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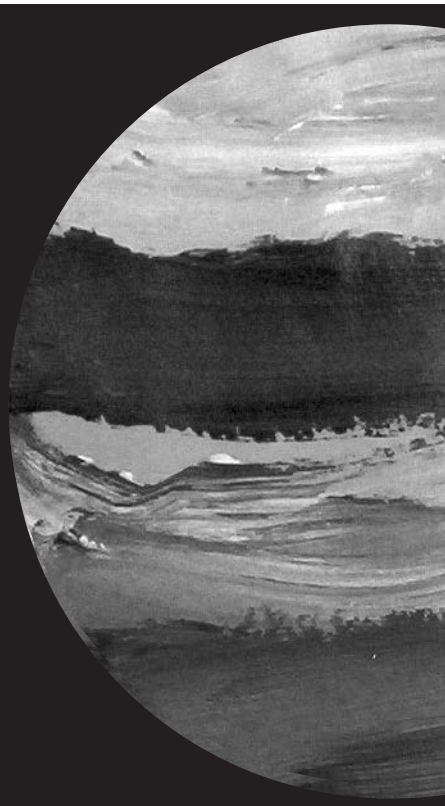
Cognitive Analytic Therapy in People with Learning Disabilities: An Investigation into the common Reciprocal Roles found within this client group



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Abstract

Developments over the last twenty years have shown that, contrary to previous opinion, people with learning disabilities can benefit from psychotherapy (Sinason 1992; Kroese, Dagnan & Loumidia, 1997. Cognitive Analytic Therapy (CAT) has been adapted for use with a learning disability population (Ryle 2002). CAT collaboratively examines the Reciprocal Roles (RRs) a client plays in relationships. These are impacted by clients' experiences of the world. The aim of this research is to identify which RRs may become apparent in working with people with learning disabilities. The therapy notes of participants (n=16) who had undergone CAT were examined and analysed using content analysis. Twenty-two different RRs were found. Four common Reciprocal Roles and two common idealised Reciprocal Roles were identified. Other observations about the data are presented. The limitations and clinical implications of the study are discussed.

Key Words: Psychotherapy, Learning disability, Reciprocal Roles, CAT

Introduction

Introduction to Cognitive Analytic Therapy (CAT)

Cognitive Analytic Therapy is a time-limited, integrative psychotherapy developed by Ryle (1990) for use within the NHS. It aims to integrate concepts from behavioural, cognitive and psychoanalytic therapies and object relations theory (see Ryle, 1991). The effectiveness of CAT has been demonstrated with a number of different client groups (Ryle, 2002). To explore the rationale for using CAT with people with learning disabilities the literature for psychotherapy for people with learning disabilities is reviewed.

History: development of psychotherapy with people with learning disabilities

Historically it was thought that people with learning disabilities would not benefit from psychotherapy (Tyson & Sandler, 1971). Until the last two decades, most published therapeutic research for people with learning disabilities was either behavioural or medical. Development of psychotherapy with people with learning disabilities was intricately tied into the political and societal changes in the fundamental treatment and understanding of people with learning disabilities (Nezu & Nezu, 1994). Nezu & Nezu (1994) presented underlying reasons for lack of evaluation of effective outpatient treatment for people with learning disabilities, which indicate why people with learning disabilities are often excluded from psychotherapy treatment

Psychoanalysis for people with learning disabilities

It is now recognised that people with learning disabilities do benefit from psychotherapy. Sinason (1992) states that patients with profound disabilities can benefit from psychoanalytic psychotherapy because communication takes place on

more than one level. She distinguishes between cognitive and emotional intelligence: 'emotional intelligence may be left intact and rich regardless of how crippled performance intelligence was'. Human contact to a fundamental emotional level can be made with most people which in itself may be therapeutic. Thereafter practitioners should adjust and apply the techniques in which they are skilled to the presenting problem, at the level at which it can be usefully accepted (Decker, 1988). Bates (1992) regarded working with people with learning disabilities psychotherapeutically to differ from working with non-handicapped peopleonly through the process having a different time span and rhythm.

'At a fundamental level, working with a person with a learning disability in psychotherapy is the same as working with anyone else, and as different. They are often not seen as suitable for treatment, but here it is psychotherapy that is handicapped.' Linington (2002).

Using Cognitive Behaviour Therapy (CBT) with people with learning disabilities

Previously the behaviour of people with learning disabilities was considered objectively but without regarding meaning. Ignoring the meaning led to labelling a persons wish for human contact in a negative way (Lovett, 1985). Specifying possible motivation driving the behaviour, e.g. wanting to make friends, informs formulation. CBT with people with learning disabilities goes some way towards redressing this balance. CBT therapists aim to make the relationship collaborative, regarding issues of social control and who sets the therapy goals (Kroese et al 1997).

Kroese et al (1997) illustrated in their seminal book, that people with learning disabilities were able to work within the structure of cognitive behavioural therapy. CBT offered these clients some control over their therapy, real choice, and an opportunity to express themselves. They found that clients were more likely to listen, take psychological concepts on board and work in a collaborative way.

This demonstration of people with learning disabilities working effectively within a CBT framework, and understanding the concepts has paved the way for the use of other therapies such as CAT.

Psychotherapeutic issues

Hollins & Sinason (2000) suggested a number of psychic organising principles, which have to be dealt with in psychotherapy for people with learning disabilities:

- **The existence of the disability,** including conscious and unconscious fantasies that accompany it. The existence of disability at birth impacts on the relationship of the individual with their family and community (Hollins & Sinason 2000). There is an increase in emotional disturbance in proportion to the severity of the learning disability (Szivos & Griffiths, 1990).

- **Issues of loss,** of the normal self who would have been born.

- **Dependency,** the problems of not being able to live autonomously. This may make it more difficult for disabled teenagers to take the first steps towards adult life.

- **Sexuality,** which may be internally distorted by the impact of the disability. People with learning disabilities may receive contradictory messages about their sexuality and the appropriateness or inappropriateness of their behaviour (Sigman 1985). Limited spoken language skills may hinder communication about the emotional feelings of emerging sexuality, sexual experience or abuse.

- **Fear of death or murder.** Being part of a group that society wishes to eliminate e.g. foetal screening. Smiling and withdrawing may be different responses to this fear. This is impacted by exclusion from more concrete aspects of death and death rituals.

Some other related themes discussed in the literature are briefly outlined below.

• Attachment

From birth, overwhelming grief and unresolved mourning impact on care giving and the development of a secure sense of self (Ainsworth & Eichberg, 1991; Bowlby 1979). 'When a baby with a learning disability looks into her parent's face for her self-reflection and finds the gaping void of no imagination, when feelings find no way to be thought and regulated, subjectivity becomes a painful absence' Linington (2002). For babies born with a learning disability, unresolved mourning and overwhelming feelings in the caregiver will have a primary etiological significance in the development of their becoming handicapped. Linington (2002) talks about the possibility of learning disability becoming the space into which unresolved intergenerational trauma is projected, a container for the parent's own overwhelming emotional experience. Bion (1959) spoke of a therapist becoming a container for the intolerable experiences of a client, as a mother does for her child, thus making the experience more manageable. Hollins & Sinason (2000) consider that where there is disruption to bonding as a result of the disability, the disability itself is experienced as a trauma.

• Trauma

Some experiences of disability may result in trauma. Hollins & Sinason (2000) considered that 'traumatic symptoms are significantly under-recognised in people with learning disabilities'. One aspect of this may be illustrated by the 'handicapped smile', which was formulated by Sinason (1992) as a function of appeasement rather than happiness. This reaction may develop as a result of fear towards an aggressor. Clark (1933) discussed handicap as a defence against trauma.

• Secondary handicap

Secondary handicap may be used as a defence, i.e. the exaggeration of a difficulty thus giving the person some control over it and therefore not finding it so unbearable. People with learning disabilities may cling to an immature way of being (Cohen, 1986), finding it more acceptable to see themselves as deficient rather than hostile, or sexual. There may be issues of envy, spoiling, and devaluing that which is good (Joseph 1986), wanting the therapist to feel stupid. Stokes & Sinason (1992) said 'we feel with nearly all our clients there is an extra potential not being fulfilled'. They found it useful to distinguish between two states that people move in and out of, one in which the handicap is predominant and another in which a more perceptive and less damaged self is predominant. This possibility depends on severity and organicity.

• Effect on therapist / community

Psychotherapy is about the mutual experience of handicap. (Linington, 2002). Handicapped individuals can represent damaged aspects of the self that people want to be rid of, realised by a wish to hide handicapped people away from the community. Someone's particular disability may reveal in another emotionally powerful aspects of their own early models of recognition and negation. Bender (1993) spoke about the therapeutic disdain towards people with learning disabilities and the attitudes of mental health professionals towards clients with learning disabilities.

Cognitive Analytic Therapy (CAT) with people with learning disabilities

CAT has been adapted for use with people with learning disabilities. Vygotsky (1978) recognises that what a child is allowed to do with the support of another influences what it can learn to do independently. CAT may aid self-reflection, which is a skill people develop as they go through life; increase in self-reflection could improve cognitive capacity. CAT is explicitly collaborative and respectful. It uses clear descriptions using picture and diagrams. This may enable people with learning disabilities to learn more equal ways of relating to others and address issues of dependency and powerlessness. Crowley (2002) has shown that people with learning disabilities are able to utilise and understand the model of CAT (see Ryle 2002, p.173). CAT has also been useful in enabling staff groups to recognise the Reciprocal Roles (RRs) of some of the clients, helping them to avoid collusion with client's maladaptive RRs.

The literature has shown that people with learning disabilities have different attachment and are more vulnerable to abuse than people without learning disabilities. They experience negative events, such as the grief of parents and have to deal with the way society views them. They lack cognitive and verbal skills, which result in limited responses, opportunity and ability to develop effective coping strategies.

These issues may result in someone with learning disabilities feeling unheard or misunderstood. They may feel overwhelmed by the relationship feeling unable to express sexual feelings towards the therapist. They may experience therapist as rejecting / abandoning unless termination is well worked though. Alternatively they may idealise the therapeutic relationship. Idealised Reciprocal Roles may lead to a belief that fulfilment of these roles will make them perfect or perfectly cared for. A therapist could collude with these by giving special care, rescue or protection, leading to inevitable disappointment. Collusion also dissempowers and de-skills the client. It does not help them prepare for everyday disappointments in life or allow them to come to terms with their learning disability and real lives, or to acknowledge what they do have.

Each of these issues results from the interactions between a person with learning disabilities and another person. CAT examines the client's relationships with others. The client's RRs will be played out in the therapy room by how they relate to the therapist. The CAT model provides a forum for these psychotherapeutic issues to be explored.

Ryle (2002) cited common RRs within this client group, as being *Abusing or Bully to Abused or Victim, Not Hearing or Understanding to Not Heard or Understood, Rejecting to Rejected and Abandoning to Abandoned.* These RRs were identified through clinical judgement rather than research.

Aim

Having worked within a department where CAT was used to work with clients with learning disabilities, the opportunity arose to conduct research into the Reciprocal Roles (RRs) of people with learning disabilities. Identification of RRs is important so the therapist does not collude with the client and reinforce unhelpful patterns.

The aim of this research was to formally acknowledge common RRs identified in working with people with learning disabilities, backing up the RRs shown in Ryle (2002); and to explore how these roles may link to common psychotherapeutic issues.

Method

Design

This was an exploratory investigation to identify common Reciprocal Roles (RRs) for people with learning disabilities. An empirical methodology was employed which involved gathering of data and induction of patterns (Coolican, 1990). The qualitative data was analysed using content analysis and presented using descriptive statistics.

Participants

The participants had been routine referrals to a psychological service for learning disabilities. Clinical judgement was employed to decide whether CAT would be an appropriate approach to use for each referral. The therapists were qualified or trainee clinical psychologists, or nurse behaviour specialists, all receiving regular supervision for their cases from a qualified CAT therapist. The participants for the research were chosen using criterion sampling (Miles & Huberman, 1994), i.e. all cases in the department which had been seen for CAT therapy were used.

There were sixteen appropriate cases. Each of these were housed either in the community or in forensic services. The distribution of participants with respect to gender and housing can be seen in Table 1.

Table 1. Description of the participants

	Community	**Forensic**	**Number of participants**
Male	5	6	11
Female	4	1	5
Number of participants	9	7	16

Procedure and data analysis

Each participant had twenty to twenty-four sessions of CAT. The reformulation letters, psychotherapy files, sequential diagrammatic reformulation, therapy notes and goodbye letters of each participant were collated. For reasons of confidentiality each participant's notes were given a case number, which was used as a reference throughout the therapy records. The records were systematically scrutinised for RRs.

Content analysis (Krippendorf, 1980) was used to analyse the data. This involved initially sampling the data and then coding it:

Sampling – Each piece of data was examined for RRs. These were extracted from the original data in order to be coded.

Coding – the data was then structured and coded in two stages:
- Stage 1: Indigenous categories – the data was coded with wording used by participants.
- Stage 2: Researchers categories – the data was then coded further using categories identified by the researchers.

Some RRs were more challenging to code than others, e.g. some RRs contained a number of different words and thus may have been appropriate for different categories. It was decided by the researchers to place these RRs according to the overall meaning.

Repetition of the research cycle – the raw data was revisited to check and re-check earlier assumptions and inferences made.

Triangulation was used in order to increase the credibility of the findings. Two methods of triangulation were used:
1. Different records were examined for each participant
2. Two different researchers coded the data.

Self reflection of researchers

Qualitative research is vulnerable to researcher bias. Some of the RRs were difficult to categorise, particularly the roles that were abstract or had many parts to them. In these cases they were coded by meaning for the first researcher. The first researcher was independent of the therapy. This was an advantage in the sense that she could be more objective about the data, but a disadvantage with regards to having a true understanding of the nature of each RR. The second researcher also coded the RRs. She was involved in the therapy of all the participants, either as a therapist or as a supervisor and therefore understood the implicit meanings of all the RRs.

Results

Overall results

Twenty-two different Reciprocal Roles (RRs) were identified, including four ideal RRs (the last four listed). The RRs and the percentage of participants whom identified them are shown in Table 2 below.

Overall, the sixteen participants identified eighty-three RRs, twenty of which were ideal Reciprocal Roles. This meant that there was an average of 5.1 RRs per participant. The range was between 3 and 8 RRs per participant.

Fifteen of the RRs were identified by more than 10% of participants. The most common RRs are highlighted with an asterisk (*) in Table 2

Table 2. Percentages of Reciprocal Roles identified

Reciprocal Roles identified		
• Abusing to Abused	62.5	*
• Rejecting to Rejected	56.25	*
• Rescuing/Caring to Rescued/Cared for	56.25	*
• Damaging to Damaged	50	*
• Abandoning to Abandoned	50	*
• Special/Perfect to Learning Disabled	43.75	*
• Controlling to Controlled	37.5	*
• Blaming to Blamed	18.75	
• Overwhelming to Overwhelmed	18.75	
• Not Hearing to Not Heard	18.75	
• Punishing to Punished	12.5	
• Critical to Criticised	12.5	
• Unloving to Unloved	12.5	
• Admiring to Admired	12.5	
• In Control to Fragile	12.5	
• Powerful to Powerless	6.25	
• Neglecting to Neglected	6.25	
• Frightening (learning disabled) to Frightened	6.25	
• Rubbishing to Rubbished	6.25	
• Threatening to Threatened	6.25	
• Depriving to Deprived	6.25	
• Sadistic to Terrorised	6.25	

* Most common Reciprocal Roles

Community and Forensic Results

Whilst analysing the data, differences between community and forensic participants were noted. Figure 1 shows how the RRs were distributed between forensic and community participants.

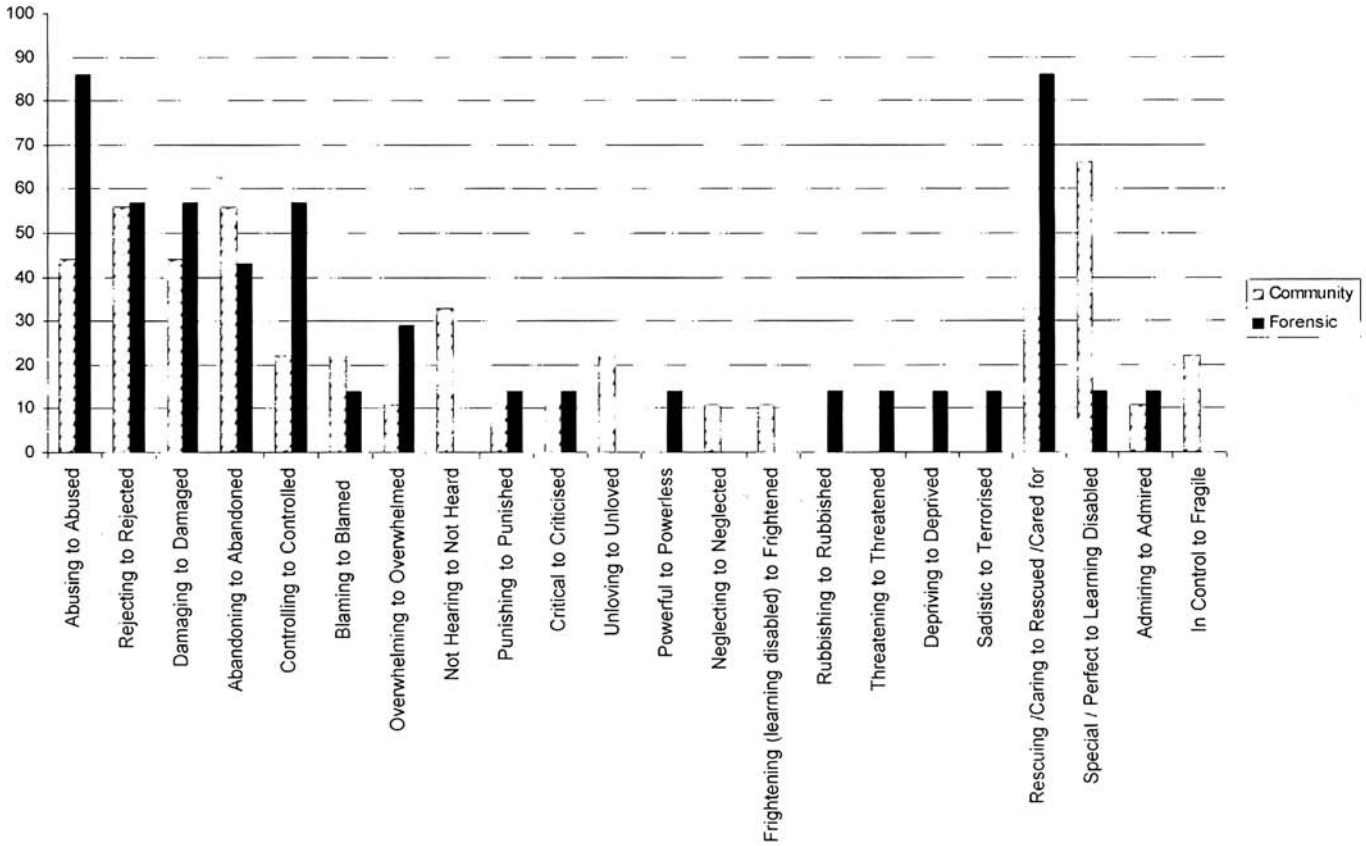
It can be seen from the graph that three of the most commonly identified RRs are found fairly evenly in both the community and forensic population.
- *Rejecting to Rejected* 56% in the community and 57% in forensic
- *Damaging to Damaged* 44% in community and 57% in forensic
- *Abandoning to Abandoned* 56% in community and 43% in forensic

Forensic

Seventeen RRs were identified within the forensic participants. Seven of these were identified in between 29% and 86% of the forensic participants; the other ten were identified in less than 15% of forensic participants.

From the graph it can be seen that the majority of forensic participants, 86%, had the Reciprocal Role *Abusing to Abused*, compared to 44 % of participants in the community. There were also more forensic participants with the ideal Reciprocal Role *Rescuing/Caring to Rescued/Cared* for 86% compared to 33% in the community. The *Controlling to Controlled* Reciprocal Role was over twice as prevalent in forensic services 57% than in the community 22%.

Figure 1. Percentage of forensic and community participants with each Reciprocal Role



Community

Seventeen RRs were also identified within the community participants. Eleven of these were identified in between 22% and 66% of the participants. The other six were found in less than 12% of the participants.

The graph also shows that some RRs were identified mainly in the community population. The Reciprocal Role *Not Hearing to Not Heard* was identified in 33% of community participants and no forensic participants. The ideal Reciprocal Role *In Control to Fragile* was identified in 22% of community participants and no forensic participants. The Reciprocal Role *Unloving to Unloved* was identified in 22% of community participants and no forensic participants. The ideal Reciprocal Role *Special/Perfect to Learning Disabled* was over four times more prevalent in the community population, where it was identified by 66% of the participants than in the forensic population, where it was identified in 14% of the participants.

Discussion

The aim of the study was to identify common Reciprocal Roles (RRs) for people with learning disabilities. Four common RRs for people with learning disabilities were identified and two common idealised Reciprocal Roles:

- *Abusing or Bully to Abused or Victim*
- *Damaging to Damaged*
- *Rejecting to Rejected*
- *Abandoning to Abandoned*

And the two idealised Reciprocal Roles

- *Rescuing/Caring to Rescued/Cared for*
- *Special/Perfect to Learning Disabled.*

Ryle (2002) had previously identified a similar list of common RRs. The difference being that *Damaging to Damaged* was not included in Ryle's original list, and N*ot Hearing or Understanding to Not Heard or Understood* was included. In this study the RR *Not Hearing or Understanding to Not Heard or Understood* was identified equally or less frequently than the following three RRs:

- *Controlling to Controlled*
- *Blaming to Blamed*
- *Overwhelming to Overwhelmed*

Further investigation would have to be undertaken to determine whether these RRs are common enough to be included as a generalisation.

There was greater variation for forensic participants with the RR *Damaging to Damaged.* The language used by forensic participants felt raw and hard-hitting, words like 'destroyed' and 'terminator' were used. This language expresses how damaging and damaged these participants felt. This could lead to further investigation into the significance of this role in people with a learning disability in forensic settings.

There were more variations of the RR *Abandoning to Abandoned* in the community. Three of the participants used the words 'blanked off' or 'cut off' in this RR. This reflects their response to being abandoned. Blanking off is a coping mechanism employed to protect the self from the experience of being abandoned, rather than being overwhelmed (see Bowlby 1980).

Five of the six presentations of the RR *Controlling to Controlled* were variations, suggesting that this RR may be experienced in a number of different ways, or that it may be a complex RR with different aspects.

The ideal Reciprocal Roles resonate with some of the psychological issues highlighted in the introduction (Hollins & Sinason 2000). It seems that through CAT these issues may be dealt with as part of the ideal Reciprocal Roles, for example the RR *Special/Perfect to Learning Disabled* was found in 44% of the cases (it was higher in the community with a ratio approximately 5:1). It was also found to be the second most frequent ideal Reciprocal Role.

Another particular psychotherapeutic issue for people with learning disabilities, according to Hollins & Sinason (2000) is dependency. This may have been reflected in the RR *Rescuing/Caring to Rescued/Cared for*. This was the most frequent ideal Reciprocal Role, 56% of the participants identifying it. Forensic participants identified this RR more frequently; the ratio was approximately 2:5.

The issues of emerging sexuality, and sexual abuse, may have been expressed through the RRs *Abusing to Abused and Damaging to Damaged.* The limitations of language skills affecting expression of sexuality were identified in the introduction. Therapy is for many people with learning disabilities the first time that they have felt heard and been helped to express these feelings.

Attachment issues for people with learning disabilities have been discussed by a number of people (e.g. Linington, 2002). The RRs *Overwhelming to Overwhelmed,* or *Unloving to Unloved* may reflect attachment difficulty. Figure 1 shows that the majority of the participants with the *Overwhelming to Overwhelmed* RR were in the forensic service, and all the participants with the RR *Unloving to Unloved* were in the community. Combining the two RRs would result in approximately equal numbers in community and forensic. These two RRs may be addressing similar issues from different perspectives.

The attitudes of mental health professionals towards people with learning disabilities (Bender, 1993) may reinforce the RR *Rejecting to Rejected*. Any RR may be played out between the therapist and client, particularly *Not Hearing to Not Heard, Rubbishing to Rubbished or Blaming to Blamed.* Bion (1959) spoke about the importance of the therapist becoming the container, sometimes when the caregiver was unable to. It is important that the therapist does not reinforce any of the RRs in therapy, although the identification of them can be a useful therapeutic tool. It is important to address these issues in supervision.

CAT and Learning Disabilities

People with learning disabilities seem to have fewer RR than people without learning disabilities. This may be influenced by dependence on other people and services, and may reflect not having a strong sense of self. Also, fewer roles are identified or can be worked on throughout the duration of therapy. This observation may be linked to Ryle's (1999) observations that people who have experienced trauma have a restricted repertoire of RRs. A formal comparison of the numbers of RRs between people with and with out learning disabilities would inform this.

Sigman (1985) and Cohen's (1986) ideas that some people with learning disabilities cling to an immature way of being may impact on how a person with learning disabilities relates to their RRs. This may differ from working with other client groups.

During the analysis of the therapy scripts it was noted that in some cases the therapist helped the client to recognise a more and less able self in order to do therapy with the more able self as described by Stokes & Sinason (1992). Time was also spent in preparation for therapy dealing with issues such as the handicapped smile (appeasement) in order to facilitate collaboration on setting therapy goals and in therapy.

Limitations

As with most qualitative research the sample size of this research was small. This was partly due to the qualitative nature of the investigation, and partly to do with the type of sampling (criterion sampling). Criterion sampling may have led to sample bias for two reasons:

- It was not recorded why these particular participants underwent CAT therapy: a more overt record of why each participant had CAT therapy and why others did not would have been informative.

- All the participants were treated by the same learning disabilities provision.

The size was sufficient for a small pilot investigation, but a larger and more diverse sample would increase the external validity and generalisability.

Further research in this area would be beneficial. Repetition of this research using a wider sample would enable further generalisation of the results. Research into the RRs of people with learning disabilities who are not referred to psychological services would give a more general idea of common RRs in this client group. Hollins and Sinason (2000) suggest that increased emotional disturbance is a function of learning disability; it would therefore be interesting to see which RRs are related specifically to having a learning disability, as opposed to mental health. This could be done by comparing RRs of people with learning disabilities with the RRs of their non learning disabled peers – e.g. forensic clients with and without learning disabilities, highlighting which RRs were specifically due to having a learning disability.

Conclusions

This study addressed the research aim by identifying common Reciprocal Role (RRs) for people with learning disabilities. Although it is not possible to generalise these results to all people with learning disabilities in psychological services, the findings are relevant and useful for therapists using CAT with people with learning disabilities, by increasing the research knowledge base. This research contributes something new to understanding, by formally endorsing the common RRs initially suggested by Ryle (2002). It may also be useful for other clinicians considering the use of CAT or any other psychotherapy with people with learning disabilities. Awareness of these findings should help therapists avoid colluding with unhelpful RRs. Further research has been suggested to find out more about RRs with people with learning disabilities. Care must be taken as more understanding is gained about RRs, clinicians must take care not to assume RRs, to listen to the client and use their words.

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