

# The experiences of therapists providing psychological treatment for adults with depression and intellectual disabilities as part of a randomised controlled trial

Ian C. Smith<sup>1</sup>  | Jaci C. Huws<sup>2</sup> | Kim Appleton<sup>3</sup> | Sally-Ann Cooper<sup>3</sup> |  
 Dave Dagnan<sup>4</sup>  | Richard P. Hastings<sup>5</sup> | Chris Hatton<sup>6</sup>  | Robert S. P. Jones<sup>7</sup> |  
 Craig Melville<sup>8</sup> | Katie Scott<sup>3</sup> | Chris Williams<sup>3</sup> | Andrew Jahoda<sup>3</sup> 

<sup>1</sup>Faculty of Health and Medicine,  
Lancaster University, Lancaster, UK

<sup>2</sup>School of Health Sciences, Bangor  
University, Bangor, UK

<sup>3</sup>Institute of Health & Wellbeing,  
University of Glasgow, Glasgow, UK

<sup>4</sup>Community Learning Disability Services,  
Cumbria Partnership NHS Trust,  
Workington, UK

<sup>5</sup>Centre for Educational Development,  
Appraisal and Research, University of  
Warwick, Coventry, UK

<sup>6</sup>Faculty of Health, Psychology and  
Social Care, Manchester Metropolitan  
University, Lancaster, UK

<sup>7</sup>School of Psychology, Bangor University,  
Bangor, UK

<sup>8</sup>University of Glasgow, Glasgow, UK

## Correspondence

Andrew Jahoda, The Academic Centre,  
Gartnavel Royal Hospital, 1055 Great  
Western Road, Glasgow G120XH, UK.  
Email: andrew.jahoda@glasgow.ac.uk

## Funding information

UK National Institute for Health  
Research Health Technology Assessment  
Programme

## Abstract

**Background:** Health professionals were trained to deliver adapted psychological interventions for depression to people with learning disabilities and depression alongside a supporter. Exploring the delivery of psychological interventions can help increase access to therapy.

**Method:** Twenty-seven participants took part in six focus groups, and the data were subject to a Framework Analysis.

**Results:** The structure and focus of the manualised therapies, and the use of specific techniques were perceived as key to service-user engagement. Supporters' involvement was valued by therapists if they had a good relationship and regular contact with the individual they supported. Regular clinical supervision was regarded as vital in understanding their role, assessing progress and delivering the interventions.

**Conclusions:** The findings highlight that health professionals can embrace a focussed therapeutic role and increase access to psychological therapies for people with intellectual disabilities.

## KEYWORDS

behavioural activation, depression, guided self-help, intellectual disability, psychological therapy, psychological therapy training, supervision, therapist

## 1 | INTRODUCTION

Depression is a common mental health problem (Cuijpers et al., 2013; McManus et al., 2009). Its prevalence in the population of people with intellectual disabilities is the same or higher than in the population as a whole and it is also longer lasting (Collishaw et al.,

2004). Psychological therapies are regarded as frontline interventions for depression (Cuijpers et al., 2013; National Institute for Clinical Excellence, 2009). Yet in many countries there is a scarcity of provision of psychological therapies for people with intellectual disabilities. One reason for this is the failure to adapt most psychological therapies to take account of cognitive and communicative

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

© 2021 The Authors. *Journal of Applied Research in Intellectual Disabilities* published by John Wiley & Sons Ltd

deficits and particular life circumstances of people with learning disabilities (Irvine & Beail, 2017). Guidance regarding best practice in working with people with intellectual disabilities and mental health problems was recently issued in England (National Institute for Clinical Excellence, 2016). However, the lack of trained therapists with the confidence to deliver psychological therapies for problems like depression has proved to be another barrier to treatment for people with intellectual disabilities (Beail, 2016).

Behavioural activation has been found to be as effective as CBT in the treatment of depression in the general population (Richards et al., 2016). Jahoda et al. (2015) conducted a feasibility study of an adapted version of behavioural activation for people with intellectual disabilities, with encouraging results. Behavioural activation focusses on promoting engagement in purposeful activity through exposure to positive environmental contingencies, which is linked with positive behavioural and emotional change.

The manualised approach developed in the feasibility study was subsequently evaluated in a large-scale randomised control trial (Jahoda, Hastings, et al., 2017), comparing the adapted version of behavioural activation (BeatIt) with an active control of Guided Self-Help (StepUp). Guided self-help is also known to be an effective treatment for depression in the general population Cuijpers et al. (2010), and it was chosen as an active control in the trial because it was thought that this psycho-educational approach has a different set of therapeutic ingredients from behavioural activation. It was found that the interventions could be delivered safely, with excellent fidelity (Jahoda, Hastings, et al., 2017). The therapists were also highly rated for the sensitivity they showed and the rapport they built with the individuals they worked with. Both interventions were associated with positive change at 12-month follow-up. The trial included nested qualitative studies concerning views and experiences of the participants with intellectual disabilities (Knight et al., 2019), their supporters (Scott et al., 2019), therapists and supervisors. This study concerns the therapists' experiences of delivering the BeatIt and StepUp interventions as part of the trial. To increase access to psychological therapies, a range of health professionals working with people who have learning disabilities were trained to deliver the therapies, rather than relying on a narrower group of specialist psychological therapists.

Previous research has suggested that social care staff can be successfully trained to deliver a CBT intervention for depression (McGillivray et al., 2008). Stimpson et al. (2013), explored the experience of day service staff, trained to deliver a group anger management intervention for people with intellectual disabilities, as part of a large-scale cluster randomised control trial. While the staff said they were initially anxious about having the necessary skills to be therapists, they were positive about the focussed nature of the manualised approach and developing new ways of working. While they found the exercises or therapeutic techniques in the manual were engaging for the group participants, some also felt constrained by the manual. Interestingly though, they described themselves as being like a group leader or facilitator, rather than as a therapist. They placed value on the opportunity to develop more positive relationships with the group members.

A Framework Analysis approach (Ritchie & Spencer, 1994) was used to analyse the therapists' views of delivering the interventions; this is a more structured form of qualitative analysis, which allows for the a priori development of a framework to organise key aspects of the data which are of interest. In this study, there was a focus on the therapists' perceptions of the process of change, therapeutic relationships and barriers and facilitators to change. Therapists' views on training and supervision were also explored, and how they thought the therapies could be adapted to address different service users' needs.

## 2 | METHOD

### 2.1 | Participants

All therapists who had worked with at least one participant during the course of the trial were invited to take part in a focus group. Forty two therapists delivered BeatIt interventions and 34 therapists delivered StepUp interventions. The majority of therapists were staff from specialist community teams for people with intellectual disabilities with experience of working with mental health difficulties but few had prior training or experience in providing psychological therapy. A small minority of those trained in England

TABLE 1 Therapists' details

Group	Biological gender	Profession	Therapy delivered to participants	Psychological therapy training
BeatIt (15)	Men = 10 Women = 5	CLDT Nurse = 10 Assistant Psychologist = 3 Primary care MH Practitioner (IAPT) = 1	Completed = 25 Incomplete = 14	Reported training = 5 No reported training = 10
StepUp (11)	Men = 1 Women = 10	CLDT Nurse = 7 Assistant Psychologist = 1 Primary care Mental Health Practitioner (IAPT) = 1 Occupational Therapist = 2	Completed = 34 Incomplete = 6	Reported training = 4 No reported training = 7

Abbreviations: CLDT, community learning disability nurse; IAPT, increasing access to psychological therapies.

( $n = 6$ ) were primary care mental health workers from mainstream Increasing Access to Psychological Therapies services. In total, 15 of the BeatIt therapists and 11 of the StepUp therapists took part in the study. One additional BeatIt therapist, who was unable to attend a focus group, was interviewed separately. The details of the therapists who took part in this qualitative study are shown in Table 1.

## 2.2 | The interventions and context

BeatIt (12 sessions) and StepUp (8 sessions) are both manualised interventions, delivered to the person with intellectual disabilities and a support person. The support person was a friend, relative or staff member. Both interventions were delivered on an outreach basis, most often at the person's home.

Two-day initial training was provided to the therapists. Regular clinical supervision was then provided on a fortnightly basis by clinical psychologists or trained therapists, with longstanding experience of delivering psychological interventions. The interventions were delivered on an outreach basis at the participant's home or somewhere that was convenient for them.

BeatIt is a behavioural activation intervention that aims to increase the person's purposeful or meaningful activity in order to improve their mood. A formulation is developed in the first assessment and socialisation phase of therapy. The second phase of therapy involves activity scheduling and tackling barriers to change. An updated formulation booklet is shared at the end of therapy, with guidance about maintaining or building on any progress which has been made.

StepUp is a guided self-help programme aimed at teaching people about depression and ways of helping themselves to feel better. The intervention is structured round four bespoke psycho-educational booklets, dealing with the nature of depression, sleep hygiene, physical exercise and problem solving.

Individuals were recruited if their presentation had a significant depressive component, and they were subsequently screened to establish whether they were clinically depressed, using the DC-LD (Cooper et al., 2003). The mean IQ scores of the 84 BeatIt and 77 StepUp participants were 55 (8) and 58 (8). It remains relatively uncommon for people with intellectual disabilities to be referred specifically for specialist help with depression. While only 19% of the participants had received previous psychological therapy for depression, two thirds of them (65%) were being prescribed antidepressants, highlighting the longstanding nature of their difficulties.

## 2.3 | Design and procedure

One focus group for each therapy was held in the three regions where the study was conducted (Scotland, England, Wales), with six focus groups in total. The groups were facilitated by two researchers

using a semi-structured topic guide and lasted for 60–90 min. Data were audio-recorded and then transcribed verbatim. Written consent was obtained from all participants.

## 2.4 | Data analysis

Using a Framework Analysis approach (Ritchie & Spencer, 1994), transcripts were analysed by three researchers who had expertise in qualitative research (Smith, Huws, and Jahoda). The analysis entailed a series of five interconnected stages of iteratively moving back and forth across the transcripts: stages 1–4 focussed on data management, and the development and refinement of a coding framework. The BeatIt and StepUp participants' data were coded and categorised separately. Stage 5 focused on interpretation of categories and development of themes. The stages were as follows:

1. Familiarisation with the data: Reading transcripts to become familiar with the content; recording analytical notes and impressions; initial coding. This stage provided a 'conceptual scaffold' for management of data and the subsequent development of codes and categories.
2. Framework development: Organising and coding data; initial codes closely related to the interview topic guide, followed by inductive 'open coding' to develop and refine a 'coding matrix' in preparation for subsequent mapping and interpretation.
3. Indexing: Methodically using the coding matrix to code all transcripts; grouping codes to develop categories.
4. Charting: Summarising and tabulating data linked to each category; developing manageable synopses and cross-referencing to illustrative quotes.
5. Mapping and interpretation: Analysing the data; exploration of similarities and differences; interpretation and clarification of concepts; making connections within and across data and categories; development of themes.

Initial analyses were completed by Huws, with subsequent reviews of the framework and analyses carried out by Smith & Jahoda, to help ensure that the process was rigorous and transparent. The final analyses were agreed by Huws & Jahoda.

## 3 | RESULTS

The final framework matrix identified five themes: (1) adapting to the role of a BeatIt/StepUp therapist, (2) delivery of therapy, (3) a future focus, (4) practical challenges and improvement and (5) working with a supporter.

In the quotes shown below, the acronyms BIT and SUT refer to BeatIt and StepUp therapists, respectively, followed by the number given to each person.

### 3.1 | Theme 1. Adapting to the role of a BeatIt or StepUp therapist

#### 3.1.1 | Sub-theme 1.1: Becoming the therapist

While some participants with prior experience of delivering psychological therapies felt that taking on the role of 'therapist' was consistent with their previous experience and training, others indicated that they were initially anxious about delivering therapy. In particular, nurses who were BeatIt and StepUp therapists described initial conflicts of expectation in having to engage in work that focussed solely on therapy rather than implementing the range of holistic care usually associated with nursing:

I thought it felt a bit surreal, you know, prioritising priorities, you were just there for the one piece of work, it was just so unique

(SUT1)

Although such preliminary role conflicts were frustrating for some of the nurses, there were also positive aspects associated with having a clearly structured therapy focus to their work:

The structure was good to have (...) to not only guide but restrict as well 'cos half the time I would be sitting there going 'oh this is a problem, I'll make a referral to this, I'm not doing it. I'm not a nurse I'm a therapist' and so it was nice to have a very defined role to be within, and a goal that was also quite clear.

(BIT5)

#### 3.1.2 | Sub-theme 1.2: Supervision

The therapists highlighted that practice and experience of delivering the interventions was key to developing mastery of the therapeutic approaches:

The more you did it the more ... it got easier ... more flexible ... more client focused, it just became quite natural as a process.

(BIT3)

Clinical supervision was valued in both BeatIt and StepUp interventions, helping therapists to understand their role and engagement with those they were working with:

It is really important to reflect and take a step back because sometimes with certain people you feel that you are not moving forward but to have somebody to come back and discuss that with and unpick it all you are able to see it clearly.

(BIT1)

Input from a supervisor was key in enabling therapists to reflect on process and progress:

[My supervisor said] you are only on session three, look what we have done and look what we have found out". I think that was really important for my development.

(BIT1)

Supervision therefore helped therapists to understand the range and scope of their professional and practice boundaries. As confidence increased, then so did therapists' capacities for confirming a sense of self-adequacy as they assimilated into their new roles.

### 3.2 | Theme 2: Delivery of therapy

#### 3.2.1 | Sub-theme 2.1 Flexibility and structure: achieving a balance

Both BeatIt and StepUp therapists viewed the structured approach to treatment positively. The restricted number of sessions was also valued. BeatIt and StepUp therapists reported clear guidance and support on how to deliver the programmes, with processes described in the manuals. They talked about how this structure aided their delivery:

[It] made me feel quite comfortable. I was like, "Yes, a bit of structure finally." I'm all over the place with lots of my clients so this was quite nice I knew what I'm doing.

(BIT 6)

However, some concerns were expressed by both sets of therapists about lack of flexibility, and repetition was a particular concern raised by some BeatIt therapists. These factors were regarded as barriers to person-centred tailoring of the interventions to individual needs:

I thought it was all useful, but I preferred it (manual) as a use it or leave it option, whereas it was prescriptive, and like you said before, I also felt that certain sessions were very repetitive. And that took a bit of something away from what could have been done rather than listening to the person.

(BIT7)

The contrasting view was that the repetition and structure were crucial, scaffolding understanding and engagement, and helping people to anticipate what would happen in subsequent sessions:

I liked the repetition for the client and I think the client liked that as well. Because you were re-visiting the last session at the beginning of the following session

and it always took the same format and we didn't deviate from that so once you got into that after a couple of weeks you got used to the format of it yourself. You'd relax into it but I also think the client did as well because they started to know exactly what to expect each week even though the topic changed, and I think that was really helpful.

(SUT6)

The structure and predictability were also seen as helping to clarify roles and ensured that the person, the supporter, and the therapist all developed a sense of ownership and control of the therapy process:

It provided a sense or predictability for the person for...whoever the supporter was and very early on we were able to identify what our roles were and I ... encourage them to take ownership of it and control.

(BIT 1)

Having a set number of sessions meant that therapists "kept on track" (SUT6; SUT7) and knew when to end treatment. This was seen as facilitating rather than constraining therapy, ensuring sessions stayed on topic, within time, and that focus was maintained across sessions:

It was an eight-session block... and after that it would stop. So I think that was just as important...to focus them... that if you're going to get something out of it you need to really concentrate and be a part of it as well.

(SUT8)

Therapists who had worked with larger numbers of participants felt that their familiarity with the materials helped them to bring the manualised interventions to life for the individuals they engaged with:

From the therapy's point of view though, the more you did it the more, I mean if it was rolling on and we were on our sixth client, it got easier and easier and easier, it got far more flexible, it got more client focused, it just became quite natural as a process and enthusiasm and looking at everything else just pops into your head as you mature in it...

(BIT3)

As the therapists became more aware of their improved competencies in delivering the interventions, the more heightened their confidence became.

### 3.2.2 | Sub-theme 2.2: Materials and relationships

There were specific criticisms of particular materials and exercises. For example, some individuals were said to have struggled to engage

with BeatIt self-report diaries and others had found materials to be child-like or 'patronising'. However, the information, examples and activities within the manuals were generally seen as therapeutically valuable on their own terms:

[The person] found it very, very useful. He asked for more copies of 'Make a Plan' and 'How Did It Go?' [so] that he could plan his time.

(BIT12)

'Learning through doing' was seen to be an important dimension of the therapies, particularly for those individuals who struggled with talking therapies. This included having the StepUp booklets to work through and the BeatIt exercises. One BeatIt therapist talked about the importance of using visual materials with one person:

He ... engaged much better in that than he ever did with any of the chatting, chatting he would just shut right up whereas if there was some physical activity to do, he opened up and he would do something with me.

(BIT5)

The materials and tasks were considered particularly useful at the initial stages of therapy, helping therapists to get to know the person, engage them in the therapy process and to build therapeutic relationships:

I just found the tool itself just a fantastic way of getting to know somebody that you'd met for the first time, to get information from somebody that might take you years to build up, it was really good at getting people to open up to you and talk;

(SUT4)

Providing a space for people to talk about themselves and to feel listened to was considered to be an important element of the therapies. Therapists reported that StepUp gave people space to start talking about themselves:

I think that was part of my engagement with the person to listen to their perspective.

(SUT9)

One of the perceived positive aspects of the BeatIt formulation was that it acknowledged the person's perspective:

I think it showed that I listened to him, which I think was the biggest thing, 'oh you've actually listened to what I've been saying.'

(BIT6)

### 3.3 | Theme 3: A future focus

Some StepUp therapists believed that they went beyond tackling people's immediate problems and helped them to view their situation differently:

... even though he hasn't solved all his problems, he feels that he's learned a lot and... he felt it had actually made a difference to the way he looked at things himself and [the supporter] said 'Yes I can see a change in his attitude'.

(SUT6)

StepUp was seen as providing knowledge and information that people could also use in the future: "It's tools for the future; that's what it's there for, not just those eight weeks".

(SUT8)

It was suggested that the booklets could be used 'proactively' to help people stay emotionally well and to promote people's emotional wellbeing. This appeared to be borne out of the observation that not all of the booklets were relevant to clients' specific difficulties, and there was a value to covering issues like 'A good night's sleep' nonetheless.

### 3.4 | Theme 4: Practical Challenges and Improvements

#### 3.4.1 | Sub-theme 4.1: Trial restrictions to be removed

There were a number of challenges raised by therapists that related to being part of a 'trial'. For example, because therapists were only given limited time to work on the trial, the majority only had opportunities to deliver the interventions to one or two individuals. Being involved in a trial meant that a number of the BeatIt therapists had only delivered therapy to one or two individuals. Lack of familiarity with the manual and materials made the process more time consuming

I had to keep reading [the manual] just to get familiar... and also the writing up of the session... and then my supervision with the psychologist... is probably three hours a week.

(BIT7)

There were trial restrictions that therapists felt would need to be changed if the therapies were to be delivered with the maximum effect. StepUp therapists were frustrated about being asked to avoid 'following up' with the individuals they worked with, for example, to find out if they had carried out plans made in their therapy

sessions and recorded in the booklets. This reason therapists were asked to do this was to try to ensure that the StepUp (guided self-help) intervention remained distinct from the BeatIt (behavioural activation) intervention. This was challenging, and as one of therapists explained:

You don't know whether they have or haven't done the things [they said they would do].

(SUT11)

This appeared to lead to a sense of skills obsolescence. Indeed, it emerged that some of the StepUp therapists were unable to override their instincts to be 'good therapists' and did follow-up with the participants to check whether or not they had carried out the plans they had made in sessions.

The strict cap on the number of sessions and guidance not to follow-up with participants after the therapy had been completed, was also considered to be a drawback on occasion by both BeatIt and StepUp therapists:

When you think how long it takes... before they are learning this skill of problem solving, they're not going to retain that with just those eight sessions if there's no continuity.

(SUT6, a StepUp therapist)

I think a few people could have done with a follow-up session, I don't mean by seeing them every week and going through but a follow-up session every three weeks then a month just to keep them on track and keep that momentum going.

(BIT1)

Looking forward, most of the therapists were able to envisage using the therapies in their future work with people who have intellectual disabilities. However, the therapists from the Increasing Access to Psychological Therapies service in England, which serves the general population, believed that the strict protocols governing their activities would make it impossible to deliver BeatIt or StepUp as a routine intervention.

#### 3.4.2 | Sub-theme 4.2: Obstacles to be considered and improvements to be made

BeatIt therapists reported that 'money's an issue, support's an issue' when trying to schedule events for people who might not have the confidence to try out new activities on their own between sessions:

They'd say 'we haven't had time this week' or 'we've not been able to do it'.

(SUT8)

The amount of time a supporter had to give might also be beyond their control,

...that person - she basically only had two hours support and that time had to be filled with shopping and things like that;

(BIT2)

The difficulty of scheduling activities for people who apparently led quite active lives was also raised by some therapists. However, a counterpoint was that some of those who had relatively busy schedules had lost interest in their activities, seemingly because they gained little sense of fulfilment from them:

of the sessions, she said that the problem was with the day services and he was getting bored there...

The StepUp therapists highlighted that suggested activities in the booklets needed to be affordable, and accessible for people with physical disabilities. When looking at problem solving, it was considered important that people's goals were achievable and realistic, and there was concern about the potential to 'set up people to fail':

For it to work properly there's no point in somebody saying this is what they want to do [if] it's not going to be achievable.

(SUT10)

### 3.5 | Theme 5: Supporter engagement

#### 3.5.1 | Sub-theme 5.1: Positive aspects

The level of supporter engagement was described as pivotal to the success of both interventions. Supporters could optimise the development of meaningful therapeutic relationships and communication between the person and therapist:

My supporter was great in the sessions and really encouraging and supportive of the communication.

(BIT6)

Therapists preferred supporters who knew the person well, and spent time with them daily, rather than someone who was supporting them for the purpose of therapy alone. The best supporter was viewed as someone who was available to facilitate activities 'outside of hours', and commitment and continuity were identified as being important for successful interventions:

It adds complications when the one who was supporting the person had to then pass it onto another organisation to then follow through what homework we'd set.

(BIT8)

Therapists also felt it was important for supporters who worked in services to share session content with their colleagues.

#### 3.5.2 | Sub-theme 5.2: Challenging aspects

In contrast, supporter negativity could impact upon the person's engagement. For example, one BeatIt therapist reported that:

You could tell from the offset that the support worker thought that it was not any use at all. "Why are we here? Why have we got to do that?" And I think my client picked up on that, didn't engage, didn't do any of the homework that he was supposed to do.

(BIT11)

In some instances, therapists felt that the presence of the supporter impeded and restricted the therapeutic relationship and communication. This was influenced by the nature of the relationship with the supporter. For example:

There was one boy who was 17 or 18 and we were doing things on relationships and his mum was sitting there and... he was embarrassed and didn't want to speak in front of his mum.

(BIT1)

This therapist went on to suggest that one way to allow people to address topics in confidence with the therapist would be set aside part of the session to talk with the therapist on their own, without the supporter.

There were occasions when the supporter changed mid-programme and did not know what the therapy was about:

"when you were turning up and the supporter didn't know who you were and what this was meant to be, that's what caused the problems".

(SUT11)

Therapists felt that supporters in the StepUp intervention would have benefitted from an initial session to explain the nature of the therapy and their role in the process. Therapists delivering both interventions found that some supporters were unaware, at the outset, of the level of commitment that was required of them:

My supporters weren't aware that they would be required to give support outside [of the sessions].

(BIT9)

## 4 | DISCUSSION

The therapists in this study were health professionals and most had previous experience of working therapeutically with people who



have intellectual disabilities. Therefore, they had to make a different adjustment from lay therapists in previous research, who had no prior therapeutic experience (Stimpson et al., 2013). The main challenge was adopting the role of a psychological therapist. In particular, the community learning disability nurses reported having initial difficulties engaging in a more focussed and time-limited piece of therapeutic work with individuals. This was at variance with the more holistic approach they would usually take. While concerns were expressed about the more restricted manualised approaches, the therapists generally embraced their new role. They felt that the clear, repeated structure made the therapies more accessible and predictable, and helped service users engage more fully in sessions. Supervision was also thought to help the therapists adjust to this new way of working and resolve specific difficulties with individual cases. Supervision is known to be important in facilitating the consistent delivery of effective therapy after brief training (Smith, 2011).

There were criticisms of the tasks and materials used with both BeatIt and StepUp, in terms of either being too complex or child-like. However, experience of delivering the therapies and familiarity with the manuals and materials gave the therapists confidence to adapt interventions to individual needs and circumstances. Overall, the tasks and materials were greatly valued, viewed as intrinsically vital to therapy and as a means of encouraging people to talk about themselves and their feelings in a ways that could quickly produce a strong therapeutic alliance.

The involvement of the supporter in sessions when they were positive about the therapy was seen as key to applying what was learned in the therapy sessions to everyday life. The potential importance of involving significant others in therapy sessions is consistent with findings of previous research concerning the delivery of psychological therapies to people with intellectual disabilities (Rose et al., 2005). However, it was also recognised that there were times when it would be beneficial for the person with intellectual disability to speak with the therapist alone. A confiding relationship might allow the person to raise issues they are unable to talk about with family, friends or workers (Pert et al., 2013).

The therapists were aware that the outcomes of BeatIt and StepUp were not confined to what happened in the sessions. When delivering therapies that promote behavioural and lifestyle change, other practical issues, such as money and practical and emotional support may play a vital part. Dagnan (2007) has argued that it is mistaken to view psychological therapies and their impact in a vacuum. One of the key differences between the two therapies was meant to be that StepUp did not have homework tasks. However, therapists in the StepUp focus groups admitted that they had followed-up with on planned life changes made in sessions. In essence, this resulted in greater overlap between the two therapeutic approaches than was intended.

The specific and non-specific components of therapy are sometimes described as being distinct, as if having time together and a joint focus are sufficient conditions for the therapist and client to develop a therapeutic alliance. However, the therapists in

this study proposed that it was only because the specific content of BeatIt and StepUp was sufficiently engaging, that it facilitated the establishment of a therapeutic relationship. This is a valuable insight, as there are a limited number of properly adapted materials developed to be used in psychological therapies with people who have intellectual disabilities (Jahoda, Stenfort-Kroese and Pert, 2017).

#### 4.1 | Limitations

Whilst more than a third of the total number of therapists in the trial attended a focus group, this sample was self-selecting and so may not be representative of the experience of all. Despite the common themes identified in this paper, there were also some divergent views represented in the focus groups (as one would expect), not all of which could be represented in our final analysis. Our findings do not shed light on the particular qualities of the two interventions or their suitability for particular clients. Unfortunately, none of our extensive quantitative or qualitative findings from the therapists, participants or supporters, who were part of the study, have helped in this regard (Jahoda et al., 2018). One of the challenges was that most therapists only delivered therapy to small numbers of individuals as part of the trial. Twenty, out of the 25 therapists who took part in the focus groups, had completed therapy with only one or two participants. This may have contributed to the fact that most of the BeatIt and StepUp focus group discussions concerned the therapists' initial experiences of taking on the role of a psychological therapist and learning to deliver a manualised intervention.

#### 4.2 | Clinical implications and future research

The views and experiences of the therapists in this study support the wider trial findings (Jahoda, Hastings, et al., 2017) that it is possible to train and support a range of health professionals to deliver psychological therapies to people with intellectual disabilities and depression. This approach has the potential to increase access to psychological therapies for people with intellectual disabilities. However, the therapists' experiences highlight the need for regular supervision and support to adapt to the role of therapist delivering a psychological intervention. The role of psychological therapist delivering focussed interventions was seen as quite distinct from their usual roles as Community Nurses or Occupational Therapists. It was clear that without this support and guidance many would not have followed the manuals properly. One of the reasons for this is people usually come to therapy with a more than one particular emotional problem or life difficulty. As Community Nurses or Occupational Therapists, they quite understandably wished to take a more holistic approach. Hence, to embed interventions like BeatIt and StepUp in services for people with intellectual disabilities require more than simply training



and supervising therapists. There also has to be a broader commitment by the service to providing therapeutic help for people with intellectual disabilities and depression. Otherwise, people's depressive symptoms may continue to be overshadowed by other difficulties, resulting in a lack of referrals and a loss of confidence in the interventions.

It may be surprising to suggest that thought and effort needs to be given to providing therapeutic help for such a commonly occurring emotional problem as depression. However, the therapists from the Increasing Access to Psychological Therapy (IAPT) services, who are meant to serve the whole population in England, were uncertain that BeatIt could be delivered as part of their routine practice, due to practical constraints they worked under. This highlights the need for mainstream services to be willing to adapt their practices in order to more truly meet the needs of the general population, including those with intellectual disabilities (Chinn & Abraham, 2016).

In addition to the need for research about the implementation of these therapies in routine practice, there may be value in further work trying to obtain more detailed insight into therapists' experiences with delivering the specific therapies, as there are distinct differences between BeatIt and StepUp. Aspects of the manuals have already been clarified and additional information added, based on the observations and insights of the therapists delivering the interventions (Jahoda et al., 2018). However, it remains uncertain whether this would help to determine which therapy would be most suitable for whom. This could be a matter of preference for the individuals with intellectual disability, just as some potential therapists may have a more affinity with BeatIt or StepUp, as a way of working. A distinction could be made between the two therapies, using a stepped care model, whereby higher intensity interventions are required to address increasingly complex mental health problems. BeatIt could be regarded as a higher intensity formulation driven approach and StepUp a more straightforward lower intensity approach. However, the therapists' accounts, of how they brought both approaches to life with individuals presenting with a range of clinical severity and often longstanding depressive symptoms perhaps challenge this stepped care model. This is an issue that deserves further examination in the future research.

## 5 | CONCLUSION

These findings complement the views of individuals with an intellectual disability and their supporters about the delivery of the BeatIt and StepUp therapies as part of the trial (Knight et al., 2019; Scott et al., 2019). The thoughtfulness shown by the therapists who engaged in this study was consistent with the excellent fidelity ratings they obtained (Jahoda, Hastings, et al., 2017). The insights provided by the therapists and their views about delivering the therapies have important implications for the use of BeatIt and StepUp in routine clinical practice.

## ACKNOWLEDGEMENTS

This independent research study was funded by the UK National Institute for Health Research Health Technology Assessment Programme. The views expressed in this publication are those of the authors and not necessarily of the National Institute for Health Research or the Departments of Health in Scotland, England, or Wales. We thank all NHS and social care services in Scotland, England, and Wales who contributed to the study.

## CONFLICT OF INTEREST

AJ, CH, RJ, S-AC, RPH, CM and CW all report receiving grant funding from the National Institute for Health Research during the course of the study. All other authors declare no competing interests.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

## ORCID

Ian C. Smith  <https://orcid.org/0000-0003-1333-2090>

Dave Dagnan  <https://orcid.org/0000-0002-5709-1586>

Chris Hatton  <https://orcid.org/0000-0001-8781-8486>

Andrew Jahoda  <https://orcid.org/0000-0002-3985-6098>

## REFERENCES

- Beail, N. (Ed.) (2016). *Psychological therapies and people who have intellectual disabilities*. London, UK: British Psychological Society, Division of Clinical Psychology.
- Chinn, D., & Abraham, E. (2016). Using 'candidacy' as a framework for understanding access to mainstream psychological treatment for people with intellectual disabilities and common mental health problems within the English improving access to psychological therapies service. *Journal of Intellectual Disabilities Research*, 60, 571–582.
- Collishaw, S., Maughan, B., & Pickles, A. (2004). Affective problems in adults with mild learning disability: The roles of social disadvantage and ill health. *British Journal of Psychiatry*, 185, 350–351.
- Cooper, S. A., Melville, C. A., & Einfeld, S. L. (2003). Psychiatric diagnosis, intellectual disabilities and diagnostic criteria for psychiatric disorders for use with adults with learning disabilities/mental retardation (DC-LD). *Journal of Intellectual Disability Research*, 47(Suppl. 1), 3–15. <https://doi.org/10.1046/j.1365-2788.47.s1.2.x>
- Cuijpers, P., Donker, T., van Straten, A., Li, J., Andersson, G., & Cuijpers, P. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine*, 40(12), 1943–1957.
- Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: A meta-analysis of direct comparisons. *World Psychiatry*, 12(2), 137–148. <https://doi.org/10.1002/wps.20038>
- Dagnan, D. (2007). Psychosocial interventions for people with intellectual disabilities and mental ill-health. *Current Opinion in Psychiatry*, 20, 456–460.
- Irvine, M., & Beail, N. (2017). Identifying and meeting the emotional and mental health needs of people who have intellectual disabilities through psychological therapies. In N. Beail (Ed.), *Psychological therapies and people who have intellectual disabilities* (pp. 13–23). The British Psychological Society.

- Jahoda, A., Hastings, R., Hatton, C., Cooper, S.-A., Dagnan, D., Zhang, R., McConnachie, A., McMeekin, N., Appleton, K., Jones, R., Scott, K., Fulton, L., Knight, R., Knowles, D., Williams, C., Briggs, A., MacMahon, K., Lynn, H., Smith, I., ... Melville, C. (2017). Comparison of behavioural activation with guided self-help for treatment of depression in adults with intellectual disabilities: A randomised controlled trial. *The Lancet Psychiatry*, 4(12), 909–919. [https://doi.org/10.1016/S2215-0366\(17\)30426-1](https://doi.org/10.1016/S2215-0366(17)30426-1)
- Jahoda, A., Hastings, R., Hatton, C., Cooper, S. A., McMeekin, N., Dagnan, D., Appleton, K., Scott, K., Fulton, R., Jones, R., McConnachie, A., Zhang, R., Knight, R., Knowles, D., Williams, C., Briggs, A., ... Melville, C. (2018). Behavioural activation versus guided self-help for depression in adults with learning disabilities: the Beattt RCT. *Health Technology Assessment*, 22(53), 1.
- Jahoda, A., Melville, C. A., Pert, C., Cooper, S.A., Lynn, H., Williams, C., & Davidson, C. (2015). A feasibility study of behavioural activation for depressive symptoms in adults with intellectual disabilities. *Journal of Intellectual Disability Research*, 59(11), 1010–1021.
- Jahoda, A., Stenfert-Kroese, B., & Pert, C. (2017). *Cognitive behaviour therapy for people with intellectual disabilities*. Palgrave Macmillan UK.
- Knight, R., Jahoda, A., Scott, K., Singer, K., Knowles, D., Dagnan, D., Hastings, R. P., Appleton, K., Cooper, S.-A., Melville, C., Jones, R., Williams, C., & Hatton, C. (2019). "Getting into it": People with intellectual disabilities' experiences and views of behavioural activation and guided self-help for depression. *Journal of Applied Research in Intellectual Disabilities*, 32(4), 819–830.
- McGillivray, J. A., McCabe, M. P., & Kershaw, M. M. (2008). Depression in people with intellectual disability: An evaluation of a staff-administered treatment program. *Research in Developmental Disabilities*, 29, 524–536.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. Health and Social Care Information Centre. <http://digital.nhs.uk/catalogue/PUB02931>
- National Institute for Clinical Excellence. (2016). *Mental health problems in people with learning disabilities: Prevention, assessment and management (NG54)*. NICE Guideline 54, <https://www.nice.org.uk/guidance/ng54/chapter/Recommendations#psychological-interventions>
- National Institute for Clinical Excellence. (2009). *Depression: the treatment and management of depression in adults (update)*. CG90 National Institute for Health and Clinical Excellence, London, UK: <https://www.nice.org.uk/guidance/cg90>
- Pert, C., Jahoda, A., Stenfert Kroese, B., Trower, P., Dagnan, D., & Selkirk, M. (2013). Cognitive behavioural therapy from the perspective of clients with mild intellectual disabilities: A qualitative investigation of process issues. *Journal of Intellectual Disability Research*, 57(4), 359–369.
- Richards, D. A., Ekers, D., McMillan, D., Taylor, R. S., Byford, S., Warren, F. C., Barrett, B., Farrand, P. A., Gilbody, S., Kuyken, W., O'Mahen, H., Watkins, E. R., Wright, K. A., Hollon, S. D., Reed, N., Rhodes, S., Fletcher, E., & Finning, K. (2016). Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (COBRA): A randomised, controlled, non-inferiority trial. *The Lancet*, 388(10047), 871–880. [https://doi.org/10.1016/S0140-6736\(16\)31140-0](https://doi.org/10.1016/S0140-6736(16)31140-0)
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R. Burgess (Eds.), *Analyzing qualitative data* (1st ed.). Routledge.
- Rose, J., Loftus, M., Flint, B., & Carey, L. (2005). Factors associated with the efficacy of a group intervention for anger in people with intellectual disabilities. *British Journal of Clinical Psychology*, 44, 305–317.
- Scott, K., Hatton, C., Knight, R., Singer, K., Knowles, D., Dagnan, D., Hastings, R. P., Appleton, K., Cooper, S.-A., Melville, C., Jones, R., Williams, C., & Jahoda, A. (2019). Supporting people with intellectual disabilities in psychological therapies for depression: A qualitative analysis of supporters' experiences. *Journal of Applied Research in Intellectual Disabilities*, 32(2), 323–335. <https://doi.org/10.1111/jar.12529>
- Smith, I. C. (2011). A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team. *Psychology & Psychotherapy: Theory, Research & Practice*, 84(3), 335–348. <https://doi.org/10.1111/j.2044-8341.2010.02000.x>
- Stimpson, A., Kroese, B. S., MacMahon, P., Rose, N., Townson, J., Felce, D., Hood, K., Jahoda, A., Rose, J., & Willner, P. (2013). The experiences of staff taking on the role of lay therapist in a group-based cognitive behavioural therapy anger management intervention for people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 26(1), 63–70.

**How to cite this article:** Smith IC, Huws JC, Appleton K, et al. The experiences of therapists providing psychological treatment for adults with depression and intellectual disabilities as part of a randomised controlled trial. *J Appl Res Intellect Disabil*. 2021;00:1–10. <https://doi.org/10.1111/jar.12886>