered for young people with learning difficulties when considering decision-making that impacts upon them.

Participants’ hopes from attending therapy were often centred around making a specific change in their lives, such as managing heightened emotions (Knight et al., 2019). However, participants often had unclear expectations about therapeutic support, increasing their apprehension. Dunsmuir and Hardy (2016) suggested writing a letter as a way for professionals to introduce themselves, set a friendly tone and explain what the intervention will and will not entail. Such a strategy might help inform young people of what to expect and reduce nerves. Participants also voiced uncertainties about confidentiality, with some unsure of what information, if any, was being shared (Morgan, 2011). Dunsmuir and Hardy (2016) referred to essential ethical considerations prior to carrying out therapeutic work. These include the professional asking themselves: ‘What has been discussed and agreed about the information shared through therapy? What knowledge and understanding does the child or young person have about the therapeutic approach offered?’ (p.10). Considering such questions could promote careful contracting, ensuring issues such as confidentiality are addressed. This is particularly important given that the Children’s Commissioner (2017) concluded that insecurity about confidentiality was a barrier to young people overcoming mental health difficulties.

**Clear communication**

Although participants recognized benefits of attending therapy, there was a sense that for many, it was a challenging process. Areas of difficulty included answering questions (Lewis et al., 2016) and sharing sensitive information (Morgan, 2011) with issues exacerbated for participants with communication difficulties (Ramsden et al., 2016). Issues could impact the therapeutic relationship, and therefore, communication should be at a level appropriate to the child or young person (Boydén et al., 2013). Research has indicated that young people can find the abstract nature of therapeutic conversations challenging (Dunsmuir and Hardy, 2016), and this, therefore, needs to be taken into account, especially for those with learning difficulties. Wills et al. (2018) found that making adaptations to meet client’s communication needs and ensuring they can express their emotions was a focus for therapists. NICE (2016) suggests recommendations such as explaining content of every session; use concrete, visual imagery and role-play to explain concepts; communicate at a pace that is comfortable for the person. These are relevant considerations when working with children and young people in an educational setting too.

**Therapeutic alliance**

The limited research available suggests that, as with the general population (cf Asay and Lambert, 1999; Jones and Donati, 2009), the therapeutic relationship is key to the effectiveness of therapeutic work with individuals with learning difficulties. In the included studies, participants praised therapists, and some suggesting they were the key to making the change (Knight et al., 2019). Beneficial factors included the development of a close relationship (Knight et al., 2019), creating a sense of ease (Morgan, 2011) and having the opportunity to talk about themselves and their problems (Lewis et al., 2016). Wills et al. (2018) reported, therapists working with people with learning difficulties alluded to being client-led, in a comparable way to person-centred approaches, therefore, focussing on their client and how they perceive the world to create a more successful alliance. This is in line with Dunsmuir and Hardy (2016) who proposed incorporating the young person’s interests, as well as fun and engagement into sessions to help the alliance. In Boydén et al.’s (2013) paper, young people acknowledged some of the smaller personal aspects as positives including humour, smiles and talking about interests.

There was both confusion over, and recognition of, professional boundaries (Knight et al., 2019; Lewis et al.,
Participants’ blurring of the professional role with friendship might be less problematic in an educational setting, where students are used to daily interactions with professionals. However, clear contracting would help to ensure that participants with learning difficulties do not become dependent on professionals, thus reducing their sense of autonomy.

Ending of therapy
Participants acknowledged the benefits of therapeutic support, such as in Boyden et al.’s (2013) study where the young people felt their problems had been addressed, and they had changed as a result. However, the ending of therapy was reportedly a significant part in the therapeutic process. Some participants found this difficult, especially if they had created a ‘dependent alliance’ (Merriman and Beall, 2009, p. 44), although it is plausible that the adults in the studies may have been more socially isolated than young people, particularly those in educational settings. Wachtel (2002) highlighted that ending of therapy entails a separation, as well as other negative emotions such as those associated with loss and separation from someone whom a person had formed an emotional attachment to. Therefore, for a person with learning difficulties, these feelings could be exacerbated, making the ending of therapy particularly difficult. For children and young people, Dunsmuir and Hardy (2016) highlighted the importance of ensuring details about the ending of therapy are made clear to from the start, although Evans and Randle-Phillips (2018) suggested promoting choice with regard to the number of sessions offered to people with learning difficulties. In work with young people, this could potentially be extended to include a follow-up session, which may help the ending of therapy to not feel as abrupt, as well as gradually easing any sense of dependency.

Most participants spoke positively about the impact of therapy on their lives and were able to describe particular benefits they had identified, such as relief from nightmares (Lewis et al., 2016) and an emotional release from having someone to talk to (Morgan, 2011). Some participants explicitly acknowledged the importance of generalizing what they had learnt beyond the sessions (Lewis et al., 2016), whereas others spoke about skills they had clearly transferred from rehearsal in sessions, such as breathing exercises (Currie et al., 2019). Others reported continued use of resources beyond the sessions to help generalize skills (Knight et al., 2019). There is suggestion that young people with learning difficulties benefit from access to additional support and tangible resources that facilitate practising/rehearsing of skills. This aids them to transfer those rehearsed skills into the real world (Atwood and Atkinson, 2020; Foundation for People with Learning Disabilities, 2015).

Limitations and future directions
Limitations of the current review include the lack of published literature that met the inclusion criteria. Notably, 25% were doctoral theses, although it has been reported that there is little difference in methodological quality of unpublished thesis (Moyer, Schneider, Knapp-Oliver, and Sohl, 2010). Indeed, McLeod and Weisz (2004) suggested that theses might be stronger methodologically.

The inclusion criteria for this review were narrowed to include at least one participant who was aged 11-25 years, in line with the SEND Code of Practice (DfE and DoH, 2015), and limited to a UK context. Broadening the parameters may have yielded more research, and thus, illuminating other means of promoting effective therapeutic practice for young people with learning difficulties. Participants included in the papers ranged from 11 to 66 years, and it is, therefore, debateable to what extent some of the adult participants’ experiences would be characteristic of those of young people, especially as the therapeutic focus might represent priorities at different lifecycle time points (e.g. health or housing concerns; financial or relationship worries). This review, therefore, advocates for further research eliciting the voices of young people with learning difficulties who have received therapeutic support, particularly around mechanisms used to support generalization of skills into the real world.

This study was limited to the UK studies, due to anticipated issues in aggregating international literature because of differences in conceptualization of, and support for mental health and learning difficulties. Despite this, it is acknowledged that international classification of both learning and mental health difficulties does exist, for example through the International Classification of Diseases (ICD)-10 (World Health Organisation, 2010) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013). It is hoped, therefore, that the findings will have relevance to international readers, and that outcomes of the study will prompt discussion, debate and further research within international contexts. It is also recognized that many of the issues identified in this review transcend national policies, for example young people’s rights to agency, involvement, respect and consent and have been internationally recognized (UNCRC, 1989).

Based on the findings from this study, Table 4 below suggests implications for future practice with regard to promoting access and participation for young people with learning difficulties. Such implications could be relevant for those professionals who work with young people with learning difficulties and want to bring about a positive change. Although this review highlights the value of understanding therapeutic models, approaches and issues in supporting young people with learning difficulties, it is acknowledged that many professionals working with this population are school-based. It is, therefore, essential that appropriate training and supervision is offered to staff working in a pastoral or therapeutic role (DoH and DfE, 2017).
Table 4: Summary of recommendations to promote access and participation

| Area to address       | Suggestions                                                                                                                                 |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Contracting           | Ensure young person is aware of the referral and reasons why. The young person needs to be given the option whether to engage with the process. This could form part of a ‘triage’ system for professionals to decide the most appropriate next step. Do not assume the reason for referral correlates with the young person’s perception of the problem. Pre-therapy considerations such as a letter to introduce the professionals and provide some information around what to expect – this allows a young person to make an informed session if they wish to attend. Ensure confidentiality is explicitly discussed with the young person in an accessible way. Joint decision with the young person about what information may be shared and with whom, including reference to safeguarding. Refer to recommendations made in NICE guidelines 2016 (chapter 1.3.1 Communication). |
| Clear communication   | Professionals need to ‘check in’ with young people to ensure they are understanding the language used while encouraging them to speak up if they are unsure. Refer to recommendations made in NICE guidelines 2016 (chapter 1.3.1 Communication). |
| Therapeutic alliance  | Use of young person’s interest to promote their engagement and set them at ease. Young people benefit from made to feel at ease and having the opportunity to talk. |
| Ending of therapy     | Consideration given to help the young person implement skills beyond the sessions through practice and rehearsal of skills. Number of sessions is made explicit and revisited each session. Follow-up session suggested to ‘check in’ on the young person after an agreed period of time. |

Conclusion

To date, there has been almost no research looking at how young people with learning difficulties perceive effective therapeutic support. To the best of the authors’ knowledge, this paper is the first to offer practical advice for professionals such as counsellors, therapists, mental health workers, clinical and educational psychologists and pastoral lead to support the mental health and well-being needs of young people with learning difficulties.

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