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Young People with Learning Disabilities: An Investigation of Counselling and Inclusion

Susan Pattison

A thesis submitted in partial fulfilment for the degree of Doctor of Philosophy in the School of Education, University of Durham

2005

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ABSTRACT

This research study examines counselling practices and processes in relation to the concept of the inclusion of young people with learning disabilities. The aims of the study are to identify how inclusive counselling is of this client group; to gain knowledge and insight into practices that either include or exclude; to identify strategies that can increase inclusivity and to use this knowledge to construct a model for inclusive counselling practice in relation to young people with learning disabilities. Mixed methodology is used to provide both quantitative and qualitative data. Research methods include a survey of counsellors listed in the BACP Directory (2001) and a series of semi-structured interviews. The hypothesis that counsellors can increase the inclusion of young people with learning disabilities in their practices is challenged. Results indicate that there are four levels of inclusivity and that inclusion is a process with potential for change rather than a static entity. The study identifies six indicators of inclusive counselling that are used to build a model for inclusive counselling practice: a proactive approach to inclusion; a focus on building relationships; operationalising equal opportunities policies; inclusive initial assessments; adopting flexible and creative approaches to counselling; and training and awareness raising in learning disabilities.

DEDICATION

This thesis is dedicated to my parents Eric and Iris Mason and my sister Linda for their continuing support of my endeavours; my children Neil, Tom, Daniel and Isla, my inspiration; and my partner Richard for his gentle, loving encouragement.

ACKNOWLEDGEMENTS

There are many people who have contributed to the production of this thesis through their moral support, advice or participation.

I am indebted to Dr. Maggie Robson for her patience and encouragement and John McGuiness for his motivational influence throughout my years as a PhD. student in CESCO. I sincerely thank you.

I am also beholden to Valerie Lake, Valerie Nossiter and Sue Lockhart for their moral support and continuing friendship.

My sincere appreciation should be extended to Peter for his support, advice and guidance.

I would also like to express my gratitude to the many counsellors who participated in this research study and who gave generously of their time.

Finally, I would like to express my appreciation for the support of colleagues and friends in CESCO, University of Durham and the School of Education, Communication and Language Sciences, University of Newcastle.

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Chapter 1: Introduction and Background

1.1 Introduction

> The truth, however nobly it may loom before the scientific community, is ontologically something secondary. Its eternity is but the wake of the ship of time, a furrow which matter must plough upon the face of essence. Truth must have a subject, it must be the truth about something; and it is the character of this moving object, lending truth and definition to the truth itself, that is substantial and fundamental in the universe.
>
> (George Santayana, 1942/72:192, Realms of Being)

This research study is essentially a search for the truth, the truth about something that is continually changing and developing, that is the inclusion and exclusion of a certain group of people in counselling. In this study I will take things a step further than merely looking for the truth, I will attempt to make the truth transparent and available to society and in doing so hope to bring about changes in that truth. As indicated by Santayana in the above quote, the truth requires a subject; in this case the subject is a disparate group of individuals, young people with learning disabilities. This study is an exploration of the emotional and psychological lives of this group of young people and the therapeutic counselling help that may or may not be available to them.

1.2 Researcher's perspective and the research problem

During my work as a teacher of young people with learning disabilities (aged 13-19years) at a college of further education, I was approached on many occasions by students, their peers, by parents/carers and other professionals from education, health, social services, employment services and the criminal justice system in their attempts to find some way of addressing the emotional distress experienced and /or exhibited by individuals. At that time I found that the only form of psychotherapeutic help available or accessible, if any, was in the form of behaviour modification programmes through the local NHS clinical psychology department. This observation is substantiated by the literature (Royal College of Psychiatrists, 2004; Sinason, 2002; Lindsay, 1999). It was apparent to me in my work and relationships with these students that young people who have learning disabilities are individuals, and in common with others exhibit psychological, cognitive, emotional, social and sexual needs. In my previous research I had found that some of those needs are either denied altogether by parents/carers, teachers, society; or were not adequately met (Pattison, 1998). I also found that these students suffered high levels of abuse, particularly sexual abuse. Sinason (2002) suggests that talking treatments, learning disabilities and sexual abuse are all previously taboo subjects that would not have been discussed together.

In recent years there have been moves towards integration or inclusion in society of all types of minority groups, the Social Exclusion Unit was set up by

the Labour Government, overseen by Anthony Giddens, whose Reith (1999) lectures referred to a more integrated and inclusive society. At the same time inclusion in education was high on the political agenda, Special Schools for children with various disabilities were beginning to close and alongside this I was discovering my enjoyment of carrying out research. My passion for improving the lives of my students found a home in these events and provided me with the motivation to investigate the possibility of improving the level of inclusivity in counselling for what I believed to be a marginalized client group.

In my work with these young people I noticed that the seemed to be more marginalised and isolated as they are integrated or included in mainstream education or society, often away from their peer groups, their friends who also have learning disabilities. In one college of further education in the north of England, adolescents with learning disabilities have been observed going to great lengths to seek out their peer group, that is, others with the same status and perceived value as themselves. In spite of wanting to treat this group of people as equitably as other groups of students in further education, this was made difficult by the above 'seeking out others like me' process. In tutorial/guidance sessions I found that many of this group of young people with learning disabilities appeared to have a lack of confidence and low self-esteem; and that seemed directly related to the level of intellectual disability and self-awareness exhibited by individuals. My observations and experience indicated that those people with a low level of cognitive ability coupled with a lack of self-awareness seemed to be the most contented or happy; whilst those with a

higher cognitive ability and a greater self-awareness tended to show quite visibly their unhappiness at being different from others. In other words, those with mild to moderate learning disabilities appeared to have the greatest level of emotional and psychological problems (Prosser, 1999). I had observed that my students seemed more trusting of people and had a certain innocence, naivety or lack of awareness of personal risk. It is this vulnerability coupled with their need for love, affection and relationships; a need to be prized or valued, that led me to believe this client group to be more open to abuse and to being involved in relationships where the balance of power is against them. The literature confirms that the prevalence of sexual and other forms of abuse is higher amongst people with learning disabilities than in the general population (Brown, 1995; Buchanan and Wilkins, 1991; Chenoweth, 1996, 1999; Elvick *et al.,* 1990; Etherington, 2000; Finkelhor, 1986).

I also found that these young people would play different roles according to the situation they were in, for example, at home an individual may be perceived as lacking in sexuality, while at college they may be an overtly sexual being. Although perhaps all young people might do this to some degree, I felt that it was more common in students with mild to moderate learning disabilities, along with their apparent need to escape from reality (Rodis *et al.,* 2001; Cordoni, 1996). This seems to fit in with Rowan's (1999) idea of sub-personalities, that is, individuals being not just one person but many. However, my students often seemed get their 'sub-personalities' mixed up and subsequently behaved inappropriately in some situations; resulting in

marginalisation and exclusion from mainstream college life and peers who were of higher cognitive ability, or 'normal'.

In my work with young people who have learning disabilities I found that an individual's perceptions of self were not always what I would have expected. One teenage girl (let us call her Jenny), for example, often appeared to have a low self-esteem and a general lack of confidence in social situations, seeking reassurance from her tutor frequently. Yet it transpired that another tutor, who had known Jenny for much longer, found her to be very confident and self-assured. Following several in-depth conversations with Jenny, it transpired that she thought of herself as a good singer, but had to keep this to herself for fear of appearing too important (or too clever) and losing friends in the process. It was interesting that Jenny could be more herself with the tutor she had built up a relationship with. The value of building relationships with students linked well with my thoughts on counselling and how such interventions may be helpful for this client group. In short, my passion for helping this group of young people with their emotional difficulties and psychological problems was the driving force behind this research study.

1.3 Aims of the study

In this study I will examine counselling practices and processes in relation to the concepts of inclusion and exclusion of young people with learning disabilities, developing my existing ideas and thoughts on the subject through

systematic investigation and research. I also intend to explore the possibility that whatever the present level of inclusivity, this can be developed and increased, suggesting that inclusion may be a dynamic process rather than a static entity. I aim to identify ideas and strategies that will increase the inclusion of this client group in counselling and gain some knowledge and insight into how, where and by whom these strategies might be used, therefore quantitative demographic data will be used to identify counsellor variables such as: qualifications, practice context and organisational context. The existing range and context of inclusion/exclusion will be explored along with the potential for increasing inclusion. Counsellors' suggestions and ideas for increasing access to counselling and their attempts to include this client group will be identified and investigated. The rationale for including this group of young people in counselling will be put forward. I also aim to address the issue of whether counselling is appropriate for young people with learning disabilities and identify related factors. I will explore the notion of the 'inclusive counsellor' and identify indicators of inclusive counselling practice. These will be placed hierarchically, distinguishing inclusion as a process and assigning levels of inclusivity to counselling practice. Barriers to inclusion will be highlighted and located within counsellors, clients, parents/carers, health and social care professionals and/or the system. Strategies and techniques in counselling that counsellors find useful in including young people with learning disabilities will be identified and along with other variables will be used to build a model of good practice in relation to quality, standards and models of good practice, which are becoming more important in the move

towards evidence-based practice in therapeutic situations (Speller and Kelly, 2003).

In this study I aim to produce the research base required to contribute to the development of a model for good practice in counselling young people with learning disabilities with the long-term goal of bringing about positive change in counselling practices and processes. The model will have the potential be used as a template against which counselling practices and processes can be assessed for inclusiveness and further developed. There are several reasons why the assessment of counselling practices could be useful. Firstly, there is a human rights issue; according to human rights legislation there should be equal access to services for all members of society, such legislation includes the Disability Rights Commission Act (DfEE 1999) and the Human Rights Act (DfEE, 1998). By assessing counselling practices it may be possible to identify how inclusive individual counsellors and organisations are and identify ways of developing more inclusive working practices. Secondly, recipients of therapeutic psychological interventions are becoming increasingly involved in their own care (Hawkins, 2003). Community groups are working towards increasing the power that clients have in therapeutic settings; for example, mental health service user groups are gaining more control over the provision of mental health services (Hawkins, 2003). People with learning disabilities are being encouraged to speak out and inform service providers of their needs by organisations such as the British Institute for Learning Disabilities (BILD, 2003). Finally, many of the voluntary and charitable organisations that provide

counselling in the wider community, such as Cruse and MIND, have to bid for funding grants in an increasingly competitive arena. Statutory organisations such as Local Education Authorities (LEAs) have joined this arena of competitive bidding for funds for projects, for example school counselling services. Therefore it may be useful to have a model for good practice that can provide guidelines on how counselling services can be inclusive of diverse groups of people. This also seems important in terms of the quality of the service is being provided and may be useful to organisations when applying for funding in terms of adding value to existing equal opportunities policies.

1.4 Rationale for the study

The rationale for including young people with learning disabilities in counselling can be found in the literature on human rights, the gaps in existing access to counselling services, the high prevalence of mental health problems in young people generally and in individuals with learning disabilities, the lack of research in counselling this client group and the need for counsellors to show that they are not discriminatory in their practices in order to comply with anti-discriminatory legislation.

1.4.1 Human rights and inclusion

The impetus for this study is provided by the Disability Rights movement, a national and international movement working towards the inclusion of all

groups of people in society, along with the policies that support and enforce inclusion and outlaw inequality and discrimination, for example the Disability Rights Commission (DfEE, 1999) and the Disability Discrimination Act (DfEE,1995). These ideals and policies are applicable to the counselling profession as service providers. The United Nations Declaration of the Rights of Disabled People (1975, section 7.2:11) states that:

> Whatever the origin, nature and seriousness of their handicaps and disabilities, disabled people have the same fundamental rights as their fellow citizens of the same age.

The United Nations Convention on the Rights of the Child (1989, section 27.9) states that children with disabilities or difficulties in learning should receive 'the fullest possible social inclusion and individual development'. The United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993) calls on all countries to have clearly stated policies on inclusion, both social and educational. The Council for Disabled Children in the UK (1994, section 9.4.6) agreed a policy statement on inclusion that states:

> Mainstream provision (school) should offer the full range of support and specialist services necessary to give all children their full entitlement to a broad and balanced education.

The above may include counselling services as referred to in OFSTED (Office for Standards in Education) recommendations (DfES/Tuckswood Community First School, 2004) and can be linked to the report by the National Advisory Committee on Creative and Cultural Education (1999): 'All Our Futures: Creativity, Culture and Education'. This report examines how schools can connect with other professionals and organisations in order to develop innovative partnerships and help all children to reach their potential. The

above report examines education, learning and social progress and emphasises the importance of learning about cultural diversity and the rights of all children to be helped to reach their full potential. According to this report, social exclusion breeds prejudice and inclusion has the potential to reduce fear and build friendship, respect and understanding between diverse groups of people and individuals. Human rights legislation and policies state that people with learning disabilities have a valuable part to play in society and this means taking an active part in all aspects of social life (Disability Rights Commission Act, 1999). Epidemiological studies also suggest that there is a demand for counselling services (Borthwick-Duffy 1994; Department of Health and Home Office 1992; Nezu and Nezu 1994; Reiss *et al.*, 1982; Rutter *et al.* 1976; Prosser 1999). It has been shown that counselling within the school context is effective for young people (Harris and Pattison, 2004) and can be a way of including children with special educational needs (Sinason, 2002). Counsellors may need to become more inclusive in their practices in order to meet this demand.

Defining and clarifying inclusion is addressed more fully in the literature review (Chapter 3). However, there are difficulties and ambiguities in providing a definitive description of the term inclusion. The Centre for Studies on Inclusive Education (CSIE) has produced a definition of inclusion in relation to learning, which I have adapted for use with counselling as follows:

> Inclusion within a counselling context means that people with learning disabilities are able to access mainstream counselling services, just like other clients, with support where necessary.

> For counselling to be effective, counsellors may have to adapt the counselling process, learn new techniques, increase physical access to include people with multiple disabilities and take account of any resource or financial considerations.
>
> (Adapted from CSIE 'Working Towards Inclusive Education, 2000:34)

Furthermore, Visser (1999:89) provides a definition of inclusion again adapted with reference to counselling as follows:

> Inclusion should not be about a place, but about a process which enables clients with learning disabilities to receive their rights and entitlements.

This reinforces the idea that inclusion is not just about welcoming people with learning disabilities into a counselling service, it is about making the processes of counselling accessible also. Do counsellors include young people with learning disabilities in their counselling practices? One could hypothesise that although there may be some counsellors who provide a service for people with learning disabilities, many do not for a variety of reasons. This study highlights the exclusive nature of counselling for young people with learning disabilities.

1.4.2 Access to counselling for young people

Young people in general may find it difficult to access counselling help because of the natural disinclination of adolescents to admit that they have a problem (DiGuiseppe *et al.,* 1996; Gil, 1996). The provision of counselling services either generally or specifically for young people is rather patchy, depending on the goals and targets of the local authorities, NHS trusts and

various charitable organisations in that area. Young people may have access to a counsellor in their school, though this would be very unlikely at this point in time due to the underdevelopment of school counselling services and the focus of educational psychologists on assessment and consultative processes. Out of thirty schools that I contacted in 1999 in the north-east of England, only three offered counselling to their students on a regular basis, although this figure has recently risen to twelve (2004), it means that more than half of the schools contacted have no counselling provision. This is at a time when recommendations have been made that counselling should form part of educational provision for children and young people (DfES, 2004). However, progress is being made in the provision of counselling, for example, National Children's Homes (NCH, 2004) has piloted a project that involves group counselling for children whose parents are separating or divorcing. Moreover, Local Education Authorities (Darlington Borough Council, 2004) are continuing to develop counselling services for schools. Counselling in contemporary society is increasing generally (Future Foundation, 2004) and in the past few years there has been an increase nationally in the number of schools offering a school counselling service (Baginsky, 2005). The British Association for Counselling and Psychotherapy also reports a significant increase in the number of counsellors employed directly by schools (BACP, 2004). Older adolescents who are studying at colleges of further education may access counselling through their college counsellor as recommended by OFSTED (DfES/Tuckswood Community First School, 2004). However, resources are likely to be limited and there may be waiting lists. Those young

people in the 18-19 years age-group who are in higher education may access their university counselling service, such services are generally well-organised and well-developed. However, young people with learning disabilities are very unlikely to be attending university. Other forms of counselling provision include drug and alcohol abuse centres, youth advice centres, youth and community projects (e.g. End House, Durham; Streetwise, Newcastle upon Tyne) and mainstream services such as Cruse, Rape Crisis, Relate and MIND. Some charitable and/or religious organisations also offer counselling help, for example, Catholic Care and St. Cuthbert's Care. In this research study I examine some of the issues surrounding young people with learning disabilities and their access to counselling exploring how organisations attempt to include diverse groups of clients and how they can increase their inclusion of young people with learning disabilities.

Experience is one way of 'knowing' or accessing knowledge, therefore based upon my experience as a counsellor, supervisor, teacher trainer and teacher of students with special educational needs; it appears that there is a lack of awareness and understanding of the issues around learning disability. The results of this study will be used to support and challenge my experience.

Issues have arisen around communication with this client group in counselling sessions. Whilst responsible for counselling and training for a branch of Cruse Bereavement Care I was asked for advice and training many times in the area of learning disability, particularly regarding communication and awareness-

raising. I also took most of the learning disability referrals, as other counsellors were not confident in dealing with these individuals. I continue to regularly provide training in counselling people with learning disabilities for voluntary and statutory organisations. A variety of training issues will be identified in this study including the nature of the training of training that counsellors want or need. Similarly, issues around communication will be investigated.

1.4.3 Learning disabilities, young people and mental health problems

An increase in mental health problems and the provision of counselling as part of an effective range of therapeutic interventions (Harris and Pattison, 2004; DoH, 2004) along with the issue of dual diagnosis of learning disabilities and mental illness makes it more likely that counsellors will encounter individuals with learning disabilities at some point. Counselling and psychotherapy are increasingly provided by Primary Care and NHS Trusts and have been shown to be as effective as medication for individuals with mental health problems, such as anxiety and depression (DoH, 2001). Young people are particularly vulnerable to mental health problems due to the nature of child and adolescent development and the stresses placed upon them by society and educational processes; counselling is shown to beneficial for a range of related issues (Orlinski *et al.*, 1994; Martin *et al.*, 2000).

Existing work in the field, such as that carried out by Prosser (1999) provides information upon which to build this study. A large proportion of people who have learning disabilities have co-existing mental health problems (known as dual diagnosis), which even if diagnosed correctly (and there are difficulties with diagnosis), there is a lack of services available to provide the required psychological care (Prosser, 1999; Lindsay, 1999). Epidemiological studies show a higher prevalence of emotional problems in people with learning disabilities (Borthwick-Duffy, 1994; Corbett, 1979; Department of Health and Home Office, 1992; Iveson, 1989; Nezu and Nezu, 1994; Patel and Goldberg, 1993; Prosser, 1999; Reiss, 1990; Reiss *et al.*, 1982; Rutter *et al.,* 1976).

The main causes of mental distress in people with learning disabilities are found to be anxiety and depression, conditions that have been made measurable by extensive psychometric tests such as those developed at the Adrian Hester Research Centre (Prosser, 1999). The prevalence of mental health problems in this population is also explored by Lindsay (1999) who suggests that the main therapeutic response to their psychological difficulties is a variety of behavioural therapies aimed at changing behaviours that are troublesome to others, rather than therapeutic help aimed specifically at the individual and their problems. Referrals to psychologists by parents, carers and teachers due to difficult behaviour is common, teachers find classroom management difficult and carers in the community have problems when socially unacceptable behaviour is exhibited. Difficult behaviour has been found in many cases to be an outward manifestation of internal psychological problems

(Lindsay, 1999). However, the principles of behaviour therapy may mean that although the symptoms (difficult behaviour) are addressed the underlying causes of the presenting difficulties are not dealt with.

A connection can be made between psychological distress and the proposed treatment or helping strategies. Examining the efficacy of particular therapeutic approaches to psychological problems can make this connection. However, as previously stated, effectiveness of counselling appears to be based upon a relationship of warmth, respect and understanding with the client rather than on particular models or approaches (DoH, 2001). This study includes an examination of counsellors' main theoretical approach and how inclusive of young people with learning disabilities that particular approach appears to be. A recent systematic review of the research literature on counselling children and young people highlights the absence of efficacy and outcome studies specifically with young people with learning disabilities (Harris and Pattison, 2004).

Pharmacological approaches to psychological problems have grown both in the range and volume of chemical preparations available to the medical profession for the treatment of conditions such as depression and anxiety in individuals. Traditionally, pharmacological preparations have been used to control difficult individuals, largely people with mental health problems and those with troublesome behaviours due to learning disabilities or emotional problems (DoH, 2003). However, many of the serotonin re-uptake inhibitors are

unlicensed for use with the under eighteens and are under review (DoH, 2003). The issue of learning disabilities and social control is discussed in the literature review along with the part that counselling may play in this control. Prosser (1999) explores the problem of dual diagnosis and highlights the difficulty of fitting individuals into diagnostic categories, a process that appears to be necessary before therapeutic help can be made available, particularly within the health and social services.

This study will identify three main approaches to counselling that are more inclusive of young people with learning disabilities, person-centred, psychodynamic and integrative. However, I acknowledge that many counsellors do not use a pure approach to their counselling work, preferring to draw upon other approaches for useful techniques and strategies (Mellor-Clark, 2000; Egan, 2001; Nelson-Jones, 1997; Gilmore, 1973). I am also aware that the self of the counsellor is also a variable that may not be adequately addressed (Smail, 2001). Counselling organisations such as the British Association for Counselling and Psychotherapy (BACP) and various training courses/organisations have given attention to this phenomenon, for example, the Centre for Studies in Counselling (CESCO, 2003).

It has been highlighted in studies on effectiveness and efficacy of counselling that it is not the particular theoretical approach or model that is important but the relationship provided by the counsellor to the client (DoH, 2001). The description of the type of relationship found to be necessary for therapeutic

change seems remarkably similar to the core conditions described by Rogers (1962). Although it has been suggested that any appropriate psychological therapy may be used, I believe person-centred counselling to sit more comfortably with the research findings regarding the proffered therapeutic relationship, holding the central tenet that the relationship is the most important factor in therapeutic change (DoH, 2001). However, the research on efficacy highlights that, in opposition to Rogers' view that the core conditions are 'necessary and sufficient' for therapeutic change, techniques are also required (McGuiness, 1998; Nelson-Jones, 2003, 1997, 1982; Rogers, 1962). This study identifies some of the approaches, techniques and strategies found by counsellors to be appropriate and effective when counselling young people with learning disabilities. The most inclusive counsellors identified in this study use a variety of creative techniques, place emphasis on the therapeutic relationship, simplify their language and pay more attention to non-verbal communication.

My experience of counselling young people with learning disabilities indicates this client group can find counselling useful and that individual clients often work very hard in the counselling process. However, the results of this study also support my professional experience of counselling not being appropriate for all individuals with learning disabilities. Anecdotal evidence from counselling colleagues and the literature on learning disabilities points to a need for the provision of counselling services for these young people due to the quite difficult and damaging experiences many of them have undergone, for

example, persistent bullying and low self-esteem (Zic and Igric, 2001). According to (Chenowith, 2002, 1999; Brown *et al.,* 1999; Elvick *et al.,* 1990; Finklehor, 1994; Buchanan and Wilkins, 1991) people with learning disabilities are more vulnerable to abuse, particularly sexual abuse due to their cognitive difficulties and lack of social awareness.

Young people, (for the purposes of this study aged between 12-19 years inclusively), are likely to be undergoing huge changes in three main areas of their development: physical, psychological and social. Research shows that dramatic changes in a person's life can contribute significantly to the development of mental health problems, such as depression (Etherington, 1995; Furey, 1994; Sobsey, 1994). Young people are more likely to be prone to rapid mood swings, emotional and psychological difficulties and crises of identity (Steinberg, 1993; Vecchio, 1991; Ebata *et al.,* 1990; Grans, 1990). Added to this are the problems often associated with relationships, particularly with parents and other authority figures.

The need for the provision of counselling services has been responded to by national organisations such as: Barnardos (Montgomery-Devlin, 2004), National Childrens' Homes (2001) and Cruse Bereavement Care (2004). Many local authorities, charitable organisations and NHS trusts now make counselling available at centres specifically for young people, for example, End House in Durham City and Streetwise in Newcastle upon Tyne. Schools are increasingly recognising the need for counselling for their students and the role

of the school counsellor is developing (Darlington Borough Council, 2003). My professional experience as a teacher, counsellor and health visitor leads me to believe that young people with learning disabilities are in a particularly vulnerable position regarding the development of emotional, psychological or mental health problems. They may be experiencing all of the difficulties associated with adolescence, coupled with the extra risk factors related to their learning disability. My review of the literature reveals that a significant proportion of these young people will also have a physical disability that affects the quality of their life. This may further increase the likelihood of developing psychological problems, for example, low self-esteem, lack of confidence, anxiety and depression (Prosser, 1999; Lindsay, 1999).

1.4.4 Evidence-based practice and a model for inclusive counselling practice

Counselling and psychotherapy are established forms of interventions for people with emotional and mental health problems and as such are included in the Cochrane database that serves to evaluate research evidence constituting best practice based on the NHS Cochrane Collaboration criteria and guidelines (Clark and Oxman, 2003). The British Association for Counselling and Psychotherapy publishes a regular research journal (CRJ) in an attempt to reduce the gap between research and practice and promote practice based on research evidence.

My intention is to add to the evidence-base and begin the process of developing a model for good practice in relation to counselling young people with learning disabilities. It was highlighted at the BACP research conference (May, 2003) that the use of mixed methodologies might help counselling research to move forward. This study incorporates quantitative methods, including a survey to generate demographic data and counsellor/practice characteristics along with qualitative interviews to obtain the views and perceptions of individual counsellors. The qualitative information is collected in order to enrich and triangulate the survey data. The resulting data are analysed and used to develop a model for inclusive counselling practice with young people who have learning disabilities. Experienced counsellors will review the resulting model and although outside the scope of this study, I intend to operationalise the indicators of inclusive counselling practice and develop an assessment and auditing tool for use with individual and organisational counselling practices. The results of a pilot study using this tool will be presented to the research and practitioner community at a later date.

1.4.5 Defense against litigation and accusations of discrimination

Although the preservation and development of human rights is the main issue in promoting the inclusion of young people with learning disabilities in counselling, it appears increasingly important for counsellors to demonstrate that they are working inclusively. The Disability Rights Commission Act (DfEE, 1999) was introduced to support and help to enforce the Disability

Discrimination Act (DfEE, 1996), which states that people with disabilities, including learning disabilities, cannot be discriminated against in the provision of services. The Act proposes that service providers should audit their own practice for evidence of inclusion and where this is found lacking provide evidence that steps are being taken to address the relevant issues. Failure to comply with the law could result in punitive action through the court system. The Disability Rights Commission Act (DfEE, 1999) makes provision for service users to follow a complaints procedure with support from the Commission, which consists of members from diverse groups of disabled people. A person with learning disabilities was appointed as the first representative on the Commission, and the Guardian newspaper described this a breakthrough for people 'who were formerly marginalised as mentally handicapped' (Brindle, 2000). My professional experience and informal discussions with counsellors indicate that physical disability is more likely to be addressed in terms of access to counselling services than learning disability. This results in the provision of loop systems for those clients with hearing difficulties, ramps for wheelchair users, signs written in Braille for those with visual impairment but demonstrates a lack of training and awareness of the diverse needs of individuals with learning disabilities.

1.5 Research questions and the research process

Can counsellors make their practices and processes more inclusive of young people with learning disabilities?

The main research question above produces the hypothesis that counsellors are able to and are motivated towards making their practices more inclusive of young people with learning disabilities. I will also find it useful to address the null hypothesis that counsellors are not able or motivated to increase the level of inclusion in their practices and processes. In order to test these hypotheses it will be necessary to look closely at what the current situation is regarding counselling provision for this group of young people. Examples of the inclusion of young people with learning disabilities in counselling will be extracted from data collected in a survey of counsellors listed in the BACP Directory (2001), interviews with counsellors and group work. Examples of how these young people are included in counselling, with the identification of strategies, policies, techniques and approaches most likely to be associated with inclusive counselling practices will be identified and examined closely in relation to the existing bodies of knowledge and theory. The characteristics of the more inclusive counsellors, psychotherapists and organisations will be explored. This study will identify who counsels young people with learning disabilities, where counselling takes place and the counsellors theoretical approach to counselling. Training issues will be identified along with the impact that counsellors' previous training has upon the inclusivity of their counselling practices. This research builds upon work carried out by Lindsay (1999) in the field of emotional disorders in people with learning disabilities and the therapeutic help that psychologists can provide. Prosser's (1999) work on the mental health needs of people with learning disabilities and the

problems of detection and diagnosis of mental health problems similarly informs the study.

> Why should counsellors include young people with learning disabilities in counselling?

This key question focuses on four main reasons why counsellors should include this group of people in their counselling practice: human rights; the prevalence of mental health problems in young people with learning disabilities; education, learning and social progress; and finally, to defend counsellors against litigation and accusations of discrimination. According to national and international legislation, all human beings should have equal rights to the provision of services and membership of the same groups. Segregation restricts those rights and limits opportunities for achieving full potential, legislation in relation to human rights includes: United Nations Declaration of the Rights of Disabled People (1975), United Nations Convention on the Rights of the Child (Article2, 23, 1989), United Nations Standard Rules in the Equalisation of Opportunities for Persons with Disabilities (1993), Council for Disabled Children (1994), Disability Discrimination Act (DfEE, 1995), Disability Rights Commission Act (DfEE, 1999), Human Rights Act (DfEE,1998), and various European Union directives.

1.6 Summary

This chapter has provided background and context to the research study, opportunities to examine my own perspective as researcher and how my

research interests have developed. The stated aims of the research: to examine counselling practices in relation to the concept of inclusion and explore the potential for increasing the inclusivity of counselling in relation to young people with learning disabilities have been outlined and I have put forward the rationale for increasing the inclusion of this group of clients in counselling. Human rights; the nature of young people, their issues and access to counselling; increased levels of mental health problems in the learning disabled population; and the movement towards evidence-based practice and the development of a model for good practice have been introduced. I have highlighted the need for counsellors to defend themselves against potential litigation and accusations of discrimination by providing more inclusive counselling services for this client group and stated the questions that will drive the research process. The next chapter forms the first of three literature review chapters and explores the nature of learning disabilities.

Chapter 2: The Nature of Learning Disabilities

2.1 Introduction

The results of this study will highlight how some of the characteristics of young people with learning disabilities impact on the appropriateness of counselling as an intervention and on the client's engagement with the counselling process. The nature of learning disabilities has implications for the potential of increasing inclusivity in counselling and the ways in which counsellors may need to adapt their practices in order to include individuals who have diverse learning disabilities. The nature of the client's learning disabilities may also determine techniques and strategies to be used or how counselling may be adapted to the individual's needs in order to include them in the process more fully. Therefore, in this chapter I explore the notion of learning disabilities, looking at several aspects, including social history and background; the nature of people with learning disabilities and features of the condition. I examine causes and effects of learning disabilities, along with

assessment and classification of the condition and how these issues may impact on therapeutic counselling interventions today. I attempt to define learning disabilities in spite of the amorphous and diverse nature of the condition. I use examples from my work as a teacher of young people with special educational needs and my counselling practice. Permission to use this material has been given by students, clients and their parents and any identifying characteristics have been changed or removed.

2.2 Social History and Background to Learning Disabilities

In this section I explore the historical perspective of learning disability; how individuals have been viewed; the language used to describe them; their social circumstances and the ideologies, policies and legislation that form the social history of learning disability. My intention is to add context to the lives of young people with learning disabilities in contemporary society in order to enrich the debate on counsellors' abilities to include such people in counselling. Some of the language used in this section is controversial, politically incorrect in contemporary western society and may appear abusive in nature. I make no apology for this; it is a reflection and an indication of the historical background of learning disability.

2.2.1 Introducing the trans-historical idiot

Throughout history people with learning disabilities have stood out as being different. Goodey (1996:93) poses the question:

> Is there such a thing as a concept of a trans-historical idiot?
> A 'type' from past cultures that we recognize as learning disabled?'

The evidence does seem to indicate such a concept exists. 'Fools' were documented as early as the 13th Century (Neugeberger, 1996), followed by 'idiots' in the 15th Century. There does appear to have been consistency down the centuries in basic terminology and definitions of learning disabilities. It appears that definitions, or rather the nomenclature that provided definitions in history, have become terms of abuse in more recent years, for example, fool, cretin, moron, and imbecile. These terms have been replaced by such terms as: intellectually challenged, developmentally retarded and differently-abled. For example, in 1994 the Spastic Society changed its name to SCOPE because the term spastic had become abusive (Davies, 2003).

In the 17th Century the notion of religion was applied to people with learning disabilities. Calvinists defined them as non-human, or beasts due to their lack of intellect. The basic tenet for this argument rested upon the belief that the 'all-perfect God' would not have created non-human humans, that is, people who had little intellect (Goodey, 1996). This appears to support Goodey's notion of a trans-historical idiot. It is this same lower intellect that provides the basis for defining learning disabilities today through the Diagnostic Statistical Manual Fourth Edition (DSM-IV, American Psychological Society, 1994) and the International Classification of Diseases, 10th Edition (ICD-10, World Health Organisation, 1996; British Psychological Society, 2000). Lack of intellect has led to the eventual segregation of people with learning disabilities and their exclusion from mainstream society, culminating in the eugenics movement of the early part of the 20th Century and attempts to remove what

were thought to be threats to society. Counsellors today are expected or encouraged to include in their practices a group of people who have been excluded, rejected, ridiculed and often feared for centuries. Is this is too much to expect of them? Perhaps knowledge of the history of learning disabilities may help them to be more aware, therefore more inclusive, not to replace the phenomenological world of the contemporary client in therapy, rather to enrich it and contextualise some of the issues. The results of this research study seem to validate this notion; counsellors have indicated that they would be better equipped to include this group of people in their practices if they had some knowledge and training to increase their awareness of learning disabilities.

Earlier in history (15th/16th/17th C) nomenclature in relation to intellect defined the individual as intellect does in contemporary society. Lower intellect remains a problematic aspect of learning disabilities, both for the individual who may struggle to perform at the level expected of him/her (School Assessment Tests in the education system) and for society in attempting to provide for his/her needs against a backdrop of achievement and meritocracy. For the individual this may translate into low self-esteem and lack of self-worth, the highest value recognized in contemporary society is given to a quality that these young people do not possess in sufficient quantity – intellect. The present education system, in spite of inclusion policies, appears to perpetuate low self-esteem in children and young people with learning disabilities, the value system being evermore achievement driven. It seems more likely therefore that young people with learning disabilities would require

counselling as a therapeutic intervention. Although, according to Morrall (1998), mental health interventions could be seen as a form of social control.

According to Dumbleton (1998), terminology has gradually narrowed the focus from the whole person 'he is an imbecile' to a particular aspect of the person 'he is mentally retarded' (the mind is affected). One can now focus on particular aspects of the mind thereby narrowing the field yet further, for example *learning* disabilities or even *specific* learning disabilities, to indicate a particular problem with literacy or numeracy (dyslexia/dyscalcula). Professional jargon has moved away from nouns (idiot, fool) to adjectives such as: mentally defective and feeble-minded, describing general mental and moral dysfunction (Mental Deficiency Act, 1913). This Act had a category, moral defectives, due to the belief that conscience and morality were considered higher functions of human beings, therefore not part of the psyche of the 'mentally subnormal'. Regarding nomenclature, in the USA in the early 1900s the term feeble-minded was used as a generic term for learning disabilities (Dumbleton, 1998). The term moron was introduced around the same time by the Greek professor, J. C. Hutchinson whilst sitting on a committee developing a categorization of people with learning disabilities (Spector and Kituse, 1977).

2.3 Definition, classification and epidemiology of learning disabilities

By examining the language and nomenclature used in connection with learning disabilities, attempting to define the condition and look at classifications and

identify the extent of learning disabilities in the population I intend to provide greater clarity on the subject.

2.3.1 The terminology of learning disabilities

'Feeble-minded, mentally deficient, cretins, mentally retarded, slow, thick, soft in the head'; these are some of the words or phrases that I have heard used to refer to individuals who have learning disabilities. The above terms have usually been adopted in ignorance of the more politically correct terms, rather than as forms of abuse. However, any terminology that has its roots in the past seems to sound or appear abusive or disrespectful towards this group of people because of the connections that can be made with past ways of dealing with or caring for those with learning disabilities.

The terminology used to describe or categorize people with learning disabilities or learning difficulties varies globally, with the term learning disabilities being the label that is most widely used in Britain (BPS, 2000) by professionals in education, health and social care, the legal system and policy makers. Historically, terminology has changed according to the various legislation and social policies of the time. The term learning difficulties/disabilities is applied to individuals who have a cognitive impairment that in some way negatively affects their ability to learn (BPS, 2000). The type of person labelled in this way may vary from having difficulty with numeracy and/or literacy to having more complex difficulties as ascribed to some of the genetic syndromes. The terminology used to define this group of

people varies in Britain between the lay population and professionals, with historical terms that professionals and practitioners now regard as disrespectful or politically incorrect, such as mental handicap, mental sub-normality and mental retardation still in use amongst some members of the general population and in legislation such as the Criminal Evidence Act (DFES, 1984); the Youth Justice and Criminal Evidence Act (DfEE, 1999) and the Criminal Justice and Public Order Act (DfES, 1994). This can cause difficulties when working in an international context because the various terminologies are applied differently in other countries. For example, in North America, legislation refers to people with learning disabilities as being mentally retarded, a term that deeply offends clients and their carers in Britain (CPS, 2003). In Britain the term learning difficulties can also apply to people with forms of dyslexia, although in these cases the word specific is most often used as a prefix to signal differentiation (APA, 2004). The Education Act (1995) states that individuals who have difficulties in learning that are proportionately greater than the majority of children of the same age can be said to have learning disabilities.

Having explored the social history of learning disabilities it is apparent that chronology has made an instrumental contribution to how the condition of learning disabilities is diagnosed, defined and classified in contemporary society. How do we know an individual has learning disabilities? How do we differentiate between learning disabilities and other psychological, physical or neurological conditions? Why do we need to know? These are some of the

questions that I will address in this section, beginning with the process of defining learning disabilities.

2.3.2 Defining and classifying learning disabilities

Through a scoping search of the literature I have identified several major sources of information regarding the definition and classification of learning disabilities. The British Institute of Learning Disabilities (BILD, 2003) refers to definitions provided by the World Health Organisation, MENCAP, the Department of Health, the American Association on Mental Retardation (AAMR), the criminal justice system (including the Sexual Offences Act, 1956, 1967) and the Social Security Benefits Agency (includes the Registered Care Homes Act, 1984) and the Direct Payments (Community Care) Act, (1996). Psychologists also identify, define and classify learning disabilities through the process of psychometric testing. Mental health remains inextricably linked with learning disabilities and is covered by the Mental Health Act (1983). WHO provides a hierarchy of formal classification for learning disabilities in the form of ICD-10 (1996) as does the DSM-IV (1994) and a variety of locally devised manuals based on these. The International Classification of Functioning and Disability (WHO, draft 1999) serves to categorise the affects of learning disabilities on individuals within a variety of domains including intellectual, physical and social. In my previous roles, firstly as a health visitor, then a teacher of young people with special educational needs I could see some of the positive results of diagnosing and classifying individuals with learning disabilities, whilst being aware of negative effects as

described by Goffman, (1963). For example, when it became obvious to me in my observations as a health visitor that certain infants were not achieving their developmental milestones appropriately or were showing physical or behavioural problems, parents seemed to desperately seek a diagnosis. As distressed though they may be by the eventual diagnosis they also displayed obvious relief claiming that they could deal more easily with what they knew, the solid, the definitive, the reliable information they had from the medical experts and psychologists. The diagnosis potentially opened up a new world of resources, medical and social care and support from charitable trusts, voluntary organisations and support groups formed by families whose children were affected by similar conditions. This appears to be a form of inclusion through exclusion, these infants were different, they were not like not like other babies and young children in some fundamental way and parents would describe to me their sense of isolation and exclusion from mainstream parenthood. This exclusion appeared to me to sometimes be a form of self-exclusion, caused by feelings of being different, not necessarily enforced exclusion by other parents. Parents also told me how they had searched until they found other parents with similarly affected children. As a health visitor I facilitated this process, supporting parents in their search. I now question this practice; did I do the right thing? Or did I really facilitate what now appears to be social exclusion and participation in marginalised minority groups? Similarly, as a special educational needs (SENs) teacher I facilitated the transition from school to college (further education), from college to the workplace or adult training centres. I bore witness to the developmental processes involved in these

transitions, from children to adolescents, from adolescence to young adulthood. The labelling process seemed necessary once again in order to access services, support and financial benefits. In such ways the diagnosis and classification of learning disabilities seems to be necessary and can have benefits for the individual and their families.

My further studies of the social sciences, particularly sociology, introduced me to a different perspective, the potentially negative effects of labelling on groups and individuals, marginalisation, disaffection and social exclusion (Goffman, 1963). As a counsellor, through my relationships with clients with learning disabilities, I have become more aware of the complexity of the whole process of diagnosis, classification and labelling and how these processes impact on the inner and outer lives of individuals. The meeting of theories and practices, the inherent ambiguities and paradoxes and the deep feelings that my relationships with clients engender in me provide me with ongoing material for reflection, personal and professional development.

I can identify similar ambiguities and some acknowledgement that there are different ways of viewing the same phenomenon (learning disabilities) within WHO's document ICDH-2 (International Classification of Functioning and Disability-2, draft 1999). This document examines the two theoretical polarities of the medical and social models of disability (WHO, 1999:25), stating that:

> ICDH-2 is based on an integration of these two extreme models.....ICDH-2 attempts to achieve a synthesis thereby providing a coherent view of different dimensions of health at biological, individual and social levels.

Regarding classification a claim is made in ICDH-2 (1995:195) that:

> ICDH-2 is not a classification of persons at all. It is a classification of people's health characteristics.

I began my search for a definitive description of learning disabilities by examining the global classification document ICD-10 Guide for Mental Retardation (WHO, 1996). ICD-10 provides categories for the majority of the world's recognised diseases and conditions, describing learning disabilities (mental retardation) as:

> ....a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. Retardation can occur with or without any other mental or physical disorder.
>
> (WHO, 1996:1)

The same document states that people with learning disabilities often have multiple problems and that one diagnosis is usually not sufficient. Therefore, a set of categories for diagnosis grouped under the following five headings are used, with one individual being expected to have several diagnoses across the following five axis (WHO, 1996, unnumbered introductory pages):

Axis I	-	Severity of retardation and problem behaviours.
Axis II	-	Associated medical conditions.
Axis III	-	Associated psychiatric disorders.
Axis IV	-	Global assessment of psychosocial disability.
Axis V	-	Associated abnormal psychosocial situations.

Caution is advised in diagnosis due to the difficulties frequently encountered in communicating with individuals during the assessment process. The ambiguity and difficulties surrounding the definition and classification of learning disabilities has been reflected in my increasing frustration and growing sense

of failure in researching and writing up my thesis. I felt as if I would never be able to produce a piece of research that is conceptually viable, robust, authoritative and yet able to be operationalised enough to provide results that were useful to counsellors in their therapeutic work with clients. The following two statements made in a NHS Health Bulletin (DoH, 2002:1) sum this up:

> The field of intellectual disability continues to be plagued with inconsistent, uncritical and unscientific terminology, apparently hiding lax conceptualisation. ...classification of intellectual disability is a complex and confused area.

Although the World Health Organisation recommends that learning disabilities be diagnosed and classified using the above axis relating to the five domains of intelligence, behaviour, physical health, mental health and psychosocial aspects, the diagnosis most frequently used by professionals in the field of medicine, psychology and psychiatry is the DSM-IV (1994). DSM-IV provides a coding system based upon IQ testing and unspecified assessment of adaptive functioning. The IQ test classification is presented below (DSM-IV, Codes 317-319):

317	Mild mental retardation	IQ level 50/55-70
318	Moderate mental retardation	IQ level 35/40-50/55
318.1	Severe mental retardation	IQ level 20/25-35/40
318.2	Profound mental retardation	IQ level below20/25
319	Mental retardation: severity unspecified (untestable by standard tests)	

Diagnosis using DSM-IV criteria also depends upon the presence of learning disabilities before the age of eighteen years, thereby excluding those individuals who have degenerative brain disease or have been involved in accidents or other brain damaging incidents. My professional experience regarding the classification of learning disabilities is that the child is labelled

rather than the condition, going against the guidelines of the World Health Organisation (ICD-10, 1996). The child, who has generally been diagnosed following ongoing academic or social problems at school, may be referred to as severely disabled or moderately learning disabled, for example. The British Institute of Learning Disabilities (BILD, 2003) suggests that psychometric tests should be used with caution, that they are open to misinterpretation and that that factors other than learning disabilities may affect results, for example, psychiatric illness or drug misuse. My experience of working with young people taking anti-convulsant medication and those using cannabis excessively leads me to believe that although an individual may have functional learning disabilities and fulfil the IQ test criteria of two standard deviations or more below the norm, they do not necessarily have learning disabilities according to the DSM-IV diagnostic caveat 'present since childhood'. The confusion regarding definitions of learning disabilities seems in part to have its roots in:

a) conceptual or explicit understanding of the construct and

b) operations or procedures through which the construct can have practical meaning and utility.

(Hammill, 1993: 86)

> The heterogeneity of individuals with learning disabilities makes a definitive description and definition fraught with difficulties for those requiring clarity and potentially leads to frustrations and ambiguities.
>
> (Hammill, 1993:84)

Information relating to the prevalence and epidemiology of learning disabilities is similarly difficult to evaluate due to the varied terms used in the literature

2.3.3 Prevalence and epidemiology of learning disabilities

Following my exploration of how individuals with learning disabilities are identified and diagnosed it seems useful to look at how many individuals may be affected in relation to the general population and from social, economic and geographical perspectives. If mental health problems are more commonly found in people with learning disabilities (Lindsay, 1999) it may be helpful to have some idea of the size of the problem. The notion of chronology was introduced in the section about social history. Is there an aspect of chronology related to the prevalence and epidemiology of learning disabilities? In previous decades Zill and Shoenborn (1988) found that developmental, learning and behavioural disorders were amongst the most prevalent conditions in young people, with 3:10 male adolescents having experienced one of these disorders. Although Zill and Shoenborn (1988) suggested that 6.5% children aged 3-17 years had learning disabilities, there are two main difficulties with these findings. Firstly, there is a problem with classification (confusion over diagnosis) and terminology of learning disabilities. This study was carried out in the USA where the terminology of learning disabilities includes such conditions as dyslexia. The figures did not separate physical growth delays from cognitive developmental delays and disorders; therefore it is difficult to get a clear picture of the situation. Secondly, Zill and Shoenborn (1988) suggest that their figures represent an underestimation of the true situation regarding the prevalence of learning disabilities. An indication that the authors were right in suggesting an underestimation is to be found in an

epidemiological report (Centre for Disease Control and Prevention, Morbidity and Mortality Weekly Report, 2001:463-5) produced in the USA. This highlights Down syndrome as the most commonly identified cause of learning disabilities with a prevalence of 1:800 live births and consistency across all racial and social groups. A review of epidemiological surveys of autism (Fombonne, 1999) has also provided significant findings. Around 80% individuals with autism also have some degree of intellectual impairment and 1.9:1000 individuals have some form of pervasive developmental disorder, a figure described by the author as being 2-3 times higher than the rate for autism. The male/female rate for autism is 3.8:1 (Fombonne, 1999:783).

The very nature of learning disabilities and difficulties in diagnosis and classification, along with ambiguous terminologies has impeded my search for clarification regarding prevalence and epidemiology. Moreover, I have found it difficult to get a clear picture from the fragmented information and data on individual conditions associated with learning disabilities. The results from a range of studies from across the world can help towards gaining clarity. For example, Smith-Magenis syndrome has a prevalence of 1:25000 live births, this can be added to the prevalence of autism, Down syndrome and others (Di Cicco *et al.*, 2001). A survey carried out in Thailand (Thavichachart *et al.*, 2001:118-26) using DSM-IV (1994) and the Composite International Diagnostic Interview tool (CIDI, Version 1.1, WHO, 1993) gives a prevalence of 1.8% population. The Global Burden of Diseases document (Murray and Lopez, 1996) proposes a high prevalence of conditions associated with learning

disabilities. Environmental and geographical factors can have a profound effect on the prevalence of learning disabilities, for example, iodine deficiency in pregnant women can cause neuro-psycho-intellectual impairment in the unborn child (Glinoer, 2001). Some geographical areas are naturally lacking in the mineral iodine whilst in situations of poor diet, for example, in areas of socio-economic deprivation and special populations such as refugees, iodine deficiency is more likely (Glinoer, 2001). This may have implications for the provision of psychotherapeutic interventions in such populations. The higher prevalence of children with learning disabilities at schools in socio-economically deprived areas is well documented (Hood, 2001). Such children, their families and communities have to cope with the problems and difficulties associated with events outside of their immediate control. Smail (2000, 2001, 2002) provides a commentary on the power of the individual in society and Morrall (2000, 2001) examines the discourse around social control in relation to mental health services.

2.4 Features of Learning Disability

In this section I focus upon some of the features that signal in various ways to others that certain individuals may have learning disabilities. These are the features that group individuals together, yet they can also be seen as divisive and have the potential to set the person apart from the rest of society because of the emphasis on differences. The generic term, learning disabilities, is most often related to a set of features including physical signs and symptoms, psychological aspects, educational indicators and social concomitants. However, my experience as a counselling supervisor highlights the difficulties

that some counsellors have in recognising that their client has learning disabilities. Anecdotal evidence from counsellors whom I supervise is that although counsellors engage with clients as individuals they sometimes fail to notice other characteristics, only becoming aware of the possibility that a client has learning disabilities when there are difficulties with communication. Although the term 'learning disabilities' may be viewed as a label, which may in itself be socially discriminating (Brunton, 1997), steps may be taken to address the difficulties rather than believing the client to be 'in denial', 'blocked', 'depressed' or 'lacking motivation to change'.

2.4.1 Physical signs and symptoms

The individual with learning disabilities may be visibly identifiable through the presence of certain physical features such as facial dysmorphism, a term used with reference to a facial form that is different to the norm. Learning disability is not a disease; rather it is a sign or symptom of a specific syndrome or condition that is either medically or socially identifiable. Therefore, facial dysmorphism or facial features that appear somewhat unusual may be the first indication that a person may belong to the section of society said to have learning disabilities. Conditions linked to an abnormal X-gene such as Down syndrome are usually immediately recognisable in young people by their facial features (at least in Western society), namely, a short, flat face with a broad nasal bridge and large mouth (Vitale *et al.*, 2001; Fichera *et al.*, 2001). A counsellor faced with such a client would instantly recognise that they were

dealing with someone who had a learning disability, although physical appearance would not necessarily indicate to the observer the degree of cognitive impairment. Nevertheless, there are cultural differences in facial morphology. Some ethnic groups such as those from the Far East and South East Asia have as their normal facial characteristics those features that may be indicative of Down syndrome in the Western world. In fact, Down syndrome until recent years was referred to as Mongolism because of these very features. Some conditions, for example, Cohen's Syndrome, have characteristic facial features with accompanying medical conditions of ear infections and sinusitis, which may result in varying degrees of hearing impairment. Dysmorphism means that a young person looks different to their peers, particularly difficult at a time when the adolescent urge to belong is likely to be at its strongest. This may cause problems with self-esteem, confidence and identity, which may be explored in counselling. Disfigurement, for example, the skin tumours of Tuberous Sclerosis can be a source of concern for the individual causing low self-esteem, lack of confidence and a tendency to withdraw from social contact. The facial dysmorphism of Down syndrome can cause functional disabilities in the form of speech defects caused by a large tongue (Vitali *et al.*, 2001; Fichera, 2002). Examples from my counselling practice suggest that such functional difficulties can be a barrier to effective communication, unless time is taken to allow clients to express themselves. However, the trend towards brief therapy, with six sessions being offered by service providers such as NHS Trusts and Primary Care Trusts (DoH, 2001), may be excluding young people with learning difficulties from counselling. The results of this study will

highlight lack of time as one of the significant barriers to inclusive counselling practice.

In some cases the use of a third person as a sign language interpreter may be necessary, raising issues in counselling such as confidentiality and privacy but also cost. Di Cicco *et al.,* (2001) refer to voice, vocal cord and speech defects in relation to facial dysmorphism and sometimes a distinct lack of speech. It may be of use to counsellors to know that there is a lack of speech due to physical abnormalities rather than making an assumption that a client has language delays due to intellectual impairment or autism. These conditions may determine the effectiveness or appropriateness of counselling for individual clients. Suggestions have been made by counsellors in the data collected for this study to the need for counsellors to liase with clients, parents, teachers and carers in order to obtain information about the client and their most effective means of communication (when appropriate and with the client's permission if possible). Hearing is closely linked to verbal communication and it is common to find ear abnormalities with resulting hearing loss in young people with learning disabilities. Ear lobe abnormalities are visually identifiable and often signal more pervasive ear and hearing problems (Di Cicco *et al.*, 2001).

Non-verbal communication provides an important flow of information between counsellor and client (Egan, 2001; Nelson-Jones, 2003, 1997). However, much of this information is visual, posing difficulties for some individuals with

learning disabilities. Visual defects are particularly prevalent amongst this population. Eye problems may be severe, for example, the retinal abnormalities of conditions such as Cohen Syndrome and Tuberous Sclerosis that are progressive and lead eventually to blindness (Kivitie-Kallio and Norio, 2001; Dabora *et al.*, 2001; Rajagopalan, 2001). Milder but visually recognisable eye defects include squints (Esmer *et al.,* 2001); the abnormal iris of Cat-Eye Syndrome (Berends *et al.*, 2001) and extra folds of skin present in Down Synrome and Sjorren-Larson Synrome (Forster-Gibson *et al.*, 2001; Willemson *et al.*, 2001). Other easily recognisable physical features of conditions associated with learning disabilities are abnormalities of the fingers and toes, such as arachnodactyly (spidery fingers); polydactyly (extra fingers); short, slender fingers; deep creases across the palms of the hands and feet as in Down Syndrome and club foot as found in Mobius' Syndrome (Cronenberger *et al.*, 2001; Rajagoalan, 2001; Esmer *et al.*, 2001; Yamada *et al.*, 2001; Forster-Gibson *et al.*, 2001; Kivitie-Kallio and Norio, 2001). It is documented that children who appear different in some way to their peers are more likely to be targeted for bullying (Zic and Ignic, 2001). Such physical abnormalities may cause fine and gross motor problems, with manipulation skills and movements that can be mistakenly attributed to more severe intellectual disability than may be the case. However, similar functional disabilities are often associated with learning disabilities and are caused by damage to the nervous system as with the nerve paralysis of Mobius' Syndrome and the peripheral neuropathy of Charcot-Marie-Tooth Disease (Gemignani and Marbini, 2001; Di Cicco *et al.*, 2001; Cronenberger *et al.*, 2001). Such neurological damage is also the cause

of the epileptic seizures, commonly, though not exclusively associated with learning disabilities, both as cause and effect (Debora *et al.*, 2001; Rajapopalan, 2001; Willemson *et al.*, 2001; Kivitie-Kallio and Norio, 2001). It is not surprising that counsellors may be uncertain or confused as to which qualities can be attributed to learning disabilities or belong with the individuals underlying syndrome or condition. Although the individual is not defined by the condition, the effects and root causes may impact significantly on how that individual operates in the world. One of my clients, a sixteen-year-old girl with what presented as learning disabilities, improved considerably following surgery for severe epilepsy. Consequently she could stop taking the medication that significantly contributed to her cognitive disabilities. She no longer had learning disabilities, which could be said to be functional rather than pervasive.

Young people grow and develop at different rates and it may be difficult to tell the age of any particular individual by their physical appearance alone. However, abnormal growth and size may be indicative of other problems related to learning disabilities. The x-linked genetic syndromes may demonstrate characteristic obesity and overgrowth or deficiency in growth resulting in short stature (Stoll, 2001; Vitale *et al.*, 2001; Yamada *et al.*, 2001). Coupled with cognitive impairments or delays this may lead the counsellor to believe the client is younger or older than they actually are. Abnormalities in growth may include stunted growth of the head and brain (microcephaly) or overgrowth (macrocephaly). Some individuals have mechanical shunts inserted to release the pressure caused by extra fluid in the ventricles of the brain

(hydrocephaly). These shunts occasionally dysfunction causing a build-up of fluid again and the resulting pressure can lead to cognitive impairment (Wakamatsu *et al.*, 2001; Stoll, 2001; Yamada *et al.*, 2001; Kivitie-Kallio and Norio, 2001). These conditions in themselves may compound the level of learning disability already present. However, if a client appears less able to engage in counselling than is usual for them it may be that something has gone wrong, for example a blocked shunt causing a build up in fluid and pressure on the brain in young people with hydrocephaly. A decrease in cognitive abilities may be the first signs that something is wrong.

Some young people suffer from distressing and disfiguring skin conditions associated with the syndromes that are the cause of their learning disabilities. Disfiguring skin tumours are a common feature of Tuberous Sclerosis (Dabora *et al.*, 2001) with reddened thickening of the skin and scaling being a feature of Non-bullous Icthyosiform Erythroderma (Rajagopalan, 2001) and intense itching in Sjogren-Larsson Syndrome (Willemsen *et al.*, 2001). Such skin conditions can be the trigger for bullying and social exclusion in schools at a time when physical appearance is especially important. Altered body image can cause low self-esteem and lack of confidence (Breakey, 1997) However, physical symptoms such as these are often only part of a wider picture presenting as a result of genetic abnormalities (genotype) and referred to as phenotypes. Such phenotypes often include multiple body organ disease, genital and hormonal abnormalities such as hypogonadism causing underdeveloped testes in boys and ovaries in girls (Rajagopalan, 2001);

digestive system abnormalities such as the bowel problems of Hirschsprung Disease and Cat-Eye Syndrome (Berends et *al.*, 2001; Wakamatsu *et al.*, 2001); kidney damage and chronic renal failure (Dabora *et al.*, 2001; Esmer *et al.*, 2001). A significant number of these conditions are life-threatening, for example, heart defects in Down Syndrome (Forster-Gibson *et al.*, 2001) and liver damage (Dabora *et al.*, 2001). Individuals affected by severe physical problems are likely to have to endure repeated hospital admissions, often painful and prolonged treatment with disruption in their education and social relationships and isolation from peer groups. These factors may result in difficulties in attachment including behaviour problems on return to school (Parker and Forrest, 1993; Bowlby, 1969/1975). My professional experience as supervisor to school counsellors supports the literature, placing the above issues as within the counselling domain.

Although a young person with learning disabilities may be recognisable through the manifestation of physical signs and symptoms, not all such individuals have learning disabilities. For example, in Mobius' Syndrome 25% of individuals are of normal intelligence, although all have the physical abnormalities associated with the syndrome (Cronenberger *et al.*, 2001:158). In some conditions males are affected either more frequently than females with physical features being presented in the carrier (usually female) but without the cognitive impairment or with a milder degree of disability (Vitale *et al.*, 2001). In some x-linked genetic disorders males have severe learning disabilities whilst females are completely unaffected intellectually (Fichera *et al.*, 2001).

In Cat-Eye Syndrome, for example, intellectual impairment is present in only 32% of individuals (Berends *et al.*, 2001). This makes it even more important that counsellors assess individuals and provide therapeutic interventions aimed at an individual level rather than making assumptions based on incomplete knowledge of a particular condition. The results of this study support the notion of careful assessment, with strategies and interventions developed for individual clients.

Although knowledge regarding the physical features of conditions associated with learning disabilities may be interesting and informative, how else can this knowledge help the counsellor to help the client? Difficulties in communication may be apparent when counselling young people with learning disabilities; such issues are identified and explored in my results and discussion chapters. It appears easier to acknowledge that visual defects, blindness and varying degrees of deafness may provide barriers to effective communication. For example, visual defects can prevent the full range of non-verbal signals from being received whilst individuals with hearing impairments may require a third person to interpret using sign language (British Deaf Association, 2004). Access to counselling may be made difficult; the results of this study indicate that counsellors use more non-verbal communication as a way of including young people with learning disabilities in counselling. Non-verbal ways of working with clients include art therapy, drama and music therapies (Royal College of Psychiatrists, 2004; Sinason, 2002). I have found it difficult to assess the nature of problematic communication when an individual has both

physical and cognitive disabilities, perhaps also with conditions affecting social and emotional intelligence, for example, Asberger's syndrome or autism.

Life-threatening conditions and those causing chronic ill-health have implications for the type of issues that may arise in counselling. The symptoms of pain and discomfort found in major organ disease, nerve damage and infections make it more likely that counsellors in primary care and hospitals will encounter clients with learning disabilities. This raises training issues for counsellors and service providers. Leukaemia and other forms of cancer are more prevalent in this group of young people and are often associated with conditions such as Down syndrome (Forster-Gibson *et al.*, 2001). Therefore counsellors attached to chemotherapy and palliative care units along with nurses and social workers who use counselling skills as part of a wider role would in theory appear more likely to encounter clients with learning disabilities. However, perhaps due to the exclusive nature of counselling highlighted in this study, my professional experience in the field indicates that the needs of this client group may be overlooked.

The symptoms of general slowness of mind associated with learning disabilities can indicate to the counsellor a higher degree of intellectual impairment than may really the case. An example from my counselling practice illustrates this point. An adolescent girl presented for counselling with a series of issues around sexuality. She appeared to have severe learning disabilities and both the client and myself found it difficult to work in sessions and

communicate effectively. However, my knowledge of learning disabilities prompted to check out the client's medical background with her carers (with the client's permission). It was identified that the client suffered epileptic seizures and was on high doses of anticonvulsant medication that made her very slow and sleepy in the mornings. In consultation with the client and her carers counselling sessions were rearranged for late afternoons when the client was alert, responsive and able to engage more fully in the counselling process. This case material provides an example of an individual with a higher degree of functional learning disability than was inherent in her condition. Goffman (1961/1991) refers to such damaging effects of medical treatment as iatrogenesis. Through specialist supervision and training counsellors may be more able to identify such difficulties and therefore be more likely to meet the needs of their clients.

2.4.2 Psychosocial features of learning disability

The main features of learning disability are seen in the psychological concepts of cognition, perception, intellect, psychosocial development, language, behaviour and emotional development (BPS, 2000). These features are identified as being problematic in counselling and may pose barriers to access and engagement in the counselling process. Borgatti (2001) suggests that their psychopathology, psychological, intellectual and language delays can identify individuals with learning disabilities. Kulkarni (2001) refers to the concept of developmental disorders such as dyslexia, dysgraphia and dyscalcula, with the notion of developmental disorder being differentiated from developmental

delay. In practice it appears that developmental delays and disorders are found together. It could be said, therefore, that although dyslexia, dysgraphia, dyscalcula and ADHD can be features of learning disability their presence does not necessarily indicate that an individual's intellectual ability is adversely affected in other ways. However, these conditions in themselves may present barriers to learning that give the appearance of low intellectual ability (Shalev and Gross-Tsur, 2001). This can lead to confusion regarding the nature of learning disability and the terminologies used with reference to the various difficulties that individuals exhibit.

Baird *et al.*, (2000) discuss how far the difficulties found in conditions such as autism and ADHD are features of learning disability, for example, some individuals have such features as part of their presentation of more pervasive learning difficulties, whilst others are normal in every other respect. However, Numminen *et al.*, (2000) suggest that the reduced levels of working memory and cognitive skills are inherent features of learning disability. These ambiguities may be difficult for school counsellors who are more likely to have clients labelled as having learning disabilities, either in mainstream education or special units for children with special educational needs. Some children may have functional learning disabilities but with high intellect and such children may pose challenges to the counsellor. My experience of supervising school counsellors, supported by the results of this study, has highlighted the need for peer support along with further training and supervision by someone with knowledge and experience of learning disabilities.

Although young people with learning disabilities are not a homogenous group, the notion of genotypes and phenotypes suggests that such individuals can be grouped into categories according to the genetic and /or physical features of their condition. The idea of typologies is also put forward as behavioural phenotypes. Certain behaviours are more likely to be found in particular conditions, for example, hyperactivity in Angelman Syndrome (Smith, 2001) and aggressive behaviour in Prader-Willi Syndrome (Beardsmore, 1998). Harmful or challenging behaviours can be separated into two main groups, aggression aimed at others and self-injury. Aggressive behaviour towards others can pose difficulties for parents, carers and teachers, resulting in negative attitudes towards the individual with disruption in their social relationships and education leading to low self-esteem in the individual (DfES, 2001a). Any increase in these types of behaviours can be an indication of psychological distress or psychopathology. Sinason (2002) suggests that challenging behaviours may be ways of externalising or expressing internal distress (Sinason, 2002) and Corbett *et al.* (1996) claims that challenging behaviours are likely to be responses to forms of abuse. Other forms of challenging behaviour include hypermotility, ADHD, obsessive-compulsive behaviours, tics and obsessive self-injury.

Eating disorders are also common in individuals with learning disabilities (Gravestock, 2000). Levitas and Reid (1998) found that up to 42% institutionalised adults with learning disabilities also had some form of eating

disorder. However, it could be argued that it is easier to observe individuals in institutions and if such research were carried out in community settings this figure might be higher, unless the eating disorders were a part of the process of institutionalisation. Eating disorders are commonly found in the general population of young people (Abraham, 2001). However, there are some forms of eating behaviour that are more commonly seen in people with learning disability, for example, pica, a compulsive behaviour that involves the individual eating dirt (geophagia) and any other food or non-food substance (Knecht, 1999; Levitas and Reid, 1998) Other food or gastric related behaviours include rumination, regurgitation, psychogenic vomiting and aerophagia (Levitas and Reid, 1998). Some of these conditions have serious consequences, for example, aerophagia (swallowing air) can lead to gangrene of the bowel (van der Kolk, 2001). Eating disorders are issues that counsellors may encounter in their caseloads, with such referrals being likely in educational or medical contexts. However, by understanding the nature of eating disorders related to learning disabilities it may be possible to distinguish between mainstream eating disorders and those directly related to learning disabilities at the assessment stage. Counselling may not be an appropriate intervention.

By far the most intractable problems associated with learning disabilities are behaviour problems; these cause huge difficulties in the education and social care systems and can result in individuals being excluded from education, employment, society and social relationships (Borgatti, 2001). This forms the basis of the social exclusion process, which has been examined more fully in

the chapter on inclusion. Exclusion from social life and in particular, relationships with others is seen in conditions such as autism (Borgatti, 2001) and psychosis (Ratiasuo, 2001). However, individuals with emotional and psychological problems referred to psychiatric and psychological services and defined as suffering from psychopathology, such as depression following bereavement and low self-esteem can also be withdrawn and socially marginalised. (Bonell-Pascual 1999). Moreover, this could be described as a cause and effect phenomena because rejection experienced by school children may lead to low self-esteem (Zic and Igric, 2001).

2.5 Aetiology of Learning Disabilities

It may appear to counsellors that the cause of a client's learning disabilities are inconsequential, that it is the effects one has to deal with. However, the cause may form an inherent part of the effects, especially as a client grows and develops, demonstrating perhaps new signs and symptoms of differing aspects of learning disability (Wilska and Kaski, 1999). It is for precisely this purpose that Wilska and Kaski (1999, 2001:325) have developed their 'Aetiological Tree', a dynamic and adaptable form of plotting or charting an individual's development of new signs and symptoms of cognitive and intellectual impairment.

2.5.1 Physical and physiological causes of learning disabilities

The physical and physiological signs and symptoms of learning disability are manifold and include: genetic causes, biochemical, environmental, physical, viral and disease related, drug and alcohol related, metabolic or caused by accidents and injury. For a significant proportion of individuals no specific cause is found for their learning disabilities (Croen *et al.,* 2001; Kristjandottir *et al.*, 2000). An epidemiological survey of children in France with low IQs (<50) showed that the aetiology was 45% unknown; 26% unclear and 25% known (Cans *et al.,* 1999). By far the commonest form of learning disability is genetic with Down syndrome and other X-linked conditions being the most prevalent. Such genetic disorders cause molecular and cellular defects that are responsible for interruptions in electrical impulses in the brain and the metabolism of chemicals essential to brain functioning (Galdzicki *et al.*, 2001; Tunbilek, 2000; Chelley and Mandel, 2001). It is this disruption to brain functioning that is highlighted by this study as being a potential barrier to the counselling process and thereby restricting access to counselling. This study identifies ways of overcoming such barriers in counselling practices and processes. The second most frequent cause of learning disability is viral, historically the Rubella (German Measles) virus, but more recently (since Rubella vaccination programmes) the cytomegalovirus. This infection usually occurs in the first year of a child's life and in women of reproductive age increasing the risk of congenital infection (Almeida, 2001). Other infections

potentially leading to learning disabilities include bacterial meningitis, where the rapidly multiplying bacteria cause an inflammatory reaction in the brain, damaging brain tissue and injuring neurones (Leib and Tanber, 2001). Inflammatory reactions have been shown to pose a threat to the body's immune system. In addition to this, it appears that some central nervous systems are particularly vulnerable to injury, which may be genetic or of unknown aetiology. The effects on the central nervous system are the cause of the learning disability (Cowan *et al.*, 2000). Infectious disease is part of our human environment, just as environmental pollution forms part of contemporary life, therefore the potential for damage to any child is always present. It cannot be assumed that learning disabilities have been present since birth. Polychlorinated biphenyls (PCBs) and polychlorinated dibenzofurans (PCDFs) are environmental pollutants that can be hazardous to the environment and to human beings. They have caused poisoning in Kyusho in Japan (2000 people in 1968) and Taiwan (Aoki, 2001). Known as Yusho Disease in Japan and Yu-Cheng Disease in Taiwan, the most tragic effects of PCBs and PCDFs has been the exposure of children in utero or during breastfeeding leading to poor cognitive development and intellectual impairment. Therefore it could be argued that people living in poor socio-economic environments and nearer to industrial areas are more likely to have learning disabilities.

2.5.2 Psychosocial factors in the aetiology of learning disabilities

Although the aetiology of learning disabilities appears clear in around 25% of individuals (Cans *et al.*, 1999), this refers to physical and physiological causes. Psychosocial causes of learning disabilities appear to be more difficult to identify as actual causes rather than factors involved in the manifestation of learning disabilities in particular individuals (Cans *et al.,* 1999). Reference is made to particular children with low birthweight; those individuals born into lower socio-economic groups; children with racial or ethnic characteristics such as being born to black, Hispanic and Asian mothers; and finally those children with parents who have a lower level of education (Callanen *et al.,* 2001; Croen *et al.*, 2001). However, it would be difficult to separate out those individuals who have physical or physiological factors in the aetiology of their learning disabilities because around 45% of learning disabilities have unknown causes and in 26% of cases the causes are unclear (Cans *et al.,* 1999). According to Stromme and Magnus (2000), learning disabilities of unknown origin are found more commonly in individuals from families with a lower socio-economic status. Research carried out in Norway (Stromme and Magnus, 2000) shows a significant correlation between IQ and socioeconomic status, also identifying an overlap between learning disabilities of unspecified causes and the lower end of normal IQ in the general population. Callanan *et al.*,

(2001) identifies that children born to fragmented families and to mothers with little formal education are more likely to have a lower IQ and a higher frequency of learning disabilities. These children are also less likely to have close follow-up by statutory services, resulting in a greater degree of functional learning disabilities in individual children (Callanen, 2000). It has been identified by Gurvits *et al.*, (2000) that there is a higher level of mental illness in the lower socio-economic sections of society. This supports the notion of a high incidence of dual diagnosis referred to by Prosser (1999) and Lindsay (1999). Gurvits *et al.*, (2000) also point out that there may be a subtle form of neurological impairment noted in individuals with conditions such as post-traumatic stress disorder. This may result in functional learning disabilities. A higher level of childhood with Attention Deficit Disorder symptoms and lower IQs has been found to correlate with certain neurological signs found in people suffering from post-traumatic stress (Gurvits *et al.*, 2000). An awareness of this type of information by counsellors may help individual clients to be offered the type of therapeutic intervention most suited to their needs. Clients may not be able to identify or articulate these needs themselves.

2.6 Summary

In this chapter I have examined the social history and background to learning disabilities, looking at the notion of a transhistorical figure. The terminology and nomenclature around learning disability have been explored, attempts being made to define and classify learning disabilities and ascertain how

prevalent the condition is. Difficulties around clear definitions and accuracy regarding the epidemiology of learning disabilities have been highlighted. The features of learning disabilities have been identified and discussed including the physical signs and symptoms and psychosocial features of the condition. The aetiology of learning disabilities has been explored, identifying the causes as physical, physiological, psychosocial or environmental. Neurological impairment causing learning disabilities has also been found in people suffering the effects of post-traumatic stress. I have explored learning disability a condition that is assessed, defined and classified according to criteria developed by the medical profession, (particularly psychiatrists) and psychologists. It has been identified that people with learning disabilities have a long-standing history of stereotyping, discrimination; disrespect, abuse and social exclusion and that contemporary human rights policies and legislation are being used in attempts to reverse or change the picture. In the next chapter will explore issues relating to the inclusion and exclusion of learning disabled young people.

Chapter 3: Inclusion and Exclusion

3.1 Introduction

The notion of inclusion is central to my thesis. In this chapter I explore the concepts of inclusivity and exclusivity, equality and inequality. The terms inclusion and exclusion are frequently used in everyday life, with reference in particular to society, education, and employment, racial and cultural issues where parallel processes of inclusion and exclusion can be observed. It may be possible for counselling and psychotherapy to learn from the practices and policies of inclusion in other fields. By examining inclusion more widely it may be feasible to apply the general principles to the specific area of counselling. However, the concept of inclusivity and the terminology employed appear to be rather vague, involving a variety of perspectives such as philosophical, cultural, political, sociological and psychological. Thomas and Tarr (1999:24) refer to the global perspective within a framework of chronology; highlighting the notion that inclusion is driven by values that have emerged at various times in history:

> .....a communitarian philosophy in Italy; the social democracy of North West Europe and particularly Scandinavia; civil rights agendas

in North America, and, more recently, social justice as a theme across the world.

The proliferation of international and national legislation such as the United Nations Declaration of the Rights of Disabled Persons (1975); the United Nations Convention on the Rights of the Child (1989); the United Nations Standard Rules in the Equalisation of Opportunities for Persons with Disabilities (1993); the Council for Disabled Children (1994); and more recently, the Human Rights Act (DfEE, 1998) indicates that the issue of human rights appears central to the concept of inclusion and exclusion. In the first section of this chapter I examine some of the issues around human rights in relation to the ideas of inclusion and exclusion. This exploration aims to build the case for counsellors making their practices more inclusive of young people with learning disabilities. In section two I examine the concepts of social inclusion and exclusion, providing background to some of the exclusionary practices and processes in society. By examining social inclusion in more depth I intend to draw parallels between the wider social issues and counselling/ psychotherapy practices. This section focuses on notions of equal opportunities, citizenship and differing ideas of exclusion, namely voluntary and involuntary. Section three looks closely at the education system, particularly relevant to young people and the subject of major reforms regarding inclusion. This section aims to provide greater insights into the difficulties and complexities that exist in trying to implement inclusion policies. I examine dichotomies such as the National Curriculum, which may lead to meritocracy and SENs inclusion policies.

3.2 Human Rights

> Daily life in Britain could be about to undergo it's most radical transformation since the Second World War. the police, courts, Whitehall and local government are involved in a review of their powers and authority as they prepare for a wave of legal challenges on human rights grounds this autumn.

(Wintour, Political Editor, Observer newspaper, 13th February 2000)

The above quote signaled an important new phase in the human rights movement in UK life. The Humans Rights Act (DfEE, 1998) incorporates the European Convention on Human Rights into English law. The Act appears to signify the new 'rights and responsibilities' culture of the prevailing governing Labour party linked to the concepts of citizenship and democracy. In theory it seems that the Act could have far-reaching effects for people with learning disabilities, providing them and their advocates with the means to challenge discriminatory practices in health care, education, civil life and other public or private services. Regarding the provision of counselling and psychotherapy, this means that individuals with learning disabilities should have equal access to services. The Human Rights Act (DfEE, 1998) makes no distinction between the rights of children, young people and adults; therefore, according to this legislation, counsellors and psychotherapists have a legal duty to include young people with learning disabilities in their practices. To avoid this duty would indicate discrimination.

However, practices such as the rationing of health care, which includes counselling and psychotherapy, have been claimed to be particularly

discriminatory against people with learning disabilities and extend to the devaluing of the lives of disabled people (Shakespeare, 1998). Article 2 of the Human Rights Act – the right to life (DfEE, 1998) attempts to address this issue. The National Health Service is the largest employer of counsellors and psychotherapists (DoH, 2001) and therefore provides a high proportion of psychotherapeutic help to young people with learning disabilities. Research indicates that counselling and psychotherapy can be an effective form of treatment for depression (DoH, 2001), a potentially life-threatening condition, sometimes leading to death by suicide. The suicide rate amongst young people has been steadily rising for some years now (Childline, 2001) and is predicted to become the second most prevalent killer in the world (WHO, 2001). This trend has been attributed to academic achievement expectations, meritocracy and high unemployment in some societies, for example, Hong Kong (Federation of Youth Groups in Hong Kong, 2001). Dual diagnosis, namely the presence of depressive illness in individuals with learning disabilities has been shown to be more prevalent (Lindsay, 1999; Prosser, 1999).

Article 10 of the Human Rights Act (DfEE, 1998) states that individuals have the right to marry and have a family, an area of difficulty for people with learning disabilities, many of whom are actively discouraged or even physically prevented from forming close personal relationships with members of the opposite sex and having children, a discriminatory practice rooted in the eugenics movement. Bowlby's attachment theory (1969/1975) indicates that the lack of close personal relationships may lead to depression and withdrawal

from others. Moreover, Erickson (1963) in his eight stages of human development, proposes that close social relationships are part of the identity formation of adolescence and the building of intimacy based on affiliation and love are essential to young adults in order to avoid social isolation. I have observed the practice of discouraging close, potentially sexual relationships between individuals with learning disabilities in my role as a teacher. As a counsellor and supervisor I have listened to narratives regarding such practices and the distress that they cause to the individuals concerned. On the other hand, as a health visitor I have witnessed the difficulties and concerns regarding the balance of power, abuse and parenting issues in couples with learning disabilities. The issue of rights is linked to responsibilities and civil life (Giddens, 1998; Donnelly, 2002).

By tracing the origins of human rights I intend to identify some of the basic philosophical assumptions and relate them to my research questions, in particular the reasons why counsellors and psychotherapists should include young people with learning disabilities in their practices, any potential barriers to inclusion and inform the discussion on how difficulties may be resolved. Although the word 'right' came from the Old English term meaning equitable or morally just, the concept of human rights can be traced back to the Ancient Greeks and Romans and the natural law doctrines of Greek Stoicism, that individuals have certain rights extending beyond those of citizenship, namely natural rights. This forms the first group of rights that I have identified from the literature. This term pertains to the right to remain alive, liberty and the

right to freedom, the right to sustain life with food and shelter and the right for an individual to follow the dictates of their conscience (Morrall and Hazelton, 2004; Donnelly, 2002; Owen, 2001;Cranston 1973; Ganji 1975; Claude 1976; Ajami 1979; Joyce, 1979). Civil rights form the second group, referred to in early legislation such as the Habeas Corpus Act 1679• and the English Bill of Rights (1689/Yale, 2004). Civil rights are based upon positive law and judicial decisions, in other words, justice and notions of fairness and even-handedness along with equality (Cranston 1973). It is this second group of rights that I examine in this section in relation to moving towards more inclusive counselling practices. In the discussion chapter I will discuss these ideas in relation to the potential for increasing inclusion through self-awareness, professional and personal development, concepts referred to as important by Norwich and Kelly, 2004; Dyson *et al.*,, 2004; Hornby *et al.,* 2003; Norwich, 2002; Hornby, 2000). These are also important components of counselling and psychotherapy training and continuing professional development for qualified therapists. Through an examination of the basis for the underlying assumptions and beliefs of the notion of human rights and related concepts such equal opportunities and discrimination, I intend to highlight how individual counsellors may hold beliefs that contribute to the exclusion of young people with learning disabilities from counselling. Pearsall (Concise Oxford Dictionary, 2002) provides the following definition of civil rights: 'the rights of citizens to political and social freedom and equality'. Examples of civil rights include equal opportunities and political equality along with the rights of

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• Habeas Corpus (1679) responds to the abusive detention of persons without legal authority.

citizenship; both within the context of freedom and the removal of legal and social discrimination. Discrimination is described as *'unfavourable treatment based on prejudice, especially regarding age, race, sex'*, prejudice being *'a preconceived idea'*, *'harm or injury that results in or may result from some action or judgement'* and *'not impartial, bigoted'* (Concise Oxford Dictionary, Pearsall, 2002). Related issues include notions of diversity and differences of social condition, in that equality does not mean *'all the same'*, it refers to equality of opportunity, whilst accepting that people are different in the levels of potential and achievement. (John Dewey, 1916). This introduces the concept of diversity, a term often used today in relation to equal opportunities and inclusive practice (Dyson *et al.*, 2004; Norwich and Kelly, 2004; Norwich, 2002; Hornby, 2000; DfEE 1999; DfEE, 1995). Dewey's proposition that equality encompasses notions such as diversity and differences, referring to equality of opportunities has persisted and is present in contemporary legislation and equal opportunities policies (Equal Opportunities Commission, Roche, 2003). The notion of equality of opportunity may be problematic when applied to young people with learning disabilities and their access to psychotherapeutic services. It seems logical that if such inequality existed one would expect to see a representative number of clients with learning disability attending for counselling. On the contrary, my results will show that this client group is greatly under-represented. My discussion of the results will examine reasons for such inequitable access to services and strategies for improving access to both the practices and processes of counselling. The notion of access to the processes of counselling resonates with my research question: Is

counselling appropriate for young people with learning disabilities? Dewey's (1916) claim that people are different in terms of potential and achievement may have implications for counsellors and psychotherapists. When assessing how suitable counselling might be for a particular client (and if diversity and difference is accepted assessment would need to be based upon the needs of the individual) perhaps the parameters of what is achievable within the limits of the individual's potential need to be addressed in some way and achievements or outcomes of therapy evaluated accordingly. However, my experience as a supervisor of counsellors in primary care indicates that the CORE system (Clinical Outcomes in Routine Evaluation, Mellor-Clark, 1998) is increasingly employed as an assessment and evaluation outcome tool. If this is administered without due regard to the cognitive and language difficulties inherent in learning disabilities, such individuals may be deemed unsuitable for counselling or thought to have received no identifiable benefits from therapy. Therefore, the administration of such assessment and evaluation tools may be classed as potentially exclusionary practices in counselling and psychotherapy. Equal access to services may mean that individuals are made the subject of positive discrimination in order to be equal to others. Equality and discrimination are concepts that are inherent in inclusion.

3.2.1 Politics: equality and discrimination

I have traced the concept of inclusion back to its place in the political life of the Ancient Greeks, its origins being related to that of human rights and such

concepts as: equality, equal opportunities, equal rights, political equality, equality of respect, and anti-discrimination. In contemporary society one of the major factors in distinguishing between left wing and right wing politics has traditionally been their differing attitude towards equality, with the left advocating greater equality and the right believing that society is hierarchical and therefore inequality is inevitable. The Left have actively pursued social justice and recognise the important part that government has to play in this, equality being of supreme importance. However, equality can be seen as a relative concept:

> What makes us care about various inequalities...is the hunger of the hungry, the need of the needy.....the fact that they are worse off in the relevant aspect than their neighbours is relevant. But it is relevant not as an independent evil of equality. Its relevance is in showing that their hunger is greater, their need is more pressing, their suffering more hurtful and therefore it is our concern for equality that makes us give them priority.'
>
> (Raz, 1986:86)

Children and young people are identified as having specialised needs in relation to the general population and have been made the subject of legislation such as the Children Act (DfE,1989), the new Children's Bill (DfES, 2004) and documents including the Annual Children's Rights Reports of the Children's Alliance for England (1977-2003). Furthermore, the literature indicates that individuals with learning disabilities are more vulnerable to abuse than other children (Corbett, 1999). Therefore, relatively speaking, the needs of young people with learning disabilities are greater than those of the general population. According to the argument put forward by Raz (1986), this group should be given priority, in other words, made the subject of positive

discrimination. This notion is discussed later in the thesis in relation to strategies that are more likely to include this group of clients in counselling and psychotherapy.

Equality is also reported to be about making use of talents and capacities of all citizens and contemporary left-wing or Third Way politics proposes that egalitarian policies increase the range of freedoms open to individuals, although equality and individual freedom may at times be in conflict, therefore, formal equality and individual rights are part of democracy (Giddens, 1998). Prior to collecting data for this study I had made the assumption that counsellors and psychotherapists, by the very nature of their work, were committed to egalitarian principles. I now accept that such a generalisation cannot be made. The political beliefs of individual counsellors vary to the extent that some indicate in the data that they do not want to include young people with learning disabilities in their practices. I expand upon this issue in the discussion chapter. Therefore, egalitarianism cannot be assumed and barriers to inclusion may be inherent in the deeply embedded political beliefs of individual therapists, along with personal, religious and moral values. Egalitarian ideas emerged concretely in Western thought in the 18th century with John-Jacques Rousseau (1754). By the time of the American Revolution (1776) equality had ceased to be solely the property of theology and religion, although religion remained inherent in the concept and was used to fire the 18th century British anti-slavery movement (Louis *et al.*, 1998). Thomas Jefferson

in the 1776 Declaration of Independence espoused equal rights, specifically to life, liberty and the pursuit of happiness.

Much of present-day politics is concerned with the issues of equality and freedom from discrimination; groups seeking equal rights include: the disabled, ethnic minorities, single parents, homosexuals and the elderly. Fowler and Orenstein (1993) state that providing a definition of equality is extremely difficult. However, the central core seems to hinge on the notion of equivalence. Critics of equality argue that people are too different to each other to be 'equivalent' to each other and that natural variations are so inherent in humans that no amount of egalitarianism can wipe out inequality (Fowler and Orenstein 1993). The diverse nature of learning disabilities ensures that individuals do not form a homogenous group. Moreover, within the client group of young people with learning disabilities there are varying levels of disability, a hierarchy of learning disability prescribed by assessment using DSM-IV. There are implications for the inclusion of young people with learning disabilities within counselling and psychotherapy. What are therapists alluding to when they claim to include this client group? The data from this research study will inform debate on the present scenario regarding inclusion in counselling and highlight how one might address the needs of individuals rather than assuming that young people with learning disabilities all have similar needs. The concept of positive discrimination as part of egalitarian practices may be valuable to the counsellor in this respect and may of use in

providing a rationale when bidding for funding for counselling services or claiming greater resources in terms of time.

The field of sociology can contribute to my exploration of equality by providing the utilitarian understanding of equality and introducing the idea of 'for the common good' referred to by Fowler and Orenstein (1993:100) in the quote below:

> Equality can only be defended when it benefits the whole, only when it results in more pleasure than pain or helps us to achieve the greatest good for the greatest number in society.

Therefore, the utilitarian perspective places equality as a second rank value, the first being common good and happiness. The utilitarian paradigm has implications for the inclusion of young people with learning disabilities in counselling. The notion of 'the greatest good' is central to the management of resources, particularly in the NHS and is supported by evidence-based practice and the values of a research hierarchy claiming random controlled trials as the highest standard (DoH, 2001). The random controlled trial attempts to identify what works best for the greatest number of people, whereas qualitative studies highlight what appears to be effective in the case of individuals, even though studies may include many individuals with a seemingly overlapping range of effective interventions (Cochrane Research and Dissemination Unit, 2001). In the research arena the results of qualitative research cannot be generalised with any degree of significance or validity (McLeod, 2001). Therefore, the utilitarian notion of equality of the needs of the minority being secondary to the

needs of the majority can help to explain the situation that exists in primary care regarding the exclusion of young people with learning disabilities from counselling. I have chosen primary care as an example of counselling provision because the NHS is the largest employer of counsellors (DoH, 2001) and my experience as a supervisor to counsellors in primary care indicates that this field of counselling and psychotherapy is increasing. The very nature of learning disabilities means that young people who have this condition find cognitive processing, memory and communication through language more difficult than others. Potentially they require a greater degree of time and persistence from the counsellor. Counselling services in primary care are limited by available resources and generally provide time limited therapy in the form of six or eight sessions. My experience of counselling young people with learning disabilities and also as a supervisor of counsellors involved with this client group indicates that more time is often required to engage such clients in the counselling process. I explore this more fully and relate these ideas to my results in the discussion chapter. The inclusion of young people with learning disabilities in counselling and psychotherapy could be seen as a microcosm of inclusion in the wider society. The following section explores social inclusion and the implications for counselling this client group.

3.2.2 Social inclusion

The notion of social inclusion is of high profile in the political and economic arena, both at a national and global level and can have a far-reaching impact on areas such as education, health and employment, which are areas of significant

difficulty for individuals with learning disabilities. By examining the causes and effects of social exclusion I hope to gain a deeper understanding of the issues around the inclusion/exclusion of young people with learning disabilities from counselling and psychotherapy. The use of such knowledge and understanding coupled with the results from my research will be used to inform interventions to increase the inclusion of this client group in counselling practices and processes. Social inclusion has an alter-ego, social exclusion and before going on to examine what this really means, I believe it is worth stopping to identify who it is that we refer to as the included or the excluded. Who exactly is the movement towards inclusion aimed at? People who are excluded, for whatever reason, from various aspects of society are often referred to as the disaffected or the marginalized. The socially excluded in Western society refers to the mentally ill, disabled, unemployed and economically disadvantaged (Morrall and Hazleton, 2004; Norwich and Kelly, 2004; Dyson *et al.*, 2004; Norwich, 2002; Hornby, 2000; Morrall, 2000, 1998). The social history of individuals with learning disabilities positions them as marginalized or excluded. Statistics can give an indication of the number of people we are talking about. According to the British Institute of Learning Disabilities (2003), there are 1.2 million people with some form of learning disability in the UK. Government figures show that the NHS and local authorities spend around £3billion per annum on this group of people (DoH, 2003).

In contemporary society the terms inclusion and exclusion are widely used with reference to groups or sections of society and individuals involved with

issues such as: education, disability, race, single parents and disaffected young people. The increasing everyday use of the terms inclusion and exclusion in Britain reflects the language used in political rhetoric, picked up and reported widely by the media. Giddens (1998:102-3) highlights how the 'new politics' defines equality as inclusion and inequality as exclusion.

> Inclusion refers in its broadest sense to citizenship, to the civil rights and political obligations that all members of a society should have, not just formally, but as a reality of their lives. It also refers to opportunities and to involvement in public space. In a society where work remains central to self-esteem and standard of living, access to work is one main context of opportunity. Education is another, and would be so even if it weren't so important for the employment possibilities to which it is relevant.

Foucault (1980) in his theory of normalisation provides an alternative definition of exclusion. This is embedded in his concept of dividing practices, which set aside the normal from the not normal. Giddens (1998) suggests that two of the concepts of the social inclusion/exclusion debate, namely equal opportunities and citizenship are set against a background of employment and education, social contexts that are overwhelmingly powerful in helping to define the value and self-esteem of individuals, including those people who have learning disabilities. In his interpretation of social democracy Giddens (1998:105) identifies six main elements of an inclusive society: equality as inclusion; limited meritocracy; civic liberalism (a renewal of public space); a 'beyond the work' philosophy; positive welfare and social investment. In opposition to this definition the neoliberals suggest that equality of opportunity should be the only equality within society. Could Gidden's (ibid.) six elements of an inclusive society be applied to counselling and psychotherapy practice?

In some ways perhaps they could; individual autonomy fits in well with the Ethical Framework (British Association for Counselling and Psychotherapy, 2003) and the use of advocacy may help young people with learning disabilities to be more autonomous (BILD, 2003). A 'beyond the work' philosophy or valuing people for more than their occupational status, productivity and a limited meritocracy or pursuit of qualifications may translate into the concept of valuing the individual as espoused by various theoretical approaches to counselling and professional bodies (BACP, 2003; UKCP, 2003; Jacobs, 2000; Assagioli, 2000; Van Deurzan, 1998; Rowan and Cooper, 1999; Dryden, 1996). Positive welfare and social investment could be interpreted as making the resources available to enable young people with learning disabilities to access counselling services, especially as professional therapy fees can be in the region of £25-£35 per hour (Friery, 2003)). However, the idea that equality of opportunity is synonymous with inclusion in counselling can be challenged. Similarly, it is difficult to see how the notion of limited meritocracy can be applied to the equality of individuals.

3.2.3 Equal opportunities and meritocracy

The potentially excluding nature of merely providing equal access to services mirrors the equal access to qualifications promoted as a social inclusion strategy by the Labour government. An example of this is the 'widening participation' policy in higher education (DfES, 2003). Equality of opportunity has been translated from the legislation into the concept of equal access in

relation to the provision of services (Dyson *et al.*, 2004; Norwich, 2002; DfEE, 1995). Moreover, it may be assumed by providers of psychotherapeutic services that access to provision is synonymous with effective delivery and use of service. Counselling and psychotherapy are about processes such as relationship building, psychological movement and change (DoH, 2001; BACP, 2003). Therefore, the use of the term access as a synonym for equality of opportunity does not allow for truly inclusive counselling practices.

The notion of access does not take into account the processes involved. In the case of higher education this means that in spite of widening participation policies, students remain excluded due to lack of socio-economic support, especially for working class undergraduates. In the case of compulsory mainstream education this means 'inclusive schooling' (Dyson *et al.*, 2004; Hornby *et al.*, 2003; Norwich, 2002; Hornby, 2000). It appears that the notion of equal opportunities alone can help to create a meritocracy with deep inequalities of outcome resulting in the excluded becoming a class of disaffected individuals. This applies to people with learning disabilities who are often excluded from mainstream society due to their poor educational attainments and their difficulties in developing transferable workplace skills due to cognitive impairment. Therefore, anti-discrimination legislation and equal opportunities policies may be ineffective at preventing social exclusion. The results from this study will address the issue of such legislation and policies in relation to inclusion in counselling.

> ...the only equality should be equality of opportunity within society .
> (Giddens 1998:101)

The above statement firmly places meritocracy as a foundation for society and in his analysis of the meaning of equality Giddens (ibid.) proposes that meritocracy creates deep inequalities of outcome resulting in the excluded becoming a class of disaffected individuals:

> In fact, a full meritocracy would create an extreme example of such a class, a class of untouchables. For not only would groups of people be at the bottom, but they would know their lack of abilities would make this right and proper; it is hard to imagine anything more dispiriting.
>
> (Giddens 1998:102)

Perhaps a limited meritocracy provides the way forward, allowing for those who are socially excluded from the meritocratic aspects of society to remain valued as individuals (Giddens 1998). However, it seems that people with learning disabilities would be excluded even with such a limited form of meritocracy because of the changes in employment and the work force. Giddens (ibid.) points out that the dramatic cuts in the demand for unskilled labour have affected the class structure in Britain with the majority of the working population being in manual jobs as recently as twenty-five years ago, the demand now being for skilled workers. Vocational qualifications such as National Vocational Qualifications (NVQs) and General National Vocational Qualifications (GNVQs) have become the benchmark for many types of skilled work (DfES, 2003), although these qualifications may be achievable for some individuals with learning disabilities, for many of this group it is just not possible. Moreover, my experience of working with young people with learning disabilities on vocational courses indicates that the actual manual skills may be possible but the process of achieving qualifications is made too

difficult through complicated programme specifications and achievement criteria (DfES, 2003). The language of NVQ appears incredibly complex for the skill level expected.

Figures show (Lee, 2003) that in a large proportion of people with mild to moderate learning disabilities social and economic deprivation may be a causal factor. Therefore, it appears logical that a 'cycle of learning disability' may be taking place with some individuals suffering social and economic deprivation, resulting in mild to moderate learning disabilities exacerbated by disruptive family backgrounds. Such individuals may be yet further marginalised by their exclusion from employment with manual work being no longer as easily available. This marginalised group of people with learning disabilities may not even have existed in feudal times when manual work formed the largest part of the employment market. The fact that workhouses actively encouraged this section of the population to stay due to their ability to work hard showed that they were well able to perform the manual tasks that were required of labourers (Rushton, 1996). According to Reeve (2002) the social exclusion of people with disabilities in contemporary society and the resulting economic disadvantages can lead to exclusion from counselling services due to lack of ability to pay and at the very least restricted choice of services and inequality of access.

Giddens' (1999) view that an inclusive society is based on equality, which can be achieved through education, particularly in the basic skills of numeracy and

literacy, the lack of which serve to exclude people with learning disabilities from the labour market, is challenged by Forrester (1999). She speaks of young people in contemporary society as being excluded from a society that essentially no longer exists, the notions of work and employment belonging to a bygone era. This may be particularly true for young people with learning disabilities who may be condemned to remain on state benefits and cannot improve their skills enough to get a job, especially when, according to Forrester (1999) jobs just don't exist. Therefore, in Forrester's view (1999:59), these young people with are excluded from what she describes as: 'the remnants of a society based on the work ethic'; also claiming that most young people have a dream of integrating into a society that is geographically close to them but inaccessible to their biographies. The biographies of people with learning disabilities often already have exclusion written into them due to their difficulties in accessing mainstream education. It is worth noting that such biographies may be valued in the narrative therapy approach to counselling and the newly emerging paradigm of client narrative as research:

> The practitioner using narrative therapy needs all the observation powers, persistence, care, deliberation, and delicacy of the archaeologist. From a few small pieces of information, the beginnings of a story located in a particular culture are constructed.
>
> (Monk, 1996:3)

Inclusivity appears to be based on the premise that individuals and groups of people have certain rights that entitle them to be included in society and all aspects of social life, for example, access to the same sort of services as others, (Disability Discrimination Act, DfEE, 1995; Disability Rights Commission, DfEE, 1999). According to present day national and international legislation,

all human beings should have equal rights to the provision of services and membership of social groups, with exclusion being seen as restricting those rights and limiting opportunities for achievement of full potential. Examples of such legislation include: Declaration of the Rights of Disabled People (UN, 1975), the Convention on the Rights of the Child (UN, 1989; Article2, 23), the Standard Rules in the Equalisation of Opportunities for Persons with Disabilities (UN, 1993), Council for Disabled Children (1994), Human Rights Act (DfEE, 1998), European Convention on Human Rights and Fundamental Freedoms (UN, 1970, 1971, 1990). However, the existence of legislation does not necessarily lead to individuals receiving equal services. Reeve (2002:13) highlights the existence of oppression in the counselling room:

> Counsellors, like all other people in society, are fed a stream of negative images and stereotypes of disabled people from a very early age, and these contribute to the continued discrimination and exclusion of disabled people in society.

Wolfe *et al.*, (1989:11) acknowledge that counselling is part of the fabric of the wider social framework:

> Counselling is a 'social enterprise' and cannot be divorced from the social, economic and political environment in which it is practised.

Therefore, it appears that the notion of equality of provision regarding counselling services is more complex than accessing the actual service provision, it is the nature, or quality of the service and the processes involved that may need to be more fully explored and made transparent. The involvement of individuals and groups of marginalized people in the planning and provision of services is an example of citizenship in action, the claiming of

the civil rights referred to in human rights legislation. Examples of support for initiatives involving young people with learning disabilities in the policy making and the planning of services include the Diana, Princess of Wales Memorial Fund (2003).

3.2.4 Citizenship

Giddens (1998) links inclusion firmly to citizenship and civil rights, concepts that have their roots in Ancient Greek and Roman democratic societies. Citizenship 'looks set to be the sound-bite for the new millennium' suggests John Crace in his article 'The New Citizens' in the Guardian Educational Supplement (February 2000). Dagger (1997:100) states that:

> A true citizen will take an active part in public life and this must involve more than an occasional trip to the polling booth.

In the area of psychological and psychiatric services, user groups have developed in order to address the issue of taking an active part in public life. User contribution to the policies impacting on the care of themselves and others may be facilitated through the use of advocates (BILD, 2003). The use of advocates to enable people with learning disabilities to participate at conferences on learning disability issues by the British Institute of Learning Disabilities is a good example of inclusion. Citizenship became a statutory subject in schools in the year 2000 with the National Curriculum for Citizenship (Crick Report, Qualifications and Curriculum Authority, QCA, 1998) and can be used to further the notion of 'inclusive schooling' (Dyson *et*

al., 2004; Norwich and Kelly, 2002) and community/parental involvement (Hornby, 2000). Crace (2000) refers to Blunkett's rationalisation of the importance of citizenship in the curriculum through examples of higher attainment by pupils in other subjects in schools where citizenship already forms part of the personal and social education curriculum, thereby further endorsing meritocracy. On the other hand, one teacher is reported by Crace (2000) to have the following to say about citizenship in the curriculum:

> We felt it was a really important way of getting the children to understand that they do have a voice and that their opinions can make a difference.

Issues included in the curriculum are those such as: democracy, community action, xenophobia, racism, refugees and human rights. Independent voluntary bodies such as: the Citizenship Foundation, the Institute for Citizenship, the Community Services Volunteers Association and the Council for Education in World Citizenship were nominated as potential resources for schools to draw upon in their implementation of the new curriculum for citizenship.

Regarding citizenship in relation to inclusivity, my experience as a tutor to young people with special educational needs highlights how individuals and groups may benefit from active citizenship: intellectually, practically and morally. One of my teaching colleagues carried out a 'Disability Access Survey' of a small town in the north-east of England, with a small group of further education students with multiple disabilities (both physical and learning disabilities). These young people assessed the accessibility of local social

venues, such as: shops, pubs, theatres, cinemas, health centres and sports centres. The results from the survey highlighted venues that excluded these students due to physical inaccessibility. In the ensuing discussions with managers, proprietors and local council representatives the students learned, at first hand, the skills of advocacy, strength in a group approach to such issues, along with a working knowledge of disability rights legislation, using their knowledge and skills to affect change. Although the notion of citizenship encompasses active participation in civil life, thereby promoting inclusion, some individuals actively choose to exclude themselves from aspects of society.

3.2.5 Voluntary and involuntary exclusion

My discussion so far has referred to the process of involuntary exclusion. Giddens (1998:103) puts forward the proposal that there are two types of exclusion, firstly, voluntary exclusion by those at the top of society (the affluent) 'the revolt of the elite', who choose to withdraw from the public arena for services such as education and health. Secondly, he describes the involuntary exclusion of those at the bottom (the poor, sick, disabled, culturally disadvantaged) who are effectively out of the mainstream of society, especially regarding access to opportunities. People with learning disabilities would fall into this second group. Giddens (1998:109) quotes from the Report of the Social Justice Commission (1974:174) in his proposal that social exclusion at

the bottom is self-producing due to the poverty cycle and that poor basic skills (e.g. literacy) lock people into this cycle:

> It is ...absolutely essential to help adults without basic skills or qualifications to acquire them...People without skills are five times more likely to become unemployed than those with higher educational level qualifications; in the end employment goes to the employable.

However, the above quote misses the point in that some individuals cannot acquire the basic skills or qualifications due to their cognitive disabilities. On the other hand, Giddens (ibid.) is accurate in his claim that those with higher educational level qualifications are more likely to be employed. Statistics are available to support this claim along with figures that indicate higher levels of pay in university graduates (Organisation for Economic Cooperation and Development, OECD, 2001). Therefore young people with learning disabilities can expect to be financially disadvantaged by their disabilities.

Alternatively, throughout history there have been individuals and groups of people who have been self-excluded from mainstream society through positively accepting poverty as a way of being, for example, monks of the Benedictine Order, who took vows of poverty and chastity (Russell 1993/1946). During the 12th century personal holiness was associated with a 'cult of poverty'. Peter Waldon (1170), a heretic crusader, gave all of his possessions to the poor and formed a society called 'the Poor Men of Lyons'; this group excluded themselves from the mainstream by practising extreme poverty and a 'virtuous life' (Russell 1993/1946). St. Francis of Assisi (1181-

1226) and his religious order also practised extreme poverty, having to beg for bread and take 'hospitality (lodgings) wherever it was offered' (Russell 1993/1946:441). Voluntary poverty and exclusion has also been associated with ascetic mysticism, as in the case of Schophauer (1788-1860), a particularly pessimistic German philosopher who embraced Hinduism and Buddhism, he insisted that:

> ....the good man will practise chastity, voluntary poverty, fasting and self-torture.
>
> (Russell 1993/1946:725).

I have introduced the concept of voluntary exclusion in order to acknowledge that exclusion from mainstream society is not always negative; it may have positive benefits for some. However, it is one thing to be excluded and living in poverty and difficult conditions by choice but completely different to be forced into hardship by personal attributes beyond your control. Smail (2001) suggests that an individual's lack of control over their own life can lead to psychological distress and mental health problems. At various points in history families with a member who suffered ill-health or disability were extremely disadvantaged, particularly if the person was an adult male who was excluded from the job market and had a family to support (Rushton, 1996). Mental illness and learning disability were conditions that often caused hardship and distress for families due to the individual's incapacity to work in the long-term and maintain their affairs. However, it was by no means certain that people known as 'idiots' could not hold down jobs because much of the employment in the past would have been well suited to the abilities of that section of society now described as having mild to moderate learning difficulties due to the repetitive

nature of work on the land. In spite of this, it remains that a family supporting a person with more severe learning disabilities would be economically disadvantaged to a significant degree (Rushton 1996:53):

> The failure of the mature male was the source of much greater anxiety and public attention: patriarchy depends on men being at the very least reliable. However, idiots may not have been regarded as being completely incapable of earning a living: one Ipswich man in the 1597 census of the poor was found 'abell' to work, though in want.

In several of these Elizabethan urban surveys the presence of a mentally disabled person is a recognised element in the family's poverty (Rushton, 1999). My experience as a vocational tutor to young people with learning disabilities in a college of further education indicates that families in contemporary society also experience disadvantage due to having a family member with learning disabilities. In a society where parents need to work in order to maintain a reasonable standard of living there may be difficulties, for example, if there is a child with learning disabilities the parent may need to be available on standby to pick up the child from school when they have, for example, frequent epileptic fits. In spite of a child's inclusion in the educational system, the family may remain excluded in ways that are not immediately transparent. Young people with learning disabilities may have to remain on social benefits for most, if not all, of their lives. If self-esteem and self-worth is gained through academic achievement and work (Forrester, 1999) then it logically follows that many of this young client group may have problems with low self-esteem and lack of confidence. This has implications for the provision of counselling services. My experience of working with the families of young

people with learning disabilities indicates that there is a need for help and support to all family members. The presence of learning disabilities can affect the individual child, has an effect upon other family members, socially, emotionally and economically. For some parents of children with learning disabilities the education system provides the first experience of social exclusion.

3.3 Inclusion: educational perspectives

Inclusion is reportedly one of the major reforms of the twentieth century and it is claimed that education can help to combat social exclusion and bring young people back from the margins (Giddens, 1998). Dyson *et al.* (2004) uses the term 'inclusive schooling' to refer to this process in the statutory compulsory mainstream education sector. However, Forrester (1999:70) suggests that education is merely a way of conning children, conditioning them into a society that will eventually exclude them, that education is essentially a fake:

> Must it be thought a bad joke, an additional insult, to teach children about the rudiments of a life already denied to them, an already confiscated life, a life of which they are deprived in advance?

Forrester (ibid.) also speaks of the education systems of the western world as educating children in a way that will exclude the vast majority, letting them keep their dreams and hopes until they reach the point of looking for work, only to have these hopes and dreams dashed, but in doing so attributing their failure to themselves, thinking themselves not clever enough or persistent enough to get work, when really there is no work to be had. My work with young people with learning disabilities in transition from school or college to

'work' supports Forrester's (1999) proposition; an individual's failure to get a job after leaving school may be internalized as their own fault. However, others may be aware that it is unlikely that a young person with more than mild learning disabilities will be offered employment. Furthermore, when young people turn to drugs or crime, perhaps to console themselves, they are further excluded from society, labelled as deviant and used by others. The excluded are then ever more convinced of their own failings. The government's New Deal initiative (Department for Work and Pensions, DfWP, 1999) attempts to address the issue of exclusion through supported employment, with some degree of success.

According to Giddens (1999), education and schooling should provide a weapon against social injustice and yet there is an alternative view put forward by Forrester (1999: 73):

> Instinctively, no doubt the children guess that teaching or pretending to teach what is cruelly anachronistic as if it is still relevant is one of the one of the only ways – the best one – for deceiving oneself so as to go on living by criteria now invalid, and thus ratifying them and prolonging illusions that engenders fatal misunderstandings and sterile suffering.

Regarding children with learning disabilities, who may find it even more difficult to get work on leaving school, it can therefore seem doubly cruel to prepare them for the world of work when this no longer exists. Interestingly, the 'world of work' also relates to the title of a Royal College of Arts (RSA) qualification available for young people with learning disabilities. Forrester (1999:10) poses the following questions:

> Since these things are superfluous should they really be taught to people who are of no use? Is there really any

> economic sense to it? Why give such people the means of waking up to the reality of their situation?

Forrester (1999) suggests that the ways in which governments try to address unemployment are out-dated and ineffective, referring to ideas as 'endlessly rehashed training sessions, lifelong education and other outworn gadgets'. She gives the example of Robert Reich, the economist and former American Secretary of Labour who has put forward the above suggestions and points out that his newest idea is the notion of employability. By promoting the notion of 'lifelong learning' it appears that the jobs exist, if only people can be properly educated to take them.

Giddens (1998:102) uses the term 'the revolt of the elite' to describe the voluntary exclusion of the upper middle class from state services, such as education and health. Traditionally this section of society would have had their children educated in the grammar schools of the 50s, 60s and early 70s. However, since the abolition of the old tripartite system of education in Britain, namely grammar schools, technical schools and secondary modern schools, in favour of comprehensive education, increasing numbers of middle and upper middle class parents have chosen the independent sector for the education of their children. Children with learning disabilities are mainly excluded from the private education sector because they cannot achieve the academic standards used as entry criteria, such as the Common Entrance Examination (Emetis, 2004). Tomlinson (1983) refers to a new tripartite system, which consists of independent education, the state comprehensive system and special education. The government's claims of priority for a well-educated population,

particularly in skills training for the poorer groups in society could be criticized by Fish (1989), who could use his American neo-pragmatist perspective to dismiss this as the kind of discourse that is essentially rhetoric not theoretical, thereby causing difficulties in executing such strategies as inclusion when people have different interpretations. Blair's doctrine hinges on education as being the most direct way to improve inequalities in society. However, Giddens (1998:110) suggests that:

> Research from the United States and Europe
>
> demonstrates that education tends to reflect wider economic inequalities and that these have to be tackled at source.

Accepting the premise that education does indeed reflect existing inequalities in society, it seems to follow logically that the exclusion of certain individuals and groups from mainstream education will involve social, economic and cultural factors as in the wider society. Giddens (1998:104) suggests that exclusion is not about 'graduations of inequality' but about 'mechanisms that detach groups of people from the social mainstream'. These mechanisms are referred to as those inherent in the cycle of exclusion, poverty, marginalisation and social exclusion and are seen as major obstacles to learning, ensuring that children from economically disadvantaged backgrounds do not do so well at school (Mittler, 1999). The results of poverty are well documented and include educational failure and ill health. Ill health and poor nutrition in pregnant women have been shown to lead to abnormalities in their children, including learning disabilities (Wood & Grigovenko, 2001). People with learning disabilities may be at least in part excluded from mainstream society because

of the extensive use of jargon in everyday life and the need for more sophisticated literacy and numeracy skills in the workforce. The Report of the Social Justice Commission (1974:174) provides evidence to support the notion that social exclusion at the bottom is self-producing due to the poverty cycle and that poor basic skills (e.g. literacy) lock people into this cycle. If Foucault's (1980) process of normalisation is applied to the education system National Curriculum in schools can work towards excluding children who have learning disabilities from mainstream education and eventually society. The testing and assessment processes mean that a comparison is produced between schools and pupils (e.g. league tables, SATs results), which differentiates between them and helps to distribute pupils, teachers and schools in a hierarchical formation. The concomitant feature of all these processes, however, is exclusion, the dividing practice par excellence. Comparison of pupils excludes individuals from some levels by through homogenisation (in spite of the fact that people with learning disabilities are not a homogenous group); differentiation and hierarchy are by definition based on exclusion (Copeland 1999). Normalisation appears to be advancing according to the statistics provided by the Department for Education (2005/1996) showing the increasing numbers of children excluded from school for each of the following years:

Year	**Excluded children**
1991	2910
1992	3833
1994	11,000
1995	12,500

However, the figures for subsequent years reflect the changes in policies regarding exclusion (DfES, 2001b):

Year	Excluded children
1997/98	12,300
1998/99	10,440
1999/2000	8320
2000/01	9140
2001/02	9540
2002/03	9290

Inclusivity appears to be based on the premise that individuals and groups of people have certain rights that entitle them to be included in society and all aspects of social life, for example, access to the same sort of services as others, (Disability Discrimination Act, DfEE, 1995; Disability Rights Commission, DfEE, 1999). According to present day national and international legislation, all human beings should have equal rights to the provision of services and membership social groups, with exclusion being seen as restricting those rights and limiting opportunities for achievement of full potential. Examples of such legislation include: Declaration of the Rights of Disabled People (UN, 1975), the Convention on the Rights of the Child (UN, 1989; Article2, 23), the Standard Rules in the Equalisation of Opportunities for Persons with Disabilities (UN, 1993), Council for Disabled Children (1994), Human Rights Act (DfEE, 1998), European Convention on Human Rights and Fundamental Freedoms (UN, 1970, 1971, 1990).Visser, President of the National Association of Special Educational Needs (1999), argues that special education has been given much attention in the political and professional arena. He also suggests that there has been a paradigm shift from seeing the child as having the problem to educational establishments having to address issues within the

organisation that act as barriers to inclusion. He goes on to criticise politicians, administrators, teachers and parents for their use of the term inclusion as a mere slogan without having any understanding of the issues and their complexities. In the United Kingdom, according to Visser (1999), all children have been included in education for the past twenty to thirty years, some of with learning disabilities in special schools with the majority in mainstream education. He highlights inclusion as a key theme in government documents and policies of recent years. Inclusion is a term used frequently in the contemporary educational context. In further education, for example, the Report of the Tomlinson Committee (Tomlinson, 1996) set out guidelines for colleges to follow in order to widen the participation of students with varying degrees of learning difficulties and disabilities in the post-16 education and training sector. The term inclusion rather than integration was used in the Report with the implication that students with learning difficulties would be included fully in the educational, social and civil processes of college life with extra support where necessary, rather than be simply 'slotted into' a mainstream class. Tomlinson (ibid.) outlined several models for the inclusion of individuals in further education: attendance in mainstream classes (with support if necessary), discrete groups, or a mixture of both. The notion of inclusion echoes across the whole of the educational system and has resulted in the closure of some special schools with the aim being to include as many children as possible in the mainstream system. Thomas and Tarr (1999) describe the placing of students in mainstream classes as functional integration as referred to in Warnock (DES:SENS, 1978) rather than inclusion, whilst

Croll and Moses (2000) link inclusion and functional integration together arguing that inclusion adds nothing that functional integration doesn't already have. Skidmore (1999) indicates that there are several barriers to inclusion, not least the different interpretations of the meaning of inclusion by educators. Zollers *et al.,* (1999:158), in their anthropological study on inclusive school culture, define inclusion as:

> A complex educational model, which has been discussed in terms of social justice, an educational programme wherein students with disabilities learn alongside their age-appropriate peers in general education classrooms with appropriate aids and services.

In order to explore the notions of inclusion and exclusion more fully it seems useful to take an historical look at how individuals come to be excluded from the mainstream educational system. A sociological approach will be used in an attempt to analyse some of the social, economic, political and professional pressures that have contributed to the process of exclusion of a large number of schoolchildren. Booth and Ainscow (1998:2) propose that in taking a broader view:

> Inclusion or exclusion are as much about participation and marginalisation in relation to race, class, gender, sexuality, poverty and unemployment as they are about traditional special education concerns with students categorised as low in attainment, disabled or deviant in behaviour.

Booth and Ainscow (ibid.) also provide a definition of inclusion, which involves:

> The processes of increasing the participation of students in, and reducing their exclusion from, mainstream curricula, cultures and communities.

Sebba and Ainscow (1996) suggest that defining inclusion is one of four broad themes that emerge from their analysis of the literature on inclusive education, arguing that inclusion is intrinsically linked to school effectiveness and cultural changes. Copeland (1999) of the University of Reading in his examination of aspects of SEN and normalisation highlights the circularity of the definition of SEN in the Warnock Report, which in providing a definition introduces the concepts of special educational provision and learning difficulties without offering any precise meaning for these terms. The Education Act of 1981 (DES) followed most of the Warnock recommendations and defined SEN in terms of learning difficulties and its relationship to special educational provision.

Copeland (1999) makes the case that what is taught in schools, in other words, the National Curriculum, is essentially normative and based upon Foucault's notion of objectification of the subject, that is the pupil, through the use of what he calls pseudo-science, or knowledge that has no empirical basis or theory. In this case the National Curriculum which involves testing and distribution on various levels is not based on any particular theory or theories of learning nor on any theory of curriculum, and to this end is arbitrary, providing an example of how normalisation creates exclusion.

> Normalising judgement and hierarchical surveillance are particularly conspicious in examinations. Exams lie at the heart of discipline..... Nowhere does the superimposition of power and knowledge assume such a perfect visibility....
> (Merquior 1991:94)

National Curriculum and testing follow closely Foucault's process of normalisation in that they compare schools and pupils, differentiate between them and distribute pupils, teachers and schools in a hierarchical formation. Booth and Ainscow (1998) highlight the revolving door process, a continual process of inclusion and exclusion, that is apparent in that some students come in through the front door in line with contemporary inclusion policies, whilst others, namely those with emotional and behavioural difficulties are sent out through the back door, or effectively excluded.

3.4 Summary

In this chapter I have explored some of the legislation, policies and practices around human rights, social inclusion/exclusion and education along with implications for counselling and psychotherapy practice in relation to young people with learning disabilities. I have highlighted some of the processes of discrimination in health care, education and civil life and the effects upon the lives of this group of young people and their families. The phenomenon of dual diagnosis and the potentially life-threatening effects of depression have helped to build my case for making counselling and psychotherapy more accessible to young people with learning disabilities. Through my discussion of equality, power imbalance and the relevance of political concepts such as citizenship and advocacy I have attempted to provide a firm rationale for inclusion of young people with learning disabilities in counselling practices and processes. This will be used in conjunction with the results of my research to provide a firm foundation for the development of a model for good practice in counselling this client group.

Although inclusion has become an important policy agenda for the education system in the UK, I have highlighted areas of potential exclusion that are not transparent such as education and training aimed at employment that is not necessarily available (Forrester, 1999). By drawing upon human rights policies, politics, economic debates and educational policies I have made more information available upon which to build my thesis. The main exclusionary practices that relate to young people with learning disabilities and appear to be inherent in the social and political fabric of contemporary British society are lack of access to services through processes of exclusion, lack of power, resulting in oppression and lack of realistic choice. The next chapter will examine the notion of counselling and examine this in relation to young people

Chapter 4: Counselling and Young People

4.1 Introduction

This chapter explores the nature of counselling as a therapeutic psychological intervention for young people. I examine the literature in an attempt to define counselling, a task made more difficult due to the nomenclature used for counselling interventions, for example, psychotherapy. The difference between counselling and the use of counselling skills used with other roles is examined along with the concept of guidance. I identify a variety of models of counselling and explore several differing theoretical orientations. The NHS is driving forward the increasing requirement that therapeutic help is based upon research evidence and as the largest single employer of counsellors (Goss and Rose, 2002) this concept is permeating other providers of counselling services and agencies as best practice. I explore the notion of effectiveness of counselling young people in relation to the quality paradigm of evidence-based practice. It seems important to find out which type of counselling works with young people in general before relating this to young people with learning disabilities.

Counselling does not take place in a vacuum; all interventions are embedded within a context. I examine briefly the various contexts in which counselling is provided for young people. The counsellor is an important variable in the provision of therapeutic help to any individual. I explore the characteristics of counsellors that are found to be most useful to younger clients and tease out the notion of an effective counsellor. Creative approaches and techniques have been found to be useful in counselling. In this chapter I examine briefly a variety of creative counselling approaches. Although there are various means of communication, including creativity, verbal language remains the most widely used. Therefore, I include a fuller section on the use of language in counselling, which explores concepts such as speech modification, verbal interaction, discourse management and simple/complex language use. Finally, I explore the nature of adolescence and look at the most commonly presented psychological problems or issues. The therapeutic relationship between a young person and their counsellor may have characteristics related to the adolescent's developmental stage. Therefore, I also examine the nature of effective counselling relationships with young people.

4.2 The nature of counselling

The use of counselling as a therapeutic intervention for psychological problems is increasing. In the context of the NHS, the largest single employer of counsellors and psychotherapists (Goss and Rose, 2002:148), there has been a significant increase with the number of GP surgeries offering counselling

rising from 31-51% between 1992-1998 and a 1996 MORI poll showed that 86% GP patients would rather see a counsellor than take tranquillisers or anti-depressants (Mellor-Clark, 2000). Counselling is accepted more readily by society and individuals have expressed positive attitudes to therapy (Future Foundation, 2004). My experience as a researcher indicates that there are more references to counselling in a variety of publications and a greater number of 'hits' on electronic databases and search engines. Moreover, there is a proliferation of internet counselling services and columns offering counselling in the popular press. Smail (2000) claims that where once in times of emotional and spiritual trouble people would have turned to religion they now find an alternative in counselling. My private counselling practice has become busier and I have had to set up a waiting list for the first time in a number of years. As a counselling supervisor I have more inquiries and act as consultant to an increasing number of individuals and organisations, whilst as a counselling trainer I see a greater variety of courses providing for a flourishing qualification market. I also see the resulting difficulties in this situation such as lack of training placements and low-paid sessional work for many qualified counsellors. The research agenda in counselling is progressing (McLeod, 2002) and the field is gaining greater recognition as a subject in its own right (Research Assessment Exercise Review, DfES, 1999). However, regarding the provision of counselling for young people with learning disabilities the results of my research will test the hypothesis that although counselling may be helpful it is difficult to access and largely excludes this client group.

4.2.1 Defining counselling

A definitive description of counselling is difficult to provide for several reasons. There is no universal definition. Firstly, individual therapists both confuse the issue and muddy the waters by using varying styles and modalities differently. Secondly, the terminology for what may be classed as similar activities includes counselling, psychotherapy and guidance. Thirdly, what counselling actually is may be determined by the context: pastoral counselling is spiritual/religion based; workplace counselling examines occupational issues (McLeod, 2002); stress counselling may provide debriefing/coping skills and motivational counselling may involve coaching. Although the terms counselling and psychotherapy are often used interchangeably, as they are in this study, differences between them are highlighted in an ongoing debate over the professional use of each (Syme, 2000). In the UK guidance traditionally belongs to the educational context in the form of help for children with special educational needs and career advice. Reflecting earlier views of counselling Milner (1980:13) suggests that counselling is part of a guidance role that includes vocational, academic and personal guidance:

> The presentation of knowledge, information and/or advice to individuals or groups in a structured way so as to provide sufficient material upon which they may base choices or decisions.

Milner (ibid.) also differentiates between guidance and counselling pointing out that guidance is offered from a wide range of people, including tutors,

doctors, social workers, nurses, welfare officers, to name a few, while counselling is provided by someone with specific training. This seems to run parallel with the BACP's (2002:3) definition of the use of counselling skills as opposed to the provision of counselling:

> The intentional use of specific interpersonal skills which reflect the values of counselling. The practitioner's primary role (e.g. nurse, tutor, line manager, social worker, personnel officer, helper) is enhanced without being changed. The client perceives the practitioner as acting within their primary profession or/and caring role which is not that of being a counsellor.

Nelson-Jones (1999:3) defines counselling as:

> .... a special kind of helping relationship; as a repertoire of skills; as a psychological process; or in terms of its goals....

How does counselling differ from the use of counselling skills? Is there a difference? According to Nelson-Jones (2003), in counselling relationships counselling is the primary activity, but in helping relationships counselling skills are only part of the role of the caring professionals who use those skills. Counselling skills are an adjunct to their primary roles, showing consistency with the BACP definition. Moreover, Woolfe (1997:4) suggests therefore that: 'the activity of counselling is not confined to the works carried out by those people formally designated as counsellors'. Sanders (1996) highlights an interesting distinction between the casual informal use of counselling skills and ethically protected, formal and contracted counselling. He claims that when he is using counselling skills he may be informed by counselling aims. However, he is undertaking the activity of pure counselling he will also have counselling aims and goals and be governed by counselling boundaries, codes of practice

and ethics of the counselling profession rather than another profession such as social work or teaching. This is a view supported by professional counselling organisations in their codes of practice and ethics (BACP, 2002). Bayne and Nicholson (1993:10) also make reference to what are essentially boundaries and ethics:

> In the use of counselling skills there are usually no standardised ways for making an offer of time and availability, negotiating the terms on which counselling is being offered, particularly with regard to confidentiality, which may be compromised by the plurality of roles, and the importance of independent supervision and support.

Therefore, counselling appears to be a contracted role with specific clients, the use of counselling skills being carried out by someone with dual roles. However, it appears that, whether provided by a professional counsellor or other caring professional, what really matters is a relationship in which the individual can share their thoughts and feelings. It also matters that they be understood from their internal frame of reference within a non-directive climate of warmth and trust (BACP, 2002; DoH, 2001; Woolfe, 1997; Sanders, 1996; Nelson-Jones, 2003).

Although differences between counselling and the use of counselling skills may now seem clearer and in spite of a somewhat blurred definition of counselling in the UK, globally the diverse nature of counselling is even more apparent, with counselling encompassing many different activities. For example, Malindzsisa *et al.*, (2001) equates academic advice in distance

learning with counselling. Nolte (2001) describes counselling as guiding, enabling, facilitating, planning, organising, motivating, educating and training the client in self-help skills. Naidoo and Sehoto (2002) point out that another term for counselling in many African countries may be healing and whereas counselling and psychotherapy in the west has its roots in theological, anthropological, psychiatric and psychological literature/theory, a vast knowledge base exists in oral form in Africa. Naidoo and Sehoto (2002:7) give a definition of psychotherapy:

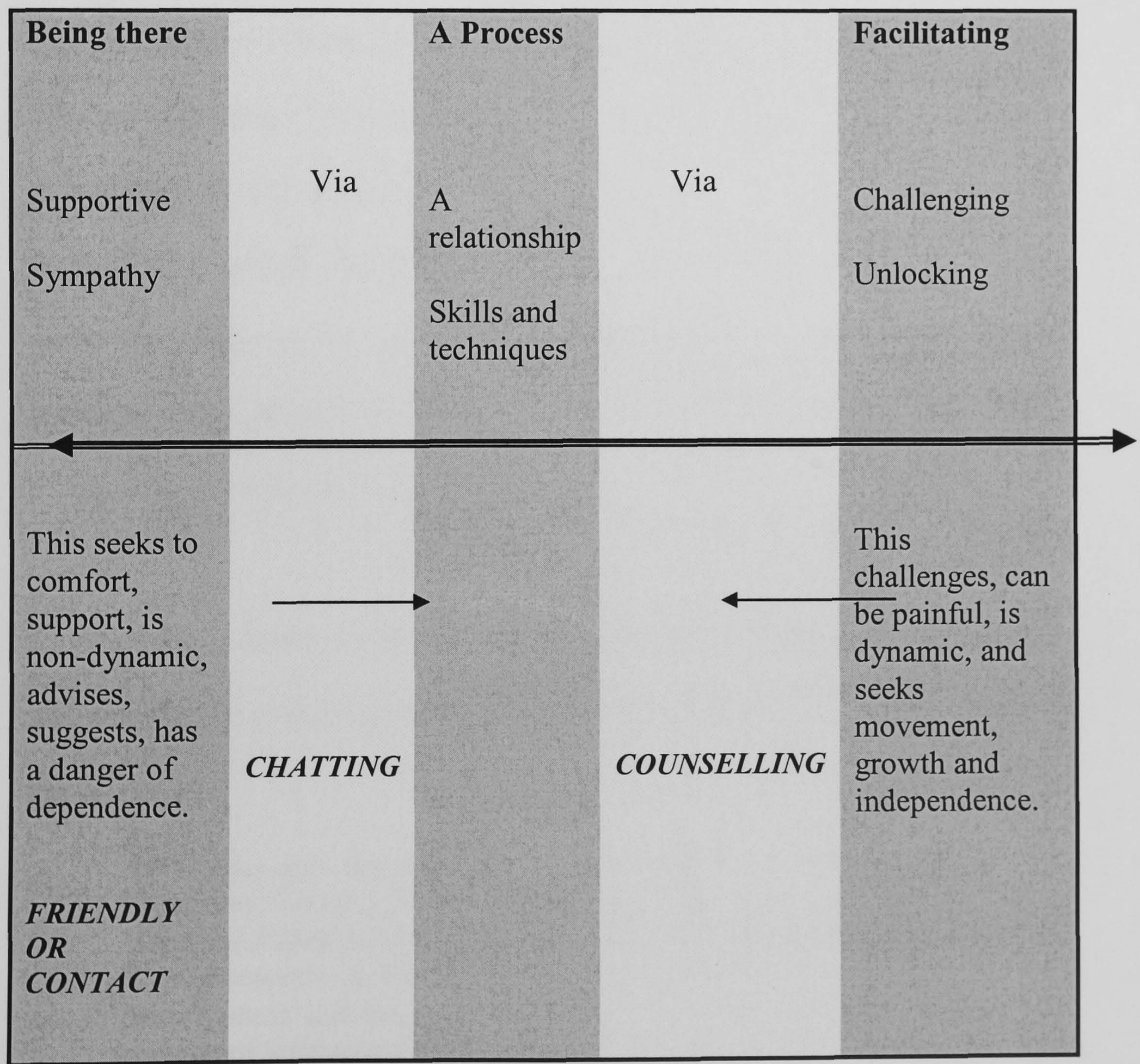
> Psychotherapy (in broad terms) is the provision of a containing, facilitative forum for the restoration of a healthy, productive level of functioning of a client seeking assistance. The question to ask is: what does one facilitate?

The above definition attempts to clarify the nature of therapy in simple and broad terms. However, it captures the very essence of the difficulties encountered when trying to be more concrete and specific, clarity is tempered by the posing of the question 'what does one facilitate?'. Such difficulties in definition make research design, control of variables and the measurement of therapy outcomes more difficult. It has also been suggested that counselling is essentially the offer of love in return for money (Smail, 1995; Ferenczi, 1955; Halmos, 1966; Lomas, 1973), which, if true, would make measurement even more complex and difficult. How does one measure love?

McGuiness (1998) recognises the diverse nature of counselling and suggests that 'counselling is a multi-dimensional concept' that is used to describe various personal contact activities. However, as counselling has become more

professionally organised in the UK there is an increased tendency to provide narrower and more exclusive explanations of counselling (Bayne and Nicholson, 1993; McGuiness, 1998; Bond, 2000). The following diagram (Figure 1) highlights the differences between various types of relationships and the use of interpersonal skills, depicting a continuum rather than strictly delineated activities.

Figure 1: Human Interaction Continuum



Adapted from McGuiness (1998:19)

For example, 'being there' for someone involves providing support and sympathy via a relationship that entails talking or chatting. Although a variety of relationship building skills are used in 'being there', counselling involves the use of specific skills and techniques and applies these to develop a dynamic therapeutic process in the client. 'Being there' can be comforting and supportive but is not necessarily a mutually dynamic process and can involve one person becoming dependent on another. Counselling, on the other hand, is likely to be challenging rather than comforting and may be painful and dynamic in its process leading to movement, growth and independence rather than a reliance on the helper. As McGuiness (1998) suggests, the provision of help through human interaction may lie along a continuum with 'being there' in a supportive way through talk and chat at one end of the scale and actively facilitating a growth process through counselling at the other. The use of counselling skills in an incidental or alternatively a measured way comes somewhere in between. Figure one highlights the polarities of 'being there' and counselling and the continuum between.

Smail (2001:3) draws attention to the difficulties in defining psychotherapy by also placing 'psychotherapy' on a continuum, which has similarities with the above chart:

> Psychotherapy' can range from the intricate and closely woven theories of human personality and mental functioning, which led Sigmund Freud and his followers to develop the techniques of psychoanalysis, to brief commonsensical chats between medical practitioners and their patients ('supportive psychotherapy') which consist of little more than sympathetic listening and more-or-less considered advice.

Counselling as a therapeutic intervention may have potential for causing harm to clients (Egan, 2001; McGuiness, 1998), therefore it should be regarded as a skilled activity that requires training (Burnard, 1997). The BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (2001:5) provides the following guidelines regarding training:

> Good standards of practice and care require professional competence, good relationships with clients and colleagues; and commitment to and observance of professional ethics.

The following definition of counselling is provided by BACP (2002:3.2):

> Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling.

BACP (ibid.) go on to clarify what counsellors actually do, listing activities such as: listening attentively and patiently, perceiving the client's difficulties from the client's point of view; helping clients to see things more clearly, possibly from a different perspective; reducing confusion and facilitating choice and change. Smail (2000) suggests that the best way to find out what is troubling a person is to listen alertly and sensitively. Furthermore, counsellors help clients to explore aspects of life and feelings; examine behaviour and difficult situations; help clients to initiate change and explore options. It is stated clearly that both advice giving and providing clients with direction are not components of counselling. This contrasts with international perspectives on what constitutes counselling (Naidoo and Sehoto, 2002; Nolte, 2002; Trivasse, 2002; Pattison, 2004). Although it could be argued that the BACP

provide information regarding practice within the British context, the perspective of other cultural views on counselling appears to be absent. The British Association of Psychotherapists (BAP, 2002) provides a similar but subtly different definition of psychotherapy on their website, differences being apparent in the use of terminology from the medical model (patient) and in reference to unconscious processes, which fit in more readily with a psychoanalytic/psychodynamic approach to therapy:

> A process of exploration undertaken by the therapist and patient together. The patient is encouraged to reflect on matters uppermost in his/her mind during regular 50 minute sessions. Feelings, thoughts, wishes, memories and dreams may be explored. The patient is helped to understand unconscious processes which affect everyday thought and behaviour. The patient will gain greater understanding and move towards more appropriate ways of being and coping with difficulties.

The above definition makes no provision for excluding certain activities such as advice giving. The two definitions above (BACP, 2002; BAP, 2003) have commonalities regarding exploration and examination of the client/patient's difficulties leading to change and increased ease in daily living.

It is apparent from the definitions examined that there are several key components to counselling, the participants (counsellor and client), the relationship, goals and processes. The BACP (ibid) definition firmly places counselling as a conscious process that occurs when one person (the client) seeks help and shares his/her concerns with another (the counsellor). Egan (2001) describes counselling as a helping process and a psychological learning process, whereas Clarkson (2003) refers to a process of self-awareness. Rogers

(1946), on the other hand, claims that the counselling process involves the client getting in touch with his/her 'real self'. Jacobs (2000) proposes that clients become aware of how the past influences the present and develop a raised awareness of unconscious psychological material, whilst Van Deurzan (2003) submits the notion of working with the client to help them to come to terms with 'being'. It appears that the counselling process as a fixed construct does not exist; rather it is the theoretical basis for therapy that determines the actual process.

4.2.2 Models and theoretical approaches to counselling

Models and theoretical approaches are two different concepts, a model being a framework for the practice of counselling able to incorporate differing approaches, for example, Egan's Problem-Solving model (Egan 2001). This model draws from both humanistic and cognitive behavioural theory. Other models include Gilmore (1973), CORE (Mellor-Clark, 2000) and Dasie (Nelson-Jones, 1997). Although there are many theoretical approaches to counselling, they can be divided into three broad groups: humanistic, psychodynamic and cognitive-behavioural, each has underlying philosophical assumptions and associated key concepts (Corey, 1995). Just as the counselling process differs with each approach the nature of the relationship between counsellor and client differs. The person-centred approach requires the counsellor to build up a relationship based upon Rogers' (1951) core conditions of unconditional positive regard or non-judgemental acceptance, empathy and congruence within an atmosphere of warmth and trust. However, the

psychodynamic approach regards the relationship as a therapeutic alliance with the dynamics of transference and counter-transference forming an integral part of therapy (Jacobs, 2000). On the other hand, there is little reference to the relationship in the literature on cognitive-behavioural therapy. The BACP (2002: section 3.1) refers to the concept of variations in the counselling relationship:

> The objectives of particular counselling relationships will vary according to the client's needs. Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others. The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources and capacity for choices within his or her cultural context.

Although there is reference to a varying objectives and types of counselling relationships in the above quote it is not made clear how they may vary. On the other hand, the qualities and values inherent in the relationship are stated with great clarity, reflecting the nature of a person-centred counselling relationship. Sinason (2004:40) refers to the use of empathy in building the therapeutic alliance of psychodynamic therapy:

> ...I became aware of the need for an empathic response with facial expression and voice tone...

Sinason (1992) proposes three main stages to therapy, firstly, working on a reduction of any secondary handicap developed to cover up the trauma of being different, examples of this include the 'handicapped smile', inappropriate dress, behaviour or speech. This is followed by the second stage where clients

may become extremely vulnerable and depressed as they work with the awareness of their learning disability. Thirdly, the client enters the stage of working with and through their disabilities with the potential to improve internal and external functioning.

With regard to multi-cultural perspectives, if a client values direction, advice and guidance (consistent with the perception of counselling in some cultures, for example China (Stanko, 2004) would this mean it is acceptable to change the nature of the relationship to reflect these values? Smail (2000) suggests that the very essence of the person (client and counsellor) is involved in a form of mutual relatedness, comprising solidarity and mutual assistance and that comfort is gained from this solidarity.

On the other hand, models of counselling tend to be based upon the systematic organisation of skills and techniques (Egan, 2001; Gilmore, 1973; Nelson-Jones, 1997; Burnard, 1997). Although Rogers (1951) claims that the relationship is both necessary and sufficient to promote therapeutic change in clients, McGuiness (1998) suggests that specific skills and techniques are needed to some degree. Consequently, counselling could be defined as 'a repertoire of skills' (Nelson-Jones, 1997, 1982). Smail (2000) claims that increasingly, therapists will be trained in listening skills and providing warmth, empathy and genuiness until they conform to the stereotyped professional therapist. Furthermore, he predicts that:

> the nature of the association between client and counsellor will be changed from a *relationship* into a time-limited *contract*
>
> (Smail, 2000:4).

Moreover, my experience as a counselling supervisor supports Smail's claim, particularly in the contexts of the NHS and occupational provision of counselling Moreover, brief therapy models such as solution-focused are increasing in use and the number of sessions allocated to each client is generally restricted to between three and six. This is in spite of NHS recommendations (DoH, 2001) that around sixteen sessions are generally needed to promote change in clients, suggesting that counselling provision may well be driven by market pressures rather than client well-being (Smail, 2001, 2000, 1995).

Counsellors' choice and use of skills differ according to their theoretical orientation, the issue the client is bringing to counselling and with different groups of clients (Sanders, 1996:8):

> Counselling skills are interpersonal communication... used in a manner consistent with the goals and values of the established ethics of the profession of the practitioner in question.

It is significant that in research on the effectiveness of counselling the theoretical approach or skills are not the primary factor, rather it is the relationship that appears more important (DoH, 2001).

4.2.3 Effectiveness of counselling and evidence-based practice in counselling young people: what works?

There is an increasing emphasis on evidence-based practice in the psychological therapies (Goss and Rose, 2002), therefore aims, objectives and outcomes have become central to counselling provision and the measurement of effectiveness. However, at the present moment there is no such significant evidence-base for counselling young people with learning disabilities, although a recent systematic review of the research in counselling children and young people in general has been carried out (Harris and Pattison, 2004). The aims of counselling and psychotherapy can vary between:

> ...the 'cure' of neurotic or other disturbances in individuals thought to be mentally ill and the 'acquisition by mentally well-adapted and socially successful people of heightened states of self-awareness, transpersonal consciousness, and individuation.
>
> (Smail, 2001:3)

The BACP (2002) gives a similarly broad idea of aims and objectives. The powerful move towards counselling practice based upon identifiable results of research is to a large part driven by the NHS and the continual addition of research evidence to the international Cochrane Collaboration Database (2001). However, this comes as no surprise because the founders of counselling and psychotherapy and their intellectual mentors were from the field of medicine (Smail, 2002). Moreover, contemporary counselling has identified itself to at least some degree with the scientific tenets of medicine in order to attract funding (O'Carroll, 2002). However, reflecting on the question of providing evidence for the claim that psychodynamic counselling is effective, suggests that the traditional scientific paradigm is limited in its capacity to explain and measure the benefits of counselling (O'Carroll, *ibid*). The Cochrane Database

is one of the most powerful and influential collections of research material world-wide and increasingly counselling studies are being added to the database, which categorises each research study according to strict quality guidelines, with random controlled trials forming 'best evidence' (Cochrane Collaboration Database, 2001). Up to date cognitive and behavioural forms of therapy make up the larger part of the research base in the Cochrane category of 'best evidence'. This may be due to more easily measurable behavioural outcomes of therapy, the affiliation of cognitive-behavioural therapies with the medical model, which is most likely to be used by psychologists and the scientific research tradition of psychology. The measurement of therapy outcomes is based upon the parameters of aims and objectives and the consequent evaluation of success or effectiveness of therapy in relation to these. Comparative studies are more likely to be found in Cochrane's category of best evidence in counselling and psychotherapy because random controlled trials involve the use of control groups (CRD, 2002) and a control group which offers no treatment or a placebo to individuals in psychological distress would be viewed as unethical (Goss and Rose, 2002). Freud's research output was vast, however, it is based upon single case studies, placing it in the category of low quality evidence (CRD 2002). More recently McLeod (2002) has highlighted the potential of case study research as valuable to practitioners and more valid if carried out rigorously and systematically. A discussion at the BACP Research Conference (May, 2003) highlighted the value of using many single case studies by different practitioners and attempting to answer the same research questions in order to produce valid and generalisable results.

It is apparent that judgements need to be made about what constitutes human mental health and happiness in order to measure them and assess whether clients have improved following therapy (Smail, 2002). Moreover, Smail (*ibid.*) claims that such judgements cannot be made without having a theory of how people are ought to be, a theory of how to bring about change and that therapists and researchers are not always fully aware of their underlying values and assumptions. For example, Freud's theory and therefore research is based on reductionism and determinism.

> At the turn of the century Freud's claims of a 'psychic determinism' competed with attempted explanations from the biological sciences that then composed scientific medicine.
>
> (Boszormeyi-Nagy and Krasner, 1986:43)

> Freud applied his instinctivist approach, with its combination of biological reductionism and cultural conservatism, to grand problems of society and history...
>
> (Cohen, 2001:37)

He viewed the therapist's role as neutral and impersonal, whereas contemporary research shows the relationship between counsellor and client to be most the most effective variable in the helping process (DoH, 2001). Therapy based upon behaviourism is more likely to be measurable by traditionally scientific criterion, however, the use of such criteria, which are deemed to be objective, appears to be based upon similar values to Freud's theories in that it is reductive, mechanistic, deterministic and impersonal, it is the technique of therapy that seems important, not the person of the therapist

(Smail, 2002). Such variables are not easily measurable and the context in which counselling takes place also presents a set of variables to be accounted for in research.

4.2.4 Contexts of counselling young people

Counselling takes place within a wide variety of settings including statutory organisations such as the NHS in the form of Child and Adolescent Mental Health Units (CAHMS), social services (looked after children, adoption services), the Youth Justice system, education (school counsellors, educational psychologists) and employment (Connexions). The voluntary sector provides counselling through charitable trusts, religious organisations and projects that rely on the work of mainly, though not exclusively, unpaid counsellors, for example, Relate and Cruse Bereavement Care. Community services consist of youth work projects and social inclusion projects such as 'Include'. However, the picture is not as clear as it may first appear because some volunteer agencies receive funding from statutory organisations to enable them to provide care where there is a perceived need and others are of a semi-volunteer nature with counsellors being paid a small fee, for example, MIND and Relate. Private provision can be delivered by organisations such as employer assistance providers (EAPs) or through self-employed individual counsellors who may also have other jobs.

4.2.5 The counsellor

> We are social animals. At times of trouble we draw comfort in being associated with others. There is a lot of truth in hackneyed sayings such as 'a trouble shared is a trouble halved'...having someone to talk to, someone to listen, is in and of itself 'therapeutic', that is to say, comforting and reassuring. It doesn't take a genius to establish this-its part of everyday human experience. Of course some people are more comforting and reassuring to talk to at such times than others...
>
> (Smail, 2000:4)

The above quote connects well with contemporary research agendas which explore the nature of the counselling relationship with the intention of identifying characteristics of the counsellor and the relationship which best provide help for distressed clients (McLeod, 2002). Moreover, the value of the counselling relationship in promoting client change and the nature of the relationship required for counselling to be effective has been well-documented (McLeod, 2002; Mellor-Clark, 2000). The BACP (2002: section C.1) provides guidelines for the type of qualities the counsellor should have in order to be working ethically with their clients: integrity, impartiality and respect for the client. Rogers (1951) promotes the notion of 'non-possessive warmth' as an essential quality of the effective counsellor. Smail (2000:4) introduces the concepts of good and bad therapist, suggesting that good therapists share the following characteristics:

> A kind of honesty, an awareness and readiness to distinguish between one's own interests and those of one's clients, a willingness and ability to face without flinching the bleaker sides of life and a tolerance of and affection for *otherness*.

Gilliland and McGuiness (1989:30) also claim that clients are most likely to be helped by counsellors with greater self-awareness, those who address the question: 'Who am I?'

Smail (2000) casts the counsellor in the role of negotiator at the beginning of therapy, changing to accomplice and supporter as therapy progresses, proposing that the counsellor's main instrument for understanding the client is him/herself. The self may be much more than merely 'counsellor'. Therapists come from diverse backgrounds, bringing with them the various layers of what has been life before counselling. Examples of distinct career changes include moving from journalism to counselling victims of violent crime (Pointon, 2002) building work and the business world (Clarke, 2002).

There is also a financial perspective to counselling with the counsellor earning a living from their work with clients. Smail (1995) claims that counsellors avoid honest talk about financial matters yet suggests that this dimension of the counsellor cannot be ignored. The following quote from Freud (Letter to Wilhelm Fleiss, 21/9/1899) highlights the subjectivity of the counsellor's financial involvement:

> A patient of mine with whom I have been negotiating, a 'goldfish', has just announced herself – I do not know whether to decline or accept. My mood also depends very strongly on my earnings. Money is laughing gas for me. I know from my youth that once the wild horses of the pampas have been lassoed, they retain a certain anxiousness for life. Thus I have come to know the helplessness of poverty and continually fear it. You will see that my style will improve and my ideas will be more correct if this city provides me with an ample livelihood.

The above quote identifies one of Freud's basic motivations as a person and the realisation that for some counsellors' financial motivation may be the primary consideration, whilst for others although the need to earn a living may be an important factor it is not necessarily the main drive. On the other hand, there are counsellors who provide their services free or at a reduced fee, both in the voluntary sector and in the private sector through the notion of a 'sliding scale' of fees (BACP, 2002). The notion of fees is discussed at length by Friery (2003) who concludes that generally counsellors provide a professional service but actually earn less than most other professionals by the time overheads and taxation costs are paid. Moreover, he claims that many counsellors provide *pro bono* work and also lose earnings through clients who cancel appointments or do not turn up for their sessions. Smail (1995) picks up on the theme of financial considerations in counselling by suggesting that counselling is essentially the provision of love for money and that this is only part of the exploitation and control of individuals through the systems of society and West (1998) discusses the economic considerations of counselling.

4.3 Counselling and creativity

Creativity is often associated most with childhood, hence the use of play therapy with children (Axeline, 1981; Landreth, 2002). Although young people with learning disabilities may be developmentally delayed in their cognitive abilities, other areas of development may be in line with normal trajectories; therefore, it seems important to provide age-appropriate ways of accessing the

counselling process creatively. Moreover, Geldard and Geldard (1999:129) suggest that adolescents are:

> ...able to think more abstractly...and are able to understand and use symbols, metaphors and other forms of creative representation. Many adolescents use artistic methods to express themselves and convey meanings about their lives to others.

Although graffiti may be classed as a negative form of artistic portrayal of identity and meaning when carried out in inappropriate places, my own experience of adolescence brings forth memories of endless doodling and decorating of objects such as rucksacks, handbags, pencil cases and clothing as both a process and a end in itself. I was an adolescent in the era of tie-dye T-shirts and jeans with velvet trims made by my friends and myself. My personal experience has informed my counselling and helped me to facilitate creative work in adolescents. Young people in contemporary society may show their individuality through artistic media such as permanent and henna tattoos, hair braiding and body piercing. Younger children may not have the words to express themselves effectively because of their stage of verbal and cognitive development (Bruner, 1986; Piaget, 1970; Vgotsky, 1962); therefore they may require creative forms of self-expression. However, adolescents may choose creativity to symbolise difficult events in their lives, relationships and feelings Geldard and Geldard (1999). Teenagers' ability to think abstractly and deal with complex concepts mean not necessarily mean that they are able to verbalise what they think or feel. Geldard and Geldard (1999:97) suggest that:

> Adolescents will often talk metaphorically, for example, a young person might say "A black cloud seems to be over my head wherever I go".

Lynch (1998:531) states that:

> We need to acknowledge that it (language) cannot of itself fully depict the true nature of an existence.

However, creative approaches and techniques in counselling are about more than the use of art materials and the full range may be used to enable young people with learning disabilities to access the counselling process. The range of creativity includes the use of objects and creative materials, art as therapy, dream work, creative writing and forms of expressive therapy such as action, movement, drama, music and movement. A report produced by the Royal College of Psychiatrists (2004) suggests that art, dram and music therapies provide useful ways of enabling people with learning disabilities to externalise and express their feelings and emotions.

4.3.1 The use of objects in therapy

The range of objects used in therapy is wide and varied with anecdotal evidence indicating that many counsellors use objects such as stones, shells buttons or small toys including miniature figures and soft toys in their work. , which may be used in order to work with learning disabled young people on self-exploratory work. Geldard and Geldard (1999) give the example of using miniature animals as a projective technique with adolescents. The beneficial therapeutic effects of such projective techniques are well documented in mainstream client populations, however, this does not extend to the learning disabled client group in the literature (Reyes, 1994; Waisol, 1995). Another

form of symbolic representation is possible using sand trays as a vehicle for projection (Kalff, 1980). However, sand tray work was initially developed as a non-verbal form of self-expression for children that took the child away from rational thinking into creative or right-brain activity (Lowenfield, 1967) and would need to be applied in an age-appropriate way with learning disabled young people. In my experience of working with adolescents it seems important to use age-appropriate approaches and techniques to avoid the client feeling patronised. As discussed in the section on the therapeutic relationship, young people are very sensitive to power imbalances due to their developmental processes, preferring equanimity with their counsellor (Everall and Paulson, 2002).

Ryce-Menulin (1992) suggests that non-verbal images can be explored symbolically through objects such as rocks, shells, stones and beads that are placed in the sand tray. Discussion can then take place regarding the nature of the symbols and their relationship to each other. Geldard and Geldard (1999:124) propose that sand tray work can help young people in the following ways:

- Tell their story
- Explore feelings, thoughts, situations and issues relating to their story
- Explore the past, present and future situations and events
- Gain a cognitive understanding of the elements or events occurring in their life

This way of working seems appropriate for young people with learning disabilities who may have problems in cognitively accessing the language

required to describe and explore complex mental concepts (Mitchell and Friedman, 1994).

4.3.2 Art as therapy

The use of art in therapy can also provide a way to enable adolescents to access the counselling process when verbalisation of problems and feelings may be difficult. Although art therapy is a well-known and specific approach with a theoretical base and requiring specialist training, some of the techniques can be adapted and used with other counselling approaches. Artwork can help young people to understand their problems and issues along with exploring their feelings and developing insight (Rubin, 2001; Rogers, 1993; Waller and Gilroy, 1992). How these techniques are used depends upon the theoretical orientation of the counsellor and the intended outcome of therapy. For example, a picture drawn by an adolescent client may be interpreted by the psychodynamic therapist (Bennick *et al.*, 2003) or explored by the person-centred therapist in a non-directive way relating to the phenomenological world of the client (Silverstone, 1996).

Although artwork may be carried out in a more systematic way by some counsellors, anecdotal evidence provided by counsellors during my supervision sessions indicates that a more spontaneous use of art is adopted, more in line with what seems to work for that individual client at that moment. Types of artwork used by these counsellors support the techniques advocated by Geldard and Geldard (1999), namely: free drawing, drawing parts of self, drawing

feelings, self-portraits and metaphor. My experience of counselling young people and of supervising school counsellors, youth and community workers indicates to me that it is useful to keep a readily accessible collection of art materials in the counselling room.

4.3.3 Working with dreams

Geldard and Geldard (1999) claim that adolescents are very interested in their dreams and sometimes believe them to be prophetic in nature. However, Freud (1900) suggests that dreams can be a window on the conscious self and explores the interpretation of dreams from his psychoanalytical perspective. The literature shows that adolescents are more likely to benefit from therapy when issues regarding the power balance between the perceived expert (the counsellor) and the client are addressed and equalised (Everall and Paulson, 2002). Therefore the Jungian approach (1974) to working with dreams may be more appropriate. Jungian dream work involves a systematic way of exploring and interpreting dreams and helping the client to become aware of what a dream might mean to them. This is different to the therapists' interpretation using symbolic images from theory or the therapist's frame of reference. Geldard and Geldard (1999:153) propose that:

> ...the only person competent and able to interpret an adolescent's dream is the adolescent himself.

According to the literature dreams can be processed through client or counsellor interpretation (Geldard and Geldard, *ibid.*). However, in order to address issues of power and the importance of egalitarian counselling

relationships when counselling adolescents it appears that client interpretation is likely to be more appropriate when working with learning disabled young people. Difficulties in communication, particularly through the use of language, are concomitant with learning disabilities (DSM-IV; ICD-10); therefore creative ways of depicting dreams may facilitate the counselling process. The use of artwork may assist such communication and stimulate exploration of dreams; whilst symbolic representation through art may be useful in helping clients to examine processes and events in the dream. Alternatively, adolescent clients with learning disabilities may engage in psychodrama or role-play using objects such as cushions and chairs (Joyce and Sills, 2001) thereby facilitating the awareness of feelings and emotions. It seems important at this point to refer to the lack of power that people with learning disabilities have had historically (Barnes *et al.,* 1999) and the difficulties that adolescents have with power and authority in relationships as part of their developmental process (Everall and Paulson, 2002) and link this knowledge to the implications for providing counselling that is over-directive in nature.

According to Freud (1900/1983) and Jung (1974) dreams are notorious for slipping away from consciousness, potentially more problematic for young people with learning disabilities who are likely to have memory difficulties associated with their condition. The literature suggests that it may be useful to record dreams in as much detail as possible while the dream is fresh in the mind, perhaps keeping a notebook at the side of the bed and to record dream

content, emotions and thoughts about the dream (Vandermark, 2002). However, problems with literacy are associated with learning disabilities; therefore other ways of recording dreams may be explored, such as audio-taping. Such adaptations to accommodate the communication abilities of the individual client are not confined to the learning disabled population, they may be generalised to other client groups, such as people with visual impairment. Paradoxically, the next section explores creative writing as a therapeutic tool.

4.3.4 Creative writing

Rotenburg (1995) suggests that diary keeping can be a valuable way of adolescents disclosing personal and intimate information and as such is part of the therapeutic process. At first glance this form of communication may be dismissed as inappropriate for young people with learning disabilities due to problems with written language. On the other hand, according to Weinhold (1987) a variety of ways of recording events, facts, feelings and emotions are possible so long as the method chosen is effective in enabling the individual to get in touch with his or her 'inner space'. My experience as a SENs teacher and a counsellor of learning disabled adolescents leads me to believe that journal writing is possible for this client group if the client's limited literacy skills are respected and supplemented with pictures, drawings and other visual materials.

Free writing is identified as an effective way of releasing a person's creativity and enabling expression of emotion and feelings (Kovacs, 2002; Jobin, 2002; Golden, 2001). This approach appears to fit well with the notion that young

people require egalitarian counselling relationships and not 'experts' in order to engage in the counselling process successfully (Lunn *et al.*, 2002). Alternatively, Nelson-Jones (1992) proposes a structured approach in which the young person is asked to record the events of the day under a series of headings that reflect events, emotions, relationships, learning and behaviour. When working with a learning disabled client the actual recording may be adapted to fit in with preferred ways of communicating. According to Bandura (1977) the learning aspect of this type of journal keeping relates to social learning theory and could be viewed as a useful tool to use as homework for clients undergoing cognitive-behavioural counselling. On the other hand, the creative, free-writing approach aligns itself more readily to less directive counselling approaches such as person-centred therapy.

Narrative therapy and narrative approaches to research are gaining the interest of counsellors and enable the subjective, phenomenological world of the individual to be explored through creative story-writing and telling (Monk *et al.*, 1996). This approach can take the place of journal writing by allowing the individual to express events and their thoughts, feelings and emotions symbolically through fictional characters. Moreover, an important aspect of the process is that the story is actually told to another person, in this instance the counsellor, and that the other person listens, acknowledges and validates the story (Androutsopoulou, 2001; Besley, 2002). Shakespeare (1998) refers to the notion of grand narratives in relation to the lives of people with disabilities and their social history. Therefore, the stories told by young learning disabled

people may contain the threads of such social history interwoven with the personal lives of individual clients. Knowledge and awareness of such narratives may enable counsellors to help their young clients to explore their own stories in relation to the broader picture. Narrative may be translated in dance and movement as in the performing arts and adapted for use in a therapeutic way.

4.3.5 Action and movement in counselling

My experience of teaching, counselling and parenting young people indicates that it is may be difficult for some individuals to sit for long periods of time without being physically active. Yong people with learning disabilities are more likely to have behavioural problems and conditions such as ADHD leading to more unsettled physical activity than the general population (Beard *et al.,* 2000). The literature (Geldard and Geldard, 1999) supports my experience and suggests that some adolescents are more able to be actively involved in a role-play process, playing out parts of their lives rather than sitting and talking through painful issues. Role-play is used in various therapeutic approaches, for example, rational emotive, psychodynamic and gestalt therapies (Moreno, 1999; Apter, 2003; Dryden, 2000). In rational-emotive therapy the counsellor may model behaviour for the client who in turn can copy this and in doing so practice dealing with various situations (Dryden, 2000). An alternative approach to the 'real life' modelling techniques used by cognitive-behavioural counsellors is the more creative psychodrama in which the client may work symbolically through objects or with others using self as

an object. The projective techniques of psychodrama are exploratory in nature and the client's movement or learning in the counselling process comes from self-exploration (Moreno, 1999; Apter, 2003). This creative approach to action and movement is diametrically opposed to the cognitive-behavioural style of role-play, which is essentially based on the practising of skills for real life situations and has its roots in social learning theory (Bandura, 1977). However, the creative techniques of gestalt therapy appear to draw the practical role-playing approach and the creativity of psychodrama together.

Gestalt therapists use role-play in a way that aligns closely with psychodrama techniques, for example, the 'empty chair' and the use of objects to represent self and others (Joyce and Sills, 2001). Empty chair work can be a useful technique in practising for real life situations, in expressing and exploring feelings and is used widely in relationship and grief work (Joyce and Sills, 2001). In spite of the value of these creative approaches to therapy, not all young people are able to express themselves in these ways. Geldard and Geldard (1999) suggest that some adolescents are far too self-conscious to engage in role-play, a claim supported by my experience of working with adolescents. Although I have explored the use of creative forms of expression in counselling as a way of engaging learning-disabled young people in the counselling process, language remains an important form of communication to the extent that counselling is referred to as 'talking therapy'.

4.4 *The use of language in counselling young people*

In counselling clients use language to give information, disclose painful experiences and memories and to tell secrets that they have kept hidden, perhaps for years, this is why counselling is often referred to as a talking therapy (Corey, 1995; Smail, 2001). Language, along with the written word, forms the basis of communication between two individuals and in counselling it appears that the therapeutic relationship is built through the use of language as a mediator, hence the term 'talking therapies' (DoH, 2001). Therefore, communicative competence (Hyme, 2000) is of great importance to the practice and process of counselling. This section examines the notion of speech modification, the field of linguistics, some of the literature on second language acquisition, verbal interaction and negotiation, discourse management and repair and the conveyance of understanding and empathy through language.

Milroy (2001) proposes that the use of a particular type of language, Standard English, leads to 'a greater efficiency in exchanges of any kind' and refers to Standard English as being a commodity using the metaphor of 'the linguistic market'. This introduces the notion of linguistic accessibility to counselling. Although the term language is most often connected with speech and linguistics other forms of communication include paralinguistics, mime and sign language. Individuals communicate their thoughts, feelings, ideas and experiences through language and at least two specific language centres are present in the human brain, Broca's area and Wernicke's area (Seifert and

Hoffnung, 2000). Several questions need to be addressed in order to advance the analysis and discussion.

Although there is little research into the area of linguistics and counselling, there is a wealth of other, related material that can be applied to the notion of language in therapeutic counselling encounters with young people. The field of linguistics has much to offer, in particular the body of knowledge on first and second language acquisition and the related subjects of sociolinguistics and psycholinguistics.

4.4.1 Speech modification

Ellis (1996) discusses the notion of 'caretaker talk', suggesting that caretakers (applied to counsellors in the context of this study) adjust their speech to ensure that the speech the individual receives is clearer and linguistically simpler. The term complex speech can be related to verbal fluency, defined by Lord *et al.,* (2000:207) as:

> .... the spontaneous, flexible use of sentences with multiple clauses that describe logical connections within a sentence. It requires the ability to talk about objects or events not immediately present.

Counsellors appear to modify their speech as part of relationship building with clients and to aid mutual understanding (Nelson-Jones, 2003). Aspects of modified speech include higher pitch, greater intonation and a slower rhythm of speech. Empirical research carried out in the late 1970s, still referred to by contemporary linguists (Ellis, 1996), includes work carried out by Snow (1972,

1977, 1978) and Snow and Ferguson (1977), who found that modifications in syntax were evident in modifications of speech. This reflects both the length and the overall linguistic complexity of what is spoken.

Snow's research (*ibid.*) suggests that special efforts are taken when modifying language to ensure that what one individual says is actually understood by another. Therefore counsellors who check a client's understanding are checking the client's comprehension. Counsellors may do this by repeating all or part of what is said by the client, referred to as the counselling skills of summarising, paraphrasing and reflecting. These skills may be especially important when client and counsellor come from different 'worlds', for example, adolescence and adulthood, or working-class and middle-class. Literature on second language acquisition (Ellis, 1996) suggests that probing and requests for clarification can expand what is said in dialogue in an effort to promote two-way understanding. Probing and clarifying have been adopted as counselling skills and as such are learned during counselling training (Inskipp, 1996; Egan, 1994, 2001). When there is a lack of understanding, the interactant uses both paraphrasing and repetition in order to increase understanding (Ellis 1996). In counselling interactions, the counsellor works at understanding thoughts, feelings and behaviours as well as factual material, this understanding when extended to the emotional world of the client is known as empathy, a concept central to the person-centred approach to counselling in particular (Rogers, 1951). The understanding reached between client and counsellor is used differently in psychodynamic therapy and is referred to by

Casement (1992) as projective identification. Through the counsellor's understanding, the client is helped to become aware of past thoughts, feelings and ways of behaving that have become manifest in the present. Reiffe *et al.*, (2000) propose that young people with developmental delays and poor social skills have great difficulty in understanding the world of emotions, both in themselves and others. Therapeutic work in counselling may therefore include helping clients to understand their own emotions before that understanding can be negotiated between client and counsellor and meanings made communicable. Individuals who have not successfully acquired a 'theory of mind' lack the ability to be empathic and because of the reciprocal nature of communication between counsellor and client, this may require great linguistic flexibility on the part of the counsellor (Chin and Bernard-Opitz, 2000). It is claimed that such individuals, (usually placed somewhere on the diagnostic spectrum of autism), can talk endlessly about a topic of interest to them, not realising that others may not have the same interest and may need to talk about their topics (Chin and Bernard-Opitz, *ibid.*). However, inappropriate this may be to normal conversation, such self-talk may be used as a path to greater communication in counselling, as a way of entering into the client's phenomenological world.

Research from second language acquisition on 'foreigner talk' can inform the exploration of counsellors' use of understanding through language. Native speakers use foreigner talk when communicating with non-native speakers. Griffiths (1991) refers to two types of such speech modification. Firstly, the

ungrammatical type, for example: 'you want drink?' rather than the correct grammatical form: 'would you like a drink?' With regard to counselling this could represent a condescending, 'talking down' way of communicating with that seems disrespectful to clients, Griffiths (*ibid.)* refers to it as such in relation to the teaching of a second language. There is no suggestion in the data that counsellors use this type of language with their clients who have differing linguistic abilities. However, in view of the lack of evidence to the contrary, this cannot be ruled out. A second type of speech simplification, grammatical modification, is characterised by a slower rate of speech, slower articulation rate and what is known in the field of linguistics as the silent pause, a phenomenon that slows down speech and gives time for the receiver to decode it (Griffiths, *ibid*). The use of silence in counselling is well documented as a way of allowing the client time to reflect upon what is being talked about and the process that is taking place (Egan, 1994, 2001; Inskipp, 1996; Nelson-Jones, 1999, 2000).

4.4.2 Verbal interaction and negotiation

Grammatical speech modifications used by teachers include a number of false starts, this signifies that the teacher has begun an explanation, realised that the language is too difficult for the student to understand and started again with a modification of their speech. This can be generalised to counselling interactions, depending upon their theoretical approach, counsellors make tentative responses to clients; therefore false starts. Rather than being a sign of miscommunication, could be interpreted as signs that counsellors are adjusting

their language and responding to clues and signals given by clients. As such, this knowledge could be generalised to any client, rather than specifically to young clients who may have learning disabilities. References to linguistic modifications of this nature are to be found in 'foreigner talk' (Griffiths 1996) and 'motherese' (Galloway and Richards, 1994; Mahoney and Seely, 1976) and also correspond to language found in simplified texts of the kind associated with graded reading (Vincent 1986). However, Griffiths (1996) argues that linguistic modifications occur spontaneously as part of the process of trying to communicate with individuals of limited linguistic competence and as such cannot be planned like graded texts as progression is not part of the process.

4.4.3 Discourse management and repair

Other concepts from the field of second language acquisition can be made use of in this analysis and exploration, namely, interactional modifications, which include discourse management and discourse repair. Discourse management is used when trying to avoid communication problems, whilst discourse repair is used in attempts to correct miscommunication (Long 1983). It appears that the most effective way of managing discourse is to ensure that the topic of conversation is understood. In counselling this may mean that a counsellor gives the bare details of the topic first, for example: 'you've come to talk to me....', rather than 'your teacher asked if you wanted to come and talk to me about your problems at home....'. This form of simplifying sentences is referred to as 'skeletonising' by Long (1983), a process referred to as

'scaffolding' by Beveridge *et al.,* (1997), also Bruner (1986). Information can then be gradually expanded and embellished, or 'embroidered' (Beveridge, *ibid.*). An example of such embroidering is: 'you've come to talk to me.....(wait for response in the affirmative).....your teacher asked you to come.....he thought I might be able to help you.....you've been crying a lot lately.....in class.....your mother is very ill.....' This also demonstrates the use of the silent pause phenomenon (Ellis, 1996) and the form of language is grammatical, non-condescending and therefore respectful to the client. Another strategy for discourse management includes the selection of topics that have a 'here and now' orientation. This is of significance with regard to both the counselling process of some theoretical approaches and with the nature of learning disabilities, which can significantly affect long and short-term memory (Seifert and Hoffnung, 2000). It is also claimed that adolescents are very much grounded in the 'here and now' regarding their problems and difficulties (Geldard and Geldard, 1999).

Person-centred counselling aims to help clients to move through a process from talking about others to talking about self; from exploring facts to exploring feelings and finally, from dwelling on the past to becoming more aware of what is happening in the here and now (Rogers 1951). The psychodynamic orientation is based upon Freudian theory (Freud 1990), which focuses on examining the client's past and how it relates to the present. Therefore, a 'here and now' focus to dialogue with clients may be a way of initiating exploration even in psychodynamic therapy and in helping the client to become aware he

dynamics in the relationship. Although Chomsky (1958) laid claim that language is an abstract structural system, unrelated to social context or meaning, Long (1991) suggests that by situating language interactions in the 'here and now' the individual receiving the language is able to make use of the immediate context to interpret meanings. This could be a useful strategy when counselling any client who has poor memory function and may be generalisable to counselling the some elderly clients and individuals who have varying types and degrees of brain injury.

The second interactional modification, discourse repairs, is used when communication has broken down (Gass and Veronis, 1991). A link is made between non-engagement and miscommunication suggesting that non-engagement occurs when there is miscommunication such as when a message is given out by the speaker and the listener understands something else. This has implications for the counselling process and the client's engagement in counselling. Therefore, discourse repairs occur when there is incomplete understanding and take the form of negotiation of meaning, a collaborative work, which counsellors and clients undertake in order to achieve a more complete understanding. The importance of an egalitarian and collaborative relationship between adolescents and their counsellors is highlighted by (Everall and Paulson, 2002). Meanings are negotiated through requests for clarification, (e.g. 'sorry?' and 'huh?'), and requests for confirmation. Clarification is also a counselling skill with aims of furthering understanding between client and counsellor. An example from my own counselling work

with an adolescent whose mother was undergoing radiotherapy for breast cancer can illustrate this point:

Client:	*My mam's clothes hurt all the time. It stops her picking me up from college.*
Counsellor:	*Your mam is in so much pain that she can't get dressed and come to pick you up from college? You miss your mam?*

As shown in the above example, negotiation of meaning can include an empathic element. Repetitions, either exact or semantic (paraphrases), form another way of negotiating meanings. According to Ellis (1996:261) there are certain social conditions that facilitate the negotiation of meaning, in particular, social relationships between interactants and '*the sharing of a need and a desire to understand each other*'. In this case the interactions are on an equal footing, however, Pica and Long (1986) suggest that interactions also take place between individuals of unequal status and when relationships are asymmetrical the negotiation of meaning is inhibited. This is of significance to person-centred counsellors because meanings related to the phenomenological world of the client form an integral part of therapy, helping the counsellor to have empathy with the client (Rogers, 1951), whilst psychodynamic therapy will provide interpretations of the client's material (Casement, 1992). Counselling and the use of counselling skills are sometimes linked with other roles such as clinical psychologist, social worker, teacher, health visitor or learning support worker. Counsellors having such roles may have intimate knowledge of the context of the individual's daily life and therefore have a

starting point for the negotiation of meanings. On the other hand, such counsellors may be disadvantaged in their endeavours to understand the young person because of their own preconceived knowledge and assumptions based on limited knowledge of the individual and existing dynamics in the relationship. For example, the nature of the teacher/student role is likely to produce relationships that are by their very nature asymmetrical in the power dynamic.

Bolinger (1980:189) claims that the rules and norms of language exist outside of the speaker and that some people, for example teachers, have *'privileged access to the mysteries of language'* gaining the status of high priests or shamans. A parallel process in counselling is referred to by Smail (2001). Regarding the discourse repair strategy of negotiating meaning, Ellis (1996) proposes that this is possible with a conversational partner but is inhibited when one of the interactants adopts a tutorial role. When there is a high frequency of discourse repair functions, such as requests for clarification and confirmation, it can be taken that higher levels of negotiation of meanings are taking place. However, Aston (1986) puts forward an alternative view with the suggestion that such repair strategies are often used to perform rituals of understanding or agreement rather than genuinely overcome troublesome communication.

4.4.4 Simple and complex language

Simple language is easily understood, uncomplicated and not elaborate. It generally consists of one idea or element at a time. It is interesting to note that the word simple was historically used to refer to people with learning disabilities (simpleton) and is recorded as such in the children's nursery rhyme 'Simple Simon'. Characteristics historically attributed to people with learning disabilities, such as foolish, ignorant, gullible, feeble-minded and foolish, can be used synonymously with the word simple in many situations (Wright and Digby, 1997). Bernstein (1961, 1970) identifies a simple language code, ascribed to the working classes, and an elaborate system of language (middle classes). However, I will show later in this section that 'elaborate' language may actually be easier to understand than 'simple' language in relation to counselling young people with learning disabilities. The movement in contemporary Britain towards social inclusion extends to the use of plain language, particularly in public government documents, to enable more of the population to access information. Milroy (2001:533) highlights the variation in speech amongst different sections of society and suggests that these variations be interpreted on a:

> ...scale of prestige, which derives from the socio-economic class of speakers.

One might assume therefore, that Bernstein's (1961, 1970) simple language code would be more appropriate for use with young people with learning disabilities than the elaborate. However, the situation is more complex than this. According to Bernstein (*ibid.*) a simple language code relies on assumed

meanings. However, the elaborated code demands fewer assumptions and shared meanings, providing the expansion and embellishment of central topics as referred to by Long (1986) in his discussion on 'skeletonising' and 'embroidering' in order to increase the listener's understanding. This is more consistent with the counselling process, particularly the person-centred approach. Nevertheless, elaboration remains the opposite of simplification. Paradoxically, there are occasions when the elaboration of speech can actually make what is being said cognitively simpler (Chaudron, 1988). This can be explained through the following example. The simple sentence: 'hold on tightly' can be more easily understand for some people than the more complex but simple: 'cling'. Findings from twelve experimental studies carried out in the 1980s found that the effects of simplification of language (e.g. simpler syntax and vocabulary) helped the listener's comprehension – but not consistently. Alternatively, elaborate modifications had a consistent effect upon listener comprehension (Johnson, 1981; Cervantes, 1983; Brown, 1987; Chaudron and Richards, 1986).

Plain language is recognised as being uncomplicated, unequivocal and is supposed to be readily understood by most people. There are strong links between language and cognition ((Bruner, 1986), therefore the use of simple language would make it more likely that counsellors and their clients were communicating effectively or 'speaking the same language'. However, this may be difficult to achieve with young people:

Some adolescents make use of words from culture-specific

> adolescent vocabularies. They may also attribute meanings to words which are different from commonly accepted meanings. Use of such vocabularies commonly occurs with adolescents who belong to peer groups or gangs associated with particular activities.
>
> (Geldard and Geldard, 1999:96)

Therefore, the counsellor may need to continually clarify meanings and learn the client's language as part of the relationship building process. In person-centred counselling this may be regarded as entering the client's frame of reference (Rogers, 1951).

Brown (1977) claims that the primary motivation of simplified speech is to communicate, to understand, to be understood and to keep two minds focused on the same topic. Yet how do counsellors determine the nature and the extent of the speech modifications required in order to communicate with their young clients? It appears that the counsellor must first get a general idea of the client's linguistic ability, particularly their ability to understand cognitively and emotively (Ellis, 1996). The extent to which a client comprehends what is said to them (and vice versa) is of crucial importance in counselling and it is likely that a young person will become inattentive when they do not understand (Geldard and Geldard, 1999). When this occurs Ellis (1996) suggests that speech can be modified until attention returns. It could be argued that counsellors who have more knowledge and experience of young people and understand the nature of adolescence would be more likely to modify their speech to take into account the linguistic abilities of their client. Counsellors are trained to listen and respond to their clients' communications. Therefore,

the implications for listening to a different form of language and responding within the client's linguistic frame of reference may be skills that can be learnt to some degree through training. However, theoretical knowledge of the developmental processes of adolescence coupled with experience of working with young people may be useful for counsellors.

4.5 The nature of adolescence and counselling issues

Adolescence is associated with the onset of puberty, signalled by physical and physiological changes. Erikson (1963:261/1994) describes adolescence as:

> .... a period of rapid change-physical, physiological and social; a time when all sameness and continuities relied on earlier are more of less questioned.

Alternatively adolescence is identified as a process necessary for the individual to achieve attitudes and beliefs that are needed for effective participation in society (Rogers, 1972). The age-range of adolescence is broad and relates to the transitional years between puberty and adulthood, usually the teenage years (Kennedy, 1975). In his seminal work on human development Erikson (1963/1994) posits that 'identity confusion' is one of the most significant symptoms of adolescence, with the individual exploring and attempting to define who he or she is as a person. This involves the domains of interpersonal relationships, vocational ideas, religion, morality, political ideals, culture, sexual orientation, community and intellectual capacity. Strong affiliation and attachment to various groups may occur with rebelliousness against parental

values (Erikson, *ibid.*). However, Erikson's ideas may be culturally relative because of the strong individualistic nature of western society compared to the collectivism of other cultures. In China, for example, young people are encouraged to grow up with the value of filial piety and respect for parents (Stanko, 2003). Contemporary Britain is a multi-cultural society; therefore, it may be prudent to exercise caution when examining adolescence from a white, western theoretical perspective.

4.5.1 Psychological problems in young people

Although it is encouraging to note that 57% adolescents follow a relatively untroubled psychological development and that 32% problems are intermittent or temporary, 11% young people have serious, chronic difficulties (Ebata *et al.*, 1990). Sinason (2002) refers to the extra vulnerability of young people with learning disabilities to abusive situations that can lead to trauma and psychological problems. Psychological problems are common in adolescence, with nearly half reporting difficulties in coping with situations at home or school (Grans, 1990). Conflicts regarding the transitional nature of adolescence and the lack of control over physical, social and physiological changes are more likely to lead to stress, depression, alcoholism, drug misuse, eating disorders, self-harm and suicide amongst young people (Steinberg, 1993; Vecchio, 1991). Depression in adolescence is related to youth suicide rates, which account for over one-fifth of all deaths in young people. According to Steinberg (1996), 1:3 young people have contemplated suicide with 1:6 actually making a suicide attempt. Furthermore, figures from the Oxford

Centre for Suicide Research (1998) estimate that 24,000 adolescents self-harmed in 1999 and that deliberate self-harm is more prevalent amongst girls. Eating disorders are common amongst young people, particularly adolescent girls (Abraham, 2001).

4.5.2 Young people and the therapeutic relationship

The nature of the therapeutic relationship between client and counsellor has been shown to be of paramount importance in the therapeutic relationship (DoH, 2001; Gelso and Carter, 1994; Martin *et al.*, 2000). Qualities such as warmth, respect and understanding have been cited as the main characteristics of successful therapy (DoH, 2001). Orlinski *et al.,* (1994) support the view that the strength of the therapeutic relationship is predictive of outcome and transcends the nature of the theoretical approach or orientation. However, many efficacy studies showing successful outcomes in counselling young people are based on the cognitive-behavioural approach and make little or no reference to the counselling relationship. Furthermore, in spite of the client's perspective becoming more highly valued as an important source of information on the effectiveness of therapy, little of the research focuses on young people's perspectives (Kazdin, 2000). Docherty and Sandelowski (1999) propose that young people can contribute much to counsellors' awareness of their experiences of effective therapeutic relationships. DiGuiseppe *et al.,* (1996) claim that most forms of psychological therapy accept that the relationship is critical to therapeutic outcome. Moreover, Hanna *et al.,* (1999) refer to the relationship as essential in adolescent therapy. In spite of the

recognition that the counselling relationship is crucial, process research on the therapeutic alliance has been minimal with research focusing instead on behaviours of adolescent client and counsellor during sessions or on specific interventions (DiGuiseppe *et al.,* 1996).

4.6 Components of effective therapeutic relationships.

Whilst accepting that the nature of the therapeutic relationship is central to effective counselling, it may be judicial to explore just what the variables are. What makes for a successful therapeutic relationship? Lambert (1992) suggests that there are several commonalities between therapeutic relationships that are deemed to be effective. Rogers (1951, 1946) proposes that trust is an essential component of a successful therapeutic relationship. The value of a trusting relationship is supported by research studies carried out amongst both adult and adolescent populations (Taylor *et al.*, 1986), Everall and Paulson, 2002). The following quote from one young person encapsulates the importance of a trusting relationship with the counsellor:

> Trust is a huge issue for me, I wouldn't have been able to open up to her if I didn't trust her.
>
> (Everall and Paulson 2003:83)

Caution is advised in the generalisation of adult-orientated research to the adolescent population because emotional and behavioural problems may be part of normal adolescent development (DiGuiseppe *et al.,* 1996; Shirk and Saiz, 1992). As part of their development process young people may have a general distrust of adults' motivations (DiGuiseppe *et al.,* 1996; Gil, 1996).

This distrust may present a barrier to building an effective therapeutic relationship, especially if young people have been let down in the past by adults. Many adolescents' emotional and behavioural problems have their roots in early attachment difficulties and abusive family histories. They may have had negative experiences with other helping professionals (Everall and Paulson, 2002) and furthermore, confidentiality, an important factor in the maintenance of trust between client and therapist, would have been betrayed. The effects of this are portrayed in the following quote from one adolescent:

> He would be discussing everything with my parents...you talk and you feel like you're totally bonding with them, and really talking with them and you find out that they go and tell everybody everything...there's no respect, no trust, and so I just wanted to get away from that.
>
> (Everall and Paulson, 2002:82)

The development of trust appears to be rooted in another component of an effective therapeutic relationship, namely equality between client and counsellor (Everall and Paulson, 2002). When the relationship is on an egalitarian basis with the counsellor being an ally, a collaborative process ensues leading to more successful therapy outcomes (Diamond *et al.,* 1999). However, there are several challenges to such an egalitarian relationship. Firstly, young people are rarely self-referred. They are more likely to come for help under pressure from parents, teachers or the legal system (Marks-Mishne, 1986). Secondly, as previously mentioned, the adolescent developmental attribute of a general distrust of adults, particularly in relation to authoritarian attitudes, can lead to suspicion and conflict. This may be compounded by a tendency to see others as being the problem rather than taking responsibility

themselves (Sommers-Flanagan and Sommers-Flanagan, 1995). A further difficulty in developing a collaborative, egalitarian relationship might be the pre-conceived notions that young people may have regarding therapy. Everall and Paulson (2002: 81) provide a good example of this in a quote from an adolescent client:

> Before I started, I pictured those movies where you see the person lying down on a leather little recliner thing and the psychologist is sitting there and they're not really paying attention to them and the person is just blabbing and blabbing.

Rogers (1957) proposes congruence as an integral part of an effective therapeutic relationship. Congruence encompasses openness, genuiness and a sense of the counsellor being 'real', not hiding behind the authoritarianism of various roles, and not appearing the 'expert'. The effects of lack of understanding and respect by the counsellor for the client are demonstrated by the following quote:

> Well, I came in and he said, 'Well you're here because you tried to commit suicide'. And I said 'Yeah'. I was really shy and didn't want to talk to him. And so 'Well, that's a really stupid thing to do' and I thought 'You know, I don't want to talk to you after that'.
>
> (Everall and Paulson, 2002: 83)

Although Rogers (1957) refers to the qualities of the effective counselling relationship and positions skills and techniques as secondary to this, listening and hearing what is said have been identified as essential to the building of a therapeutic relationship by Everall and Paulson, 2002. They describe effective listening skills in relation to the client's perception of being fully 'heard, which

is identified with 'empathic resonance'. Rogers (1957) claims that empathy is one of the central or 'core' conditions necessary for effective therapy. Therefore, it appears that there is an argument for the use of counselling skills in the development of therapeutic relationships as reflected in the content of counselling training programmes.

4.7 Summary

Although it has been difficult to provide a definitive description of counselling, I have explored the nature of counselling and examined the literature in order to gain greater clarity regarding the notion of counselling as a therapeutic intervention for young people. I have highlighted the increasing demands that counselling is grounded in research and as a psychological intervention is based on evidence. I indicate the varying contexts of counselling for young people and explore the concept of the effective counsellor. Creative approaches are briefly discussed, for example, sand tray work, dreams, creative writing and psychodrama. I have explored the use of language in counselling in some depth and examined the nature of the client/counsellor relationship. The aim has been to provide background and richness to my research study and in particular, my results. The next chapter sets out the design of the study and maps the research process, along with exploring methodological issues.

Chapter 5: Research Process, Design and Methodology

5.1 Introduction

In this chapter I explore issues around epistemology including the theory of knowledge related to what is 'known' about young people with learning disabilities. These issues are explored in relation to my own knowledge and the notion of reflexivity. Different approaches to the nature of reality are discussed and the validity of knowledge along with the research traditions and underlying philosophical assumptions examined. The design of the research study is described including data collection methods, pilot and pre-pilot work and the two main research tools, namely a survey of the counsellors listed in the BACP Directory (2001) and a series of semi-structured interviews. Issues of validity, reliability and generalisability are addressed. The data analysis methods are explained in relation to both quantitative and qualitative data. My intention is to make the research process and methods transparent and to link the process to the relevant research literature.

5.2 Epistemology: Ways of knowing

I wish to examine a number of key theories, ideas and concepts with regard to research methodologies in relation to this study. In this section I will look closely at fundamental issues such as: positivism, phenomenology and postmodernism in relation to research methodologies. I will provide a clear rationale for the choice of dual methodology and an evaluation of the methods employed. I will explore a reflective approach to research methods, based upon an increasing sense of personal awareness of knowledge and where the source of knowledge comes from. I also endeavour to track down and identify some of my own biases or preconceived ideas regarding counselling and young people with learning disabilities. Clarkson (1998:303-4) has the following to say about the values and biases of the researcher or therapy practitioner:

> It has been argued that a value-free practice is as impossible as a value-free science and that all of us are involved in the structuring and construction of our world, complicit with its ideological assumptions and never free from the moral and epistemological consequences of our actions or non-actions.

By holding my personal values and biases up to the light and helping them to become transparent I will indicate how I have prepared the ground for this research project. By endeavouring to 'bracket off' (Aanstoos 1983) these preconceived ideas, I aim to become more open to new thoughts, theories and

notions. Firstly, I will examine the concept of epistemology taking a logical approach, looking at the terminology, then allowing the exploration to take its own course and become more creative.

5.2.1 The theory of knowledge

At the beginning of this research project I had limited knowledge and understanding of the notion of epistemology, therefore this exploration has greatly increased my personal awareness of the process of research and related research issues. Epistemology has strong links with ontology; different ways of viewing reality and what reality is; ways of knowing what is real and strategies for validating reality. The various subject disciplines, such as: psychology, sociology and philosophy frame their view of the world in different ways. Social psychologists, for example, coming from a constructionist perspective, may use discourse analysis as a research tool, thus supporting their view that social and psychological realities are constructed through the use of language; they would generally deny the existence of an intra-psychic world that can be entered through the utilisation of language, (Coyle, 1998; McNamee and Gergen, 1992). When knowledge of reality is looked at from a constructionist perspective it can draw on the diverse domains of semiotics, structuralism, and post-structuralism and look at the relationship between language and reality; the constructionist approach also puts an emphasis on knowing 'reality as it is' and pays close attention to the way in which we deal with '*versions or constructions of reality in our everyday lives*', (Cowie *et al.,* 1998:212-219).

However, the notion of reality as social construction and the idea that alternative approaches to research can be truly scientific is challenged by Sokal and Bricmont (1997/2003) who suggest that there is only one reality or phenomenon that may be experienced or viewed from different perspectives without changing the actual object, event or phenomenon. Therefore, according to Sokal and Bricmont (*ibid.*) the scientific method is more valid than alternative methods, which measure perceptions of phenomenon rather than the phenomenon itself. When working within primary health care, for example, it becomes obvious that counsellors and medical practitioners have different ways of viewing knowledge or reality. Medical practitioners work within the medical model, diagnosing the patient and endeavouring to treat their symptoms; while the client-counsellor relationship is generally based upon a more collaborative relationship, not necessitating diagnosis or cure (Taylor 1991), although, of course, this may depend upon the orientation of the therapist and the nature of the counselling work. Clarkson (1998:305) looks at the epistemological values of the therapist:

> ...(behavioural scientists in psychology) endorse quantitative, empirical, and objectivist approaches to the study of human behaviour...

Clarkson (1999) goes on to suggest that non-behavioural scientists are more likely to endorse humanistic and subjectivist approaches to epistemology. Research carried out by McGovern *et al.*, (1986); Plutchik *et al.*, (1988) and Messer (1992) serves to back up the claims to researcher bias regarding epistemological preferences. Rowan (1999) examines the notion of pluralistic epistemologies, a conception that aligns itself with postmodernism;

alternatively, Sokal and Bricmont (1997/2003) claim that postmodern approaches to research may be fundamentally flawed. Rowan (1998) suggests that there is a certain stage in a qualitative researcher's personal development, the first level of four 'levels of consciousness', when the researcher's values and interests are the most important. Progression to the second level involves collaborative research; the third is transformative and fourthly a form of meditation very rarely reached. Alternatively, Clarkson (1998:254) outlines a seven level model of epistemological discourse analysis to help researchers to differentiate in discussion between the realms of:

1. The body and sensations
2. Feelings and emotions
3. The labels or nominations of language and linguistics
4. Values, ethics and ideals
5. Facts, logic and probabilities
6. Theories, myth, narrative and stories
7. Transpersonal realm (which may be on the one hand the imponderables of quantum physics and chaos theory or, on the other hand, the inexplicable of spiritual or other awe-inspiring experiences).

Clarkson's model, although providing a useful guide to the various dimensions of epistemological issues and feeding into my personal sense of creativity, also leads to the realisation that although as an organism I have a great deal of knowledge, the amount that I really know in terms of research methodology is limited. After looking more closely at what is meant by epistemology, I was

left feeling as if on the one hand some clarity had been gained, whilst paradoxically feelings of 'fumbling about in the dark' had been generated leading me to question how I would have the time and resources to even begin to unpack the various bodies of knowledge. A deep need to really understand the multitude of ideas, theories and concepts that have been required for this research study to be well informed and rigorous has become apparent. I believe that some exploration and decision-making may be required regarding the following questions: what can be accepted as real? What do we know to be real? How do we know it? What does 'knowing reality' really mean?

5.2.2 The researcher and the 'known'

I am an experienced teacher, tutor, counsellor, supervisor and counselling trainer; previously having designed, managed and taught courses in special educational needs (SENs) at a college of further education and trained counsellors and teachers at postgraduate level as a university lecturer. Therefore, most of my knowledge about young people with learning disabilities comes from my interactions with this group of people across the various roles. In my previous career as a nurse and health visitor, I have been involved with individuals with learning disabilities and their families, carrying out home visits; at a local hospital clinic and within the environment of several SENs schools. There are some things that I have known at a felt level, other knowledge that feels a little uncertain and yet further knowledge that is highly questionable. There is also a distinct shortfall in both my knowledge and understanding of counselling and of young people with learning disabilities.

I could therefore pose the question: what do I really know about young people and about learning disabilities? I know through my observation and personal experience that this group of young people is not a homogenous group. I know that as individuals and human beings they have psychological, cognitive, emotional, social and sexual needs. I also know that some of those needs are either denied by parents/carers, teachers, and society; or not adequately met for whatever reason. I have observed that sometimes other people (those without learning disabilities) are somewhat wary of people with learning disabilities and sometimes can avoid contact with them. This knowledge centres on the concept of social exclusion, people with learning disabilities being different, not 'normal'.

There are moves towards integration or inclusion of many types of minority groups in contemporary society, to the extent that the present Labour government places great store by the Social Exclusion Unit. Gidden's Reith (1999) lectures referred to a more integrated and inclusive society and have been instrumental in fuelling my desire to explore the notion of the inclusion in counselling of young people with learning disabilities. I have observed that young people with learning disabilities often appear marginalised and isolated even as they are integrated or included in mainstream society, often away from their peer groups who also have learning disabilities. In discussion with colleagues from special schools and from the Inclusive Education Unit at the University of Newcastle, it appears to be the experience of some teachers and

counsellors that young people with learning disabilities go to great lengths to seek out their peer group, others with the same status and perceived value as themselves. In spite of wanting to treat this group of people with equity regarding other groups of students and pupils, it is experientially known that this group of young people exhibit marked differences to those young people classed by society as 'normal'.

On reflection, most of my knowledge about young people with learning disabilities has come from personal experience, from working with this group of young people on a daily basis; this is the knowledge that seems to refer to real life in ontological terms. Having read widely and studied research findings from various disciplines, such as psychology, sociology and philosophy, each of these having different views of the world and varying strategies for framing reality; it appears that each discipline makes its own claims about reality, having its own rules about what can be accepted as real, or what is valid knowledge. My knowledge or findings are also based upon conversations with young people who have learning disabilities; their parents and carers; other professionals, such as social workers and medical staff and colleagues; discussions and disclosures during counselling sessions; also narratives and diary work carried out by clients; and something that is hard to pin down, generalised knowledge, common knowledge, or the generally accepted world-view, though the latter is may be value-laden and based upon stereotypical views.

5.2.3 Knowledge of others, knowledge of self: reflexivity

Although I believe that some of my knowledge is valid, I am also aware that I carry with me many of society's prejudices and internalised values; some of which are more easily identifiable, while it is doubtless that others are lurking around in my unconscious; may bias the research process. Winnicott (1975) adds the dimension that, in terms of the individual, one can be the knower and the known, concepts that are explored similarly by Gergen (1991); indicating therefore, that when an individual has 'knowledge' of others, they also have knowledge of the individual. This introduces the notion of reflexivity, the idea that the process of interacting with young people who have learning disabilities is actually changed by the very process itself, by being able to reflect upon the relationship and the knowledge gained about the individual, also about how that knowledge was gained. West (2004) refers to the value of the self in the research process and how the use of self can be critical in spite of the inherent subjectivity in the use of self. Having come to a better understanding of my knowledge of young people with learning disabilities; where that knowledge may have come from; and how it was obtained; it seems important now to look to how the various academic disciplines view knowledge; the claims they make about reality; how they validate reality; and the different ways they have of knowing what is real.

5.2.4 Different approaches to the nature of reality: the validity of knowledge

I recently attended an experiential workshop facilitated by a colleague at a local university; the session was about depth and connectedness in counselling

and the colleague wrote the following statement on the blackboard at the beginning of the session, as a prompt to starting a round with students:

> One thing that I know, it isn't logical, rational or scientific.
> I just KNOW it!
>
> (Nonie Cohen, 1999)

I also feel quite strongly about 'knowing' certain things about young people with learning disabilities; as my colleague suggested, they are not necessarily logical, rational or scientific. The task now is to invert that premise and try to identify where this knowledge comes from; for the purposes of this research project, 'just knowing' is not good enough and what we 'just know' might be wrong.

The various subject disciplines, such as: psychology, sociology and philosophy, make different claims about 'reality', truth and the validity of knowledge. Laungani and West (2004) refer to the assessment of truth and the validity of therapies. Hart (1998:86) ponders the question 'what is reality?' then goes on to suggest that it is:

> ....the ontological issues concerned with what we
> believe to exist and are able to be investigated.

Hart (1998) goes on to consider the question: 'what is the subject matter?' and whether it exists apart from the individual and their perceptions and cultural biases or whether 'reality is shaped by prior understanding and assumptions. There are many diverse ways of knowing what is real, often based upon research carried out from the perspective of the originating discipline of the researcher, and carrying with it the bias of the researcher. There may be great

disparity between the various approaches and their preferred ways of acquiring, evaluating and validating knowledge, the debate between positivism and phenomenology. The next section looks at how far the measures of reliability, validity and generalisability are met with regard to this research project.

5.2.5 Reliability, validity and generalisability of the study

In this section I describe and evaluate how appropriate measures of reliability, validity and generalisability are in relation to my research and how far I have tried to ensure that the research process, instruments and results met these measures.

Hart (1998) questions which process of research can guarantee valid knowledge or what is classed as knowledge: 'the logic of inquiry that allows us to have assurance in our knowledge'. The above process can be either deductive or inductive. Hart (1998:82) provides the following definitions of the concepts of deduction and induction:

> It is (deduction) commonly a statement or theory whose truth or falsity is known in advance of experience or observation (a priori: prior to experience)..... (Deduction mof inference) can proceed from the general to the particular, general to general or particular to particular.....(induction) a statement whose truth or falsity is made more probable by the accumulation of confirming evidence (a posteriori: based on experience).

The nineteenth century philosopher and empiricist, John Stuart Mill (in Hamlyn 1989:277) attached great importance to inductive argument, moving

from particular cases to general truths, suggesting that all arguments based on deduction originally came from individual cases, from which people automatically make generalised statements or judgements. Moving from the more logical forms of reasoning, one can gain a different type of insight into 'knowing' as proposed in the following quote by Richardson (1994:517 in Clarkson 1998:302), which highlights the releasing effect of poststructuralism upon our ways of knowing:

> Specifically, poststructuralism suggests two important things to qualitative writers: first, it directs us to understand ourselves reflexively as persons writing from particular positions at specific times; and second, it frees us from trying to write a single text in which everything is said to everyone. Nurturing our own voices releases the censorious hold of 'science writing' on our consciousness, as well as the arrogance it fosters in our psyche. Writing is validated as a method of knowing.

Speaking of the work of writing as another process of discovery after outlining her experience as a laboratory researcher, Clarkson (1998:302-3) tenders the following words:

> The poet in me went into hiding and it is only with my increasing grasp of the postmodernist, poststructuralist Zeitgeist that I begin to see the possibilities – not only as a wholesome final product called 'integration', but a continuing endeavour of validating all the forms of my search and my knowing even as I subject these very processes to both intuition, dialogue and objective inquiry.

The above references to creative and poetic methods of knowing resonate quite powerfully with the creative side of my own nature, as does the idea of doing something for its own sake, as a process; this also seems to fit in with the notion of counselling as a creative process. However, to challenge, or perhaps balance the creativity, (or is it the other way around?), one may need to be able

to see the usefulness of things (processes); this seems somewhat akin to the validity of research or methods.

Returning to a more logical, though less exciting aspect (to me) of knowing, Rowan (1999) discusses the concept of knowledge, highlighting that knowledge is essentially based on theories, some researched and others not. To help clarify the situation, one might ask how a theory or system of ideas is proven or disproved. Rowan (1999) points out that theories can be proven or disproved by research, bearing in mind that any results depend upon the methods used and the researcher's bias; reasoned argument; observations of common experience; and that there is often a general world view of whether a theory stands up as proven. Theories, for example quantum theory, chaos theory; in psychology: developmental, dynamic, structural, cognitive, counselling, humanistic; models and paradigms (such as the new paradigm); are all subject to epistemological issues within the world of the subject disciplines: psychology, philosophy, sociology, neurology, biology and mathematics, to name but some. Historical discussion has fired debates on epistemology and helped to develop the disparity between disciplines, also resulting in 'general intellectual world-view(s)' (Rowan 1999:95) expanded in the following quote:

> ...(there is) substantial agreement about epistemological issues central to the understanding of culture processes and science.

If historical debate has helped the numerous theories to evolve over time and there are general views within the disciplines, it may prove fruitful to explore

some of the contemporary issues. The term discipline infers a sense of order, a certain neatness, or tidiness; something that appears to be lacking in a postmodern world. Rappoport and Kren (1996 in Rowan 1999:95) propose the following:

> ....the modern ideal of progress through rationality, efficiency and social control died at Auschwitz, and that certain foundation principles of postmodern thought such as the critique of positivist science and the deconstruction of language can find their justification in the failure of modern institutions to prevent the Holocaust.

In losing sight of rationality and traditional ways of defining and structuring our lives, the processes of acquiring and validating knowledge have also changed. If one is to go along with a constructivist view of knowledge it may be that material reality is apprehended differently, or as suggested by Baudrillard (1995) seen increasingly through representations, metaphor or images. Rowan (1999) has highlighted the general agreement about epistemological issues in the understanding of culture processes and science; he takes a step further by submitting that:

> ...it is no longer unusual to find philosophers and historians describing science itself as a culture process.

In relation to this research project, I have an attraction to the notion of pluralism of approach and methodology; it has seemed judicious to carry out such a study. The following section looks at some of my own value-laden judgments about adolescents with learning disabilities.

5.2.6 Intellectual traditions and philosophical assumptions

Having explored to some degree my own ideas about the world, in particular the world of young people with learning disabilities, it seems valuable to now take a look at some philosophical assumptions as a series of windows on the world. This research project involves synthesizing difficult and large amounts of material and whilst being creative and original in that process; involving the evaluation of ideas, methodologies and techniques used to collect data and picking out both the strengths and weaknesses of that data, thereby gaining new insights. The intellectual traditions of positivism and phenomenology both shape and frame the way in which one views the nature of the world, how one knows about the world. I have gained knowledge of historical ideas, philosophy and social theory, which both stimulates and frightens me in their enormity. By learning more about the various ideologies, I have been able to assess and analyse different methodologies from an enhanced critical position, showing a clearer understanding of the limitations of the various approaches. This learning has enabled a higher degree of rational argument and helped me to develop a coherent framework or structure for the argument in support of the research project.

Part of the excitement experienced in working on this project is around the notion of originality; being able to play with ideas, access the research imagination and in some ways become a child again by getting in touch with

the curious and almost obsessively inquiring part of myself, which does not just belong to my mind but is located in my core, feeling as well as thinking and imaginary as well as real. Nevertheless, there is a paradox in this; after looking at what the term originality really means (one of the criteria for a PhD. thesis), the following alternative words: innovativeness, innovation, inventiveness, newness, novelty, break with tradition, freshness, creativity, imaginativeness, resourcefulness, individuality, unusualness, unconventionality, unprecedentedness are identified. This leads me to ask myself the following question: 'Can I, as a researcher, really be or do all or indeed any of this?' My answer to this question is that some of these things are possible within the remit of this study, namely, opportunities for me to play around with ideas, get in touch with my inherent curiosity and engage my enquiring mind to focus on the topic and discover new meanings from this process. However, there are limitations to what is possible in this study. The conventions of a doctorate thesis need to be adhered to and therefore, restrict the creative process to some degree. I have had to focus on what is appropriate and achievable within the parameters of this study.

5.2.7 Methodological traditions

One of the major debates in the social sciences is based upon positivism versus phenomenology as ways of knowing. Positivism puts the emphasis on measuring behaviour or phenomena that can be directly observed and the application of methods and assumptions of the natural sciences. It is one of the

methodological traditions firmly rooted in science; one that provides a view of the world based on observable, testable, reliable methods, validation of research being acceptable only if it follows strictly controlled scientific procedures. Key figures in the field include: Auguste Comte (1798-1857); Karl Popper (1902) and finally, Emile Durkheim (1858-1917) who transferred scientific methods into sociology, establishing the laws of cause and effect in relation to social phenomena (functionalism). Positivists construct general laws or theories based upon observable relationships of cause and effect between the different phenomena under examination; one can look at science as a philosophy based upon the above premises. In relation to this research project, positivism can inform the examination of ideas using a more scientific eye, enabling a focus on the knowledge and data that is required about counselling and young people with learning disabilities, and the methodologies that would be acceptable to the research community. The psychological research community remains rooted in the empirical traditions of positivism, although there are moves towards accepting the validity of qualitative methods (McLeod, 2001a). Increasingly, especially in the field of counselling psychology (Clarkson 1998), researchers trained in empirical methods are exploring the usefulness of examining phenomena from a qualitative viewpoint, accepting that what may be a truth for one individual may be true for others, though not necessarily so. The truth for that individual, nevertheless, can give me valuable insights into the 'world'. In the field of counselling as opposed to counselling psychology, phenomenological ways of knowing remain more deeply embedded.

Alternatively, phenomenological research involves the discovery of meaning and interpretation of that meaning (or meanings); this makes objective measurement and establishment of simple cause and effect impossible. The meanings attached to experiences or phenomena are subjective and constructed through intuition, personal insight and understanding. Interactionism falls within the broad spectrum of phenomenology because it is based upon the premise that human beings create their own meanings and construct their reality in relation to their interactions with others; these meanings being subject to negotiation and renegotiation (Mead 1959). In order to understand the development of phenomenology I have explored a little of the history involved. The German philosopher Immanuel Kant (1724-1804) was highly significant in the development of the philosophy known as phenomenology, embracing the view that the phenomenal world or the world of internal experience derives its structure from the subjective mind of the person experiencing it. Kant (in Hamlyn, 1989) claimed that reality cannot be scientifically confirmed, denied, or demonstrated but it can be interpreted through subjective experience and organised into twelve categories of thought, under four main classifications: quantity, quality, reason, and modality. Another German philosopher and a pupil of Kant, Johann Gottlieb (1762-1814), carried the phenomenological tradition a little further and proposed that the ego is the only basic reality. Hegel (1770-1831) also wrote a major work, 'The Phenomenology of Mind' (1807), which describes the progression of the human mind from

consciousness through to self-consciousness, the ability to reason, spirituality, and religion to absolute knowledge (Hamlyn 1989).

In continuing the historical pathway to understanding how phenomenology developed, Max Weber (1864-1920) was earliest key figure associated with phenomenology as a form of interpretive sociology. Heidegger (1889-1976) examined the human condition, looking at consciousness, the human situation and the field of human existence. Jean-Paul Satre (1905-80) followed on from Heidegger, closely examining the notions of personal experience, the human condition, existentialism (Hamlyn 1989). Merleau-Ponty (1906-61) attacked behaviourism and the empiricism of psychology; he praised Gestalt as a way of paying attention to the phenomenological needs of the individual. This alliance to phenomenological ways of understanding the world was so strong that his theories were dismissed completely by the scientific establishment when he examined the notion of time using a subjective approach (Hamlyn 1989).

After tracing some of the history of phenomenology and identifying the key figures, the application of this approach to what is known about the world resonates very strongly with my own ideas about research and what I would like to know about counselling and young people with learning disabilities. My 'gut feelings' and intuition – phenomenological terms in themselves – tell me that although events in the external world or 'real world' can be shared, experience of that world is individual, therefore can only be examined from a subjective, therefore individual perspective. However, that examination, let it

be called research, can stand a stronger chance of being validated by the scientific community if an empirical study is carried out in support of the qualitative claims. My personal view on this is divided: on the one hand part of me rails against the idea that the external world is deemed to be the real world by the scientific community, compounded by the fact that science is given a greater value in our society than individual experiencing of the world. However, there do seem to be some changes afoot, in the postmodern sense of pluralistic ways of collecting and analysing data about the world and the rise of interest in Eastern cultures and philosophies (Sokal and Bricmont, 1997/2003). On the other hand, my earlier training as a nurse and health visitor is set against a backdrop of the empirically based world of medicine, leaving me with a residual alliance to the positivist tradition. In spite of these seemingly opposing views, I am drawn to using research methods belonging firmly in both traditions (plurality of methodology in the postmodern sense (Rowan and Cooper, 1999; Clarkson, 1998) to shape and inform this research project. By carrying out a quantitative study to identify characteristics of those counsellors who include young people with learning disabilities in their counselling practices, followed up by a qualitative study to examine individual, subjective experience of counsellors, I intend to maintain credibility and validity with the scientific community, bearing in mind the huge area of influence retained in our culture.

5.2.8 Quantitative and qualitative research

Bannister *et al.* (1994:142) produces a clear definition of qualitative research:

> It (qualitative research) is theory generating, inductive, aiming to gain valid knowledge and understanding by representing and illuminating the nature and quality of a person's experiences. Participants are encouraged to speak for themselves. Personal accounts are valued, emergent issues within the accounts are attended to. The developing theory is thus firmly and richly grounded in personal experiences rather than a reflection of the researcher's a priori frameworks.

Therefore in qualitative research the data collected reflects the experiences of both the research subjects and the researcher. Bannister *et al.,* (1994:143) claims that the researcher's knowledge and experiences are brought to the research process and that this has an effect on both the knowledge produced by the research and vice versa. The researcher's knowledge provides a perspective on the research process and is essentially a constructed and representative reality leading to the notion of multiple existing realities. Qualitative research demands that the researcher be actively engaged in the research process, which means that there needs to be:

> ...a focus on critical examination on a number of levels, in the form of the researcher's reflection on both the process and experience of doing research and the ways in which the findings were constructed.
>
> (Bannister *et al.* 1994:143)

The notion of reflexivity refers to this engagement both with and in the research process. However, the notion of reflexivity can carry with it the researcher's bias towards the topic, the research process, subjects, instruments and finally, the resulting data and discussion of findings.

5.3 Research design and methods

The systematic research necessary for this project has been conducted by first operationally defining the main concepts of counselling, psychotherapy, inclusion and young people with learning disabilities through the literature in order to counteract any of my preconceived ideas regarding these concepts. Bryman and Cramer (1990:61/2) suggest that:

> An operationalised definition specifies the procedures (operations) that will permit differences.....to be precisely specified.

I use quantitative data analysis to form part of the process of research in a survey of counsellors and psychotherapists listed in the British Association for Counselling and Psychotherapy's (BACP, 2001) Directory. The research process began with an exploration of the theory around the concept of inclusion and exclusion of certain groups and individuals within society, moving from this general theory of inclusion to the inclusion of young people with learning disabilities in counselling and psychotherapy. The hypothesis, that counsellors can increase the inclusiveness of their practices and make counselling more accessible to young people with learning disabilities, is tested through two

main research tools, a survey of counsellors listed in the BACP Directory (2001) and semi-structured interviews. The question of where counselling practice may be at the present moment regarding inclusivity is addressed; the survey is designed to search for and inquire into aspects of counselling that indicate the present level of inclusivity. The above hypothesis encompasses the concepts of counselling and inclusion and provides the focus for exploration. However, according to Bryman and Cramer (1990), hypotheses may focus researchers in one direction to the detriment of other interesting facts to be found in the resulting data. Therefore I have tried to remain as open as possible to emerging themes and ideas from the data. Measuring the concepts that are contained in this hypothesis can assess the validity of the hypothesis. The concepts in question are: counselling, psychotherapy, inclusion, young people and learning disabilities. Therefore I have made counselling more concrete as a concept by translating it into variables obtained from exploratory pre-pilot work. The variables identified from this pre-pilot work form the basis for the questionnaire and the interviews.

The results of this study are not intended to be generalisable to the larger counselling population; results are restricted to counsellors and psychotherapists listed in the BACP Directory for 2001. It is not feasible with the resources available to survey all counsellors and psychotherapists, also this is a population that is not possible to reach with any degree of accuracy, therefore, I have chosen a working population. Moreover, this sample is appropriate in the sense that there are moves nationally to regulate counselling

and psychotherapy, in which case lists, such as the BACP Directory, will become more representative of the total counselling population. However, the results from this study may be used to infer common themes across the counselling population and applied critically to other minority or marginalized groups, for example, refugees, the physically disabled, the mentally ill.

5.3.1 Data collection

In order to measure inclusivity in counselling practice certain indicators are required to represent the main concepts. How are these indicators identified? Firstly, a survey of counsellors listed in the BACP directory (2001) has been carried out in order to examine the level of counselling regarding young people with learning disabilities in the wider sense (mainstream) and to search for indicators of inclusiveness. Secondly, this information is subject to triangulation and supplemented by data from a series of semi-structured interviews with counsellors. Following the operational definition of each of the concepts, (inclusion, counselling, young people, learning disabilities) I have developed a questionnaire to include multi-item measures (Appendix 1).

> Triangulation is essentially the use of different vantage points
> And takes a variety of forms, it allows illumination from
> multiple standpoints, reflecting a commitment to thoroughness,
> flexibility and differences of opinion.
> (Bannister *et al.* 1994:145)

According to Bannister, research methods can be extremely well constructed, yet still have limitations, threats to validity and distortions. As researcher, my biases, blind spots and perspective have the potential to limit the validity of the

research methodology. Therefore, two different data collection methods have been used to triangulate the data and increase the validity of the findings, namely survey and interview methods. Triangulation includes the use of quantitative and qualitative data collection methods, research tools and data analysis methods.

5.3.2 Research instrument one: survey of counsellors listed in BACP Directory

Can counsellors make their practices more inclusive of young people with learning disabilities?

In order to answer this question I have investigated the current position regarding inclusion of this group in counselling and used this as a baseline. In the wider population potential clients are able to contact a counsellor through the British Association for Counselling and Psychotherapy's (BACP) Directory, which is available on request from the BACP and local libraries. Some Citizens' Advice Bureaus also retain copies of the directory. Details of the BACP can be obtained from the telephone directory and their website on the Internet. The results will show how access to information about counselling may prove to be a major issue for young people with learning disabilities.

The results of the survey are intended to inform individual counsellors and interested parties, for example organisations dealing with young people with learning disabilities in the statutory, voluntary and private sector regarding

inclusive counselling practice. Although specialised services, such as educational psychologists, are available to provide psychological help to this group of people, one aspect of the notion of inclusion refers to inclusiveness within the mainstream. Therefore there is a need to find out about counselling and psychotherapy provision available to the wider populace in order to assess the present level of inclusivity.

The survey has been designed to identify any emerging issues involved in counselling young people with learning disabilities. The next step of the research process has been designed to build upon these issues and explore them further. Interviews with counsellors and psychotherapists enable the characteristics of inclusive counselling practices to be highlighted and a theory to support the notion of a model for inclusive counselling practices to be developed. However, I am aware that the data collection is biased towards the views of counsellors as service providers rather than clients as service users. Kazdin (2000) also claims that little of the research focuses on young peoples' perspectives. Moreover, Docherty and Sandelowski (1999) claim that young people can contribute much to the body of knowledge with their own experiences of therapy. Nevertheless, I believe that the assessment of the present level of inclusivity in counselling and counsellors' ideas and experiences of strategies for increasing inclusion form the basis for further work in this field and can be of value in adding to the existing knowledge bases of both counselling and social inclusion.

The survey questionnaire aims to identify counsellors who demonstrate inclusiveness in their practices and the main characteristics of an inclusive counselling practice. I aim to identify any difficulties in providing a counselling service to young people with learning disabilities from the resulting data and any highlight operational difficulties. It is my intention to use this knowledge to facilitate the design of a model that stands as good practice for counsellors. The questionnaire aims to collect both quantitative and qualitative data and will be used to build up a profile of counsellors and their practices regarding the counselling of young people with learning disabilities. The quantitative aspect of the survey is primarily designed to establish relationships between the various constructs, such as counselling approach and level of counselling young people with learning disabilities, with the qualitative aspects reflecting counsellors' opinions and suggestions.

Gall *et al.*, (1996) suggest that survey questionnaires are measures that present a number of written questions to be completed by research subjects deemed representative of a particular population (sample). Munn and Drever (1995) support this view of and suggest that questionnaires are a valid form of data collection. The main reason for using a questionnaire as a research tool is that a snapshot of the present state of counselling provision for young people with learning disabilities seems necessary as a baseline for the development of a model for good practice. There are several advantages to using questionnaires; firstly, they can be anonymous and this can encourage a greater degree of honesty in giving answers. Secondly, questionnaires can provide more

structured data, including numerical data. Finally, the data collected can be more straightforward to analyse, therefore more reliable in the positivistic sense (Anderson and Arsenault 1998). Munn and Drever (1995) suggest that one of the greatest advantages of survey questionnaires is that all participants are presented with the same questions in the same order, giving a standardisation of stimulus presentation resulting in more consistent information. However, survey questionnaires may be problematic in several ways: it can be difficult to clarify some question responses in surveys, whereas interviews enable explanations and explorations to take place through communication and interaction (Fink, 1995); open-ended responses may be difficult to analyse (Lee, 1994); there may be a poor response rate (Keeves, 1988) and questionnaires may be biased towards the researcher's perspective (Hopkins, 1993). In spite of these potential problems, the survey questionnaire seemed to be the most appropriate way of collecting the volume and range of data required ((Keeves, 1988; Fink, 1995; Lee, 1994). Weaknesses that may be inherent in the data collection tool were countered by pre-pilot work and piloting the questionnaire to ensure that questions were understood, responses were clear and researcher bias kept to a minimum; follow-up interviews allowed for exploration of a sample of respondents; an accompanying letter to the questionnaire provided the 'personal touch' and an opportunity for the respondent to make contact with the researcher if they chose to do so; and response rates were monitored with more questionnaires being sent out to make up for any shortfall.

To enable statistical generalisations to be made the sample is required to be representative of the counselling population across a range of variables. The sampling procedures chosen for this survey facilitated the highest degree of external validity possible within the restraints of resources available for the research project. Although a survey of the full counselling population may provide more valid and accurate data, the cost in terms of resources would be prohibitive and there would be difficulties in gaining access to this disparate group of individuals. Moreover, Smith (1975) suggests that in some cases representative samples can give a better estimate of the target population than a complete count survey. Smith (1975) explains this apparent paradox by the number of mechanical and clerical errors in such a large survey, suggesting that such error margins can be controlled more easily in a smaller sample. Smith (1975) also introduces the concept of universe in relation to the sampling process and suggests that in order to generalise from data a clearly defined conceptualisation needs to be made of the target population.

According to May (1997) surveys measure facts, attitudes or behaviour through questions, which indicates that the hypotheses involved in this study need to be operationalised into measures. These measures are essentially the questions that the respondents can understand and answer. I have carried out pre-pilot work in order that answers can be categorised and quantified. Initial fieldwork for this study was conducted to inform and test the questionnaire to ensure that the questions were unambiguous, to invite feedback on the type of questions any difficulties experienced in answering the questions and the order of the

questions, as suggested by Vogt (1993). This has enabled the layout of the questionnaire to be revised, along with the question wording and design to take account of any criticisms and problems.

5.3.3 Research instrument two: semi-structured interviews

The second research tool used in the study is the semi-structured interview. This was designed to collect qualitative data to both enrich and triangulate the data from the survey questionnaires. Brown and Dowling (1998) propose a scale with structured interviews reflecting positivism at one end and unstructured interviews representing interpretivism at the other. The difference in interview types can be made sense of in terms of epistemological positions. It may be possible to obtain similar information from questionnaires and structured interviews. In contrast, unstructured interviews are purely qualitative and could be described as conversations. A common factor of all types of interviews is interaction and relationship (McLeod, 1998).

In order to collect enriching data the interviews needed to provide opportunities for participants to present their own ideas and extend their thoughts with the minimum of restrictions. However, to enable opportunities for triangulation of data from the survey, the interviews were required to address the same themes and issues. Therefore, structured interviews were not appropriate; they would have restricted the enrichment of the data obtained. On the other hand, unstructured interviews could not guarantee that all related themes and issues would be discussed. Semi-structured interviews provided the

structure required for each topic of importance to the study to be covered, at the same time giving the participants opportunities to answer open questions in their own way, thereby enriching the data.

Interviewees were selected from information provided in the survey questionnaire and contacted by letter, telephone or email. The interviews were conducted through the same range of media depending on accessibility and resource constraints, for example, time, and geography or travel expenses. Face to face interviews were audio-taped and extensive notes were taken to capture the data from all the interviews as recommended by Brown and Dowling (1998).

5.3.4 Pilot Study

May (1997) suggests that the methodology of survey research should include the piloting of questionnaires. This questionnaire was piloted amongst a group of counsellors (n=25) primarily in order to identify any potential problems with the questionnaire itself rather than for the value of data collected. Respondents were requested to critique the format of the questionnaire to ensure that it was user-friendly and effective in line with good research practice (Morse and Field 1996). The pilot survey was valuable in that the sample chosen for the pilot included experienced counsellors with a strong academic background in counselling, some were counselling trainers and educators, some had active research backgrounds. This sample provided an expert panel, referred to by

Presser and Blair (1994), and consisted of a group of experts in the field who were well placed to give advice and critical feedback on the research tool.

The actual data from the pilot study provided a perspective on the provision of counselling and psychotherapy to young people with learning disabilities amongst experienced counselling practitioners. This group of counsellors may be expected to be more aware of any issues involved in counselling young people who have learning disabilities and therefore more likely to respond to their needs due to their high level of theoretical knowledge, extensive training and counselling experience.

The piloting of the questionnaire was a test of whether the tool would collect appropriate data before going on to survey the main BACP Directory (2002). Although I paid great attention was to the design of the questionnaire it was in no way certain that the tool would fulfil the data collection needs. Oppenheim (1973:49) captures this uncertainty:

> In reality questioning people is more like trying to catch a particularly elusive fish, by hopefully casting different kinds of bait at different depths, without knowing what goes on beneath the surface.

According to Czaja and Blair (1996) the first draft of a questionnaire is based upon the assumptions of the researcher in that there is some preconceived idea of the types of answers that respondents might give. These preconceived ideas may be completely wrong. A pilot questionnaire tests both assumptions and presumptions (Czaja and Blair 1996). Czaja and Blair (1996) suggest that a

pre-test assesses how true respondents answers are to the questions; in other words, how valid and reliable they are.

5.3.4.1 Reliability and validity of the research tool

Czaja and Blair (1996) refer to the availability of pre-test methodologies and research that compares these methods (Bischoping 1989, Presser and Blair 1994, Carrell *et al.,* 1989, Campanelli *et al.,* 1991). However, it is suggested that there is no one best method applies to particular circumstances and that it is reliant upon the researchers own judgement to weigh up rigor and resources. It is advised by Czaja and Blair (1996) that a small number of respondents are used in the pilot, gaining critical feedback, which can be summarised and presented as data, as is the case with this pilot study.

May (1997) suggests that a first draft of a survey questionnaire should be piloted and a way of pre-coding the questions devised to make analysis easier. A questionnaire utility guide provided by Czaja and Blair (1996:61) was used to assess the usefulness of the survey questionnaire. Importantly, pre-testing may not address all aspects of the data collection process, focusing mainly on the questionnaire.

The validity and reliability of the questionnaire is examined to assess whether it is consistent. Bryman and Cramer (1990) suggest that test/retest procedures are used to test external reliability and if the results remain constant over time

then external reliability is established. However, the available resources for this research project do not allow for tests of external validity. According to Bryman and Cramer (1990), internal reliability is of particular importance in connection with multiple-item scales. Are the items that make up the scale reliable?

> Reliability refers to the extent to which a test or technique functions consistently and accurately by yielding the same results.
>
> Verma and Mallick 1999:202)

Regarding validity, how far do research instruments give valid information about a subject, construct or concept? Regarding face validity, does the research tool reflect the ideas in question? Concurrent validity means that:

> ...the researcher employs a criterion on which people are known to differ and which is relevant to the concept in question.
>
> (Bryman and Cramer 1990:72).

According to Bryman and Cramer (1990) in order to be valid a questionnaire needs to provide information about the constructs identified as relevant to the study, in the case of this study: theoretical approach to counselling, level of counselling activity with young people who have learning disabilities, strategies employed and counselling context. In order to ensure validity I also made sure that respondents had an understanding of the questions and interpreted them as intended. I also increased the reliability of the research tool by asking another researcher (a colleague) to administer the questionnaire to a small sample using the same procedures. Weaknesses of the research tool

included the misinterpretation by respondents regarding the term 'learning disabilities', which was taken to represent young people who had specific learning difficulties such as dyslexia and discalcula; and complaints that the questionnaire was too long and not user-friendly. I revised the tool following feedback from my colleague and pre-pilot/pilot participants. A further pilot study was carried out and is referred to in more detail in the following section.

5.3.4.2 Summary of pilot study

The data from the pilot questionnaire was analysed question by question with quantitative data being converted into representational statistics. Figure 2 presents some of the feedback given by participants regarding the pilot questionnaire:

Figure 2: Feedback on survey questionnaire

Feedback on research tool:
It would be useful to provide a definition of learning disabilities.
Typing, spelling and grammatical errors.
Answer boxes need to correspond more closely to question options.
The clarity and polite style was commented on.
A well-constructed questionnaire.

Written feedback on the questionnaire has enabled a more effective research tool to be designed. I modified the questionnaire to include a definition of the term learning disabilities, corrected typing and grammatical errors and changed the layout slightly to improve clarity. The full data from the pilot study is available in Appendix 2.

5.3.5 Main survey

Following further development work based on the pilot study and discussions with experienced counsellors, trainers and researchers I distributed 600 questionnaires by post each with a covering letter and an enclosed stamped addressed envelope.

Figure 3: Survey respondent details

Number of counsellors sampled	3000
Number of respondents	396
Sub-group consenting to interviews	15

I chose 600 counsellors to receive questionnaires in order to try and achieve a 10% sample of returns, 10% being the statistically valid sample advised by Cramer (1990). I did not seek permission from the British Association of Counselling because the counsellors surveyed were all listed in the BACP Directory (2001), a resource fully in the public domain. The return rate was higher than I had expected with 396 questionnaires returned within the requested period of time (two weeks). In order to generalize from quantitative

research findings Bassey (1981) suggests that a sample of 10% of the research population would be acceptable; the 396 sample for this study is a little higher than 10%, the full BACP list amounting to 3000 counsellors. However, this sample can only be taken to be representative of the population of counsellors listed in the BACP Directory (2001) because the full population is disparate for several reasons. Firstly, the profession is not fully regulated; therefore counsellors may not be affiliated to a professional body. Secondly, even if counsellors ascribe to such a professional body there are a variety of national and local organisations available. Finally, the nomenclature used in relation to counselling includes a range of terms and counsellors may advertise their services in accordance with their particular variance or approach to therapy and register with specialist organisations, for example, counselling and hypnotherapy, life coach and counsellor; counselling itself is not easily definable.

Bassey (1981) highlights problems of generalising from insufficient data such as the sample being unrepresentative of the population under scrutiny. Therefore in this study an alternative type of generalisation will be applied. Silverman (2000) proposes that by developing hypotheses and then testing them out successfully, generalisations can contribute to theory building. This fits well with my thesis, which is essentially concerned with developing a theory regarding inclusive counselling practice; based on the hypothesis that counsellors can make their practices more inclusive of young people with learning disabilities.

Silverman (2000) suggests that social science researchers tend to adhere to the paradigm learnt in their training, usually either quantitative or qualitative but not both. Therefore for part of the analysis I have stepped outside of my preferred (and comfortable) paradigm to venture into the little known (for me) world of quantitative research. Bryman and Cramer (1990:63) suggest that:

> ...units of analysis differ with respect to the concept in question.

Therefore the analysis of data for this study is varied, along with differing forms of presentation to fit in with the nature of what is being measured. The analysis indicates which of the concepts are constant and the range of variables exhibited. This range is analysed in three different ways; firstly, univariate analysis is carried out to see how individual counsellors are distributed in relation to a single variable, such as theoretical approach to counselling. This information is also examined in terms of averages. Secondly, a bivariate analysis is carried out to look for connections between two variables at a time, for example, frequency of counselling young people with learning disabilities and theoretical approach to counselling. The Statistical Package for the Social Sciences (SPSS, 1999) is used for this purpose.

5.3.5.1 Semi-structured interviews

The second research tool used in this study is the semi-structured interview. This was designed to collect quantitative data to both enrich and triangulate the survey data. Brown and Dowling (1998) propose a scale with structured

interviews at one end reflecting a positivist approach and unstructured interviews at the other end representing interpretivism. The difference in interview types can be made sense of in terms of epistemological positions. It may be possible to obtain both qualitative and quantitative information through questionnaires or structured interviews whilst unstructured interviews could be viewed as conversations and only collect qualitative data. A common factor in all types of interviews is interaction and relationship (Brown and Dowling, *ibid.*). In order to collect enriching data for this study I required the interviews to provide opportunities for participants to present their own ideas and extend their thoughts with the minimum of restrictions. However, to enable data to provide opportunities for triangulation with the survey the same themes and issues needed to be covered. Therefore, structured interviews were not appropriate; they would restrict the enrichment of data obtained. On the other hand, unstructured interviews could not guarantee that all related themes and issues would be discussed. Semi-structured interviews provided the structure required for each topic of importance to be covered whilst at the same time giving participants opportunities to answer open questions in their own way, thereby enriching the data.

Interviewees were selected on an opportunistic basis from information provided in the returned survey questionnaires; all who had responded were contacted by telephone, email or letter.

Figure 4: Interviewee details

Interviewee background	Interview medium
Person-centred approach x 11	Face-to face x 10
Gestalt approach x 2	Telephone x 3
Psychodynamic approach x 2	Email x 2

The interviews were conducted mainly face to face, with some by telephone or email depending on accessibility and resources, geography and travel expenses. Face to face interviews were audio-taped and extensive notes were taken to capture the data. As recommended by Brown and Dowling (1998) I conducted pilot interviews in order to allow the interview process to be reflected upon by interviewees and test the interview question, evaluating data collected in terms of relation to the survey data, thereby also testing out data analysis methods.

Pre-pilot work included firstly, in-depth unstructured interviews with young people with learning disabilities, parents, carers and counsellors. Secondly, I carried out discussions with counsellors at various workshops and professional development activities on learning disabilities and asked for their feedback on training. This pre-pilot work helped me to design the first research instrument, the questionnaire and develop a series of prompts for the qualitative semi-structured interviews.

Figure 5: Sources of data

a	Pre-pilot interviews Young people with learning disabilities
b	Pre-pilot interviews Carers
c	Pre-pilot interviews Counsellors
d	Pre-pilot interviews Workshops and professional development activities
e	Main study interviews with counsellors
f	Main study survey

The interviews were standardised using a set of questions (see appendix 6). Prompts and probes were used to collect as much subjective data as possible. Interview questions were arranged in groups according to themes as suggested

by Bannister and Fransella (1986). As interviewer I aimed to put participants at ease and build up rapport in order to facilitate the process and encourage the sharing of information. I used a variety of skills as recommended by McLeod (1995), including the use of open questions, listening, reflecting and monitoring the flow of the interview.

5.4 *Data Analysis Methods*

Two main types of data analysis were used, with quantitative analysis and statistical methods adopted for data collected from the survey questionnaires and qualitative analysis for the data from semi-structured interviews.

5.4.1 Quantitative analysis

Simple statistical procedures are used to analyse the quantitative data because generalisations will be theoretical rather than statistically based. In order to apply these tests or procedures it is necessary to first identify the different types of variables. For instance, quantitative data from the questionnaires is collated producing four main categories for analysis very early in the process, namely therapists who never, rarely, sometimes or often counsel young people with learning disabilities. Bryman and Cramer (1990) refer to this category as ordinal, in which counsellors can be assigned a value of more or less. Counsellors are also categorised in this nominal way according to counselling approach, psychodynamic, person-centred, integrative, psychosynthesis,

transactional analysis; this is the most simplistic way of classifying variables. Dichotomous variables comprise another simple type of variable, with only two categories, such as yes (a counsellor does come in contact with young people with learning disabilities in their main occupational role) or not. The analytic process may have been biased towards these categories due to the initial responses from fieldwork, however, I remained aware of this possibility and of any preconceived ideas that may influence the data analysis and interpretation process.

5.4.1.1 Statistical procedures

Simple statistical procedures of median, mode, averages and percentages are used to translate data into numerical forms that can show proportions and be presented in easily accessible graphical formats. Bell (1998) recommends that data be presented in a variety of ways, for example: tables, bar charts, pie charts, adopting the clearest form of presentation for each category. Descriptive statistics are used in this analysis to give a proportional weighting to the data. Hayes (1997) suggests that by describing aspects of the world (the research subject/topic under scrutiny) using numbers and summarising data, the complexity of the world can be reduced, facilitating a greater understanding of phenomena. Following the collation of data from the survey it has become apparent that at this stage of the analytical process graphical representation is essential before any further understanding can be gained.

5.4.2 Qualitative analysis

Morse and Field (1996) outline approaches to qualitative research that may have been appropriate to this study. Firstly the grounded theory approach (Glaser and Strauss, 1990) where the researcher works inductively, carrying out the literature search after the data collection and analysis; secondly, an approach where the researcher reads all information available about the topic and brackets off this information whilst collecting data. In order to obtain results relating to the survey data and identify any other relevant issues it seemed more appropriate to adopt a thematic approach informed by grounded theory (Glaser and Strauss, 1990; Rennie, 1992) rather than a pure grounded theory approach. By using ideas from grounded theory to facilitate a thematic approach within the structure of questions related to the survey questionnaire categories and themes were identified. These were then analysed using existing theory whilst building original theory of good practice for including young people with learning disabilities in counselling. I coded and classified the data from interviews following ideas on thematic approaches to data analysis outlined by Burnard (1997) and Morrall (1998).

5.4.3 Ethical issues

There were several ethical issues that needed addressing in this study. The central issues were related to participants and involved their welfare and dignity. I have found it useful to focus upon the rights of participants as described by Kitchener (1984), using the following concepts:

- Respect for autonomy
- Nonmaleficence
- Beneficence
- Justice
- Fidelity

These five concepts have been adopted as the basis for the most recent code of ethics by the BACP (2004). The use of informed consent addresses the first concept of respect for autonomy by giving participants enough information to enable them to decide whether they wanted to take part in the research. Bond (2004a, b;) and McLeod (1999) suggest that informed consent is essential to the research process. I also obtained permission from the Ethics Committee at the University of Durham and I explained to participants that they had the right to withdraw from the research at any time. Participants may want to please the researcher, therefore by being clear about the potential to withdraw, researchers are likely to prevent harm (McLeod, 1999). This fits with the BACP Ethical Framework (2004) and Bond's ideas in ethical practice (2004a, b; 2003).

Maintaining participant confidentiality and privacy (McLeod, 1999) through the use of a numbering system for data collection purposes and removing all

identifying information from quotes and comments used in the thesis addressed the concept of non-maleficence (BACP, 2004; Bond, 2004a, b, 2003). The issue of confidentiality and privacy also link in with the concept of 'fidelity' because it is my responsibility to ensure that confidentiality is maintained even if this negatively affects the research (McLeod, 1999). When considering Kitchener's (*ibid.*) concept of justice I used the rationale that this research may benefit potential clients who have learning disabilities and help to raise awareness in counsellors who participated in the study.

5.5 Summary

In this chapter I have explored epistemology and theory, relating this to young people with learning disabilities and my personal and professional knowledge. Theory around the intellectual traditions and assumptions of qualitative and quantitative research has been explored and linked to the process of research for this study. I have attempted to make the research process clear and transparent and have provided details of pre-pilot and pilot work, data collection methods, the research instruments and data analysis procedures. Weaknesses of the methods and tools have been identified and the steps taken to overcome these weaknesses explained. Relevant ethical issues have been briefly outlined. In the next section I present the results from the research study.

Chapter 6: Presentation of Results

6.1 Introduction

In this chapter I first systematically present the results in relation to the survey questions (n=396), followed by data from a sub-sample of semi-structured interviews with counsellors (n=15). I have chosen to present these results in graphical, table and chart form with accompanying narrative relating directly to hypotheses derived from the research questions in order to facilitate a clear, logical and progressive process. Analysis of the survey data is largely quantitative, using descriptive statistics. The qualitative data from the survey are analysed using a thematic approach based on techniques of grounded theory. It must be stressed that a pure grounded theory approach is not adopted, rather some of the techniques identifying themes through coding are used and the themes build theory in the form of a model for good practice (see Discussion chapter). There is an integration of both research paradigms in the presentation of results and the method is indicated clearly. I have subjected data collected from the survey sample (n=396) to descriptive statistical analysis using the SPSS software package (Version 1999) and summarised the results

for presentation. The evidence I put forward in this chapter challenges my hypothesis that counsellors are able to make their practices more inclusive.

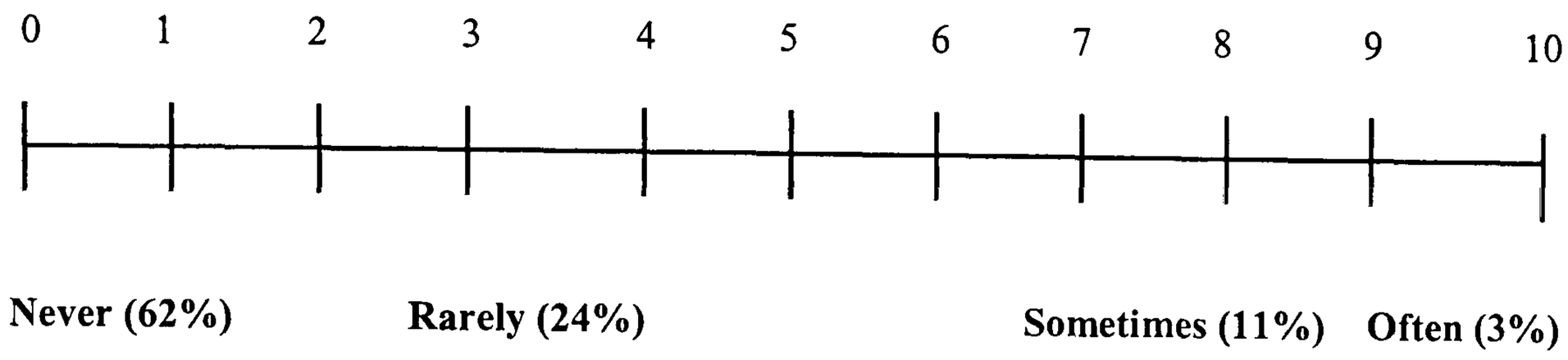
6.2 Range of inclusion/exclusion and potential for increasing inclusion (survey question 1)

This section relates to the main research question 'Can counsellors make their practices more inclusive of young people with learning disabilities?' and the first survey question. I begin by exploring the present counselling landscape regarding the inclusion/exclusion of this client group.

6.2.1 Frequency of counselling young people with learning disabilities

I have arranged data (e, see figure 5, page 205) indicating counsellors' answers to the question: 'How often do you counsel young people with learning disabilities?' on a simple frequency scale with the variable ***never*** forming the lower end of the scale (0), ***often*** the higher end of the scale (10) and the remaining variables of ***rarely*** and ***sometimes*** at appropriate points in-between (fig. 6). These concepts were originally identified from a qualitative analysis of pre-pilot data (c, see figure 5, page 205). I have presented the data in this linear way (visually rather than numerically) in order to give an impression of a continuum of inclusion.

Figure 6: Frequency scale of including young people with learning disabilities in counselling

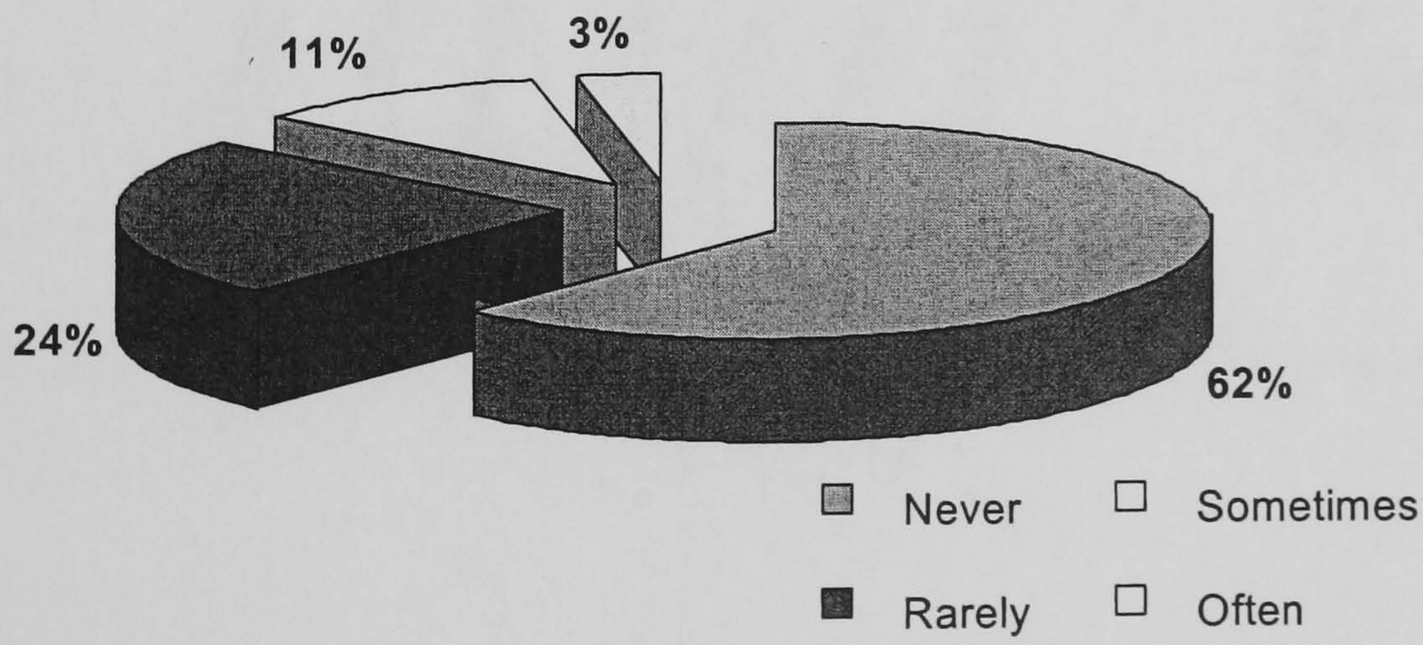


The scale indicates that the level of counselling provided to this client group is variable with a potential of counselling this group of young people ***often***. If 3% counsellors are able to make such provision it seems reasonable to expect that other counsellors may be able to change their practices in some way to become more inclusive, in other words, there appears to be a potential for a higher level of inclusivity in spite of the general appearance that counselling is exclusive of this client group.

A further finding of significance in relation to the inclusion variables appears in a breakdown of the statistics from the main survey (f, see figure 5, page 205) placing counsellors in the frequency categories derived from qualitative interviews (c, see figure 5, page 205) I carried out in pre-pilot work (never, rarely, sometimes and often). The majority of counsellors do not counsel this

client group (62%) and the remainder can be divided into three sub-groups based on the variables of ***rarely***, ***sometimes*** and ***often***. It is significant that the group of counsellors who most often counsel these young people is in the minority (3%). The following pie chart highlights the huge differential between counsellors who do not counsel this client group and three sub-groups of counsellors who rarely, sometimes and often counsel these young people (fig. 7). Therefore, although it appears that counselling mainly excludes young people with learning disabilities some counsellors are including this type of client. This indicates the potential for inclusion and shows that it may be possible for counsellors to make their practices inclusive if they are motivated towards this.

Figure 7: Frequency of counselling young people with learning disabilities



6.3 Theoretical approach (survey question 2)

The following diagram presents the range of theoretical approaches identified from survey question two in relation to the variables of 'never', 'rarely, 'sometimes' and 'often'. The most inclusive counsellors are shown to be psychodynamic, integrative and person-centred. These are also the most commonly used approaches, as depicted in figure 8.

Figure 8: Counsellors theoretical approach and degree of inclusivity/exclusivity

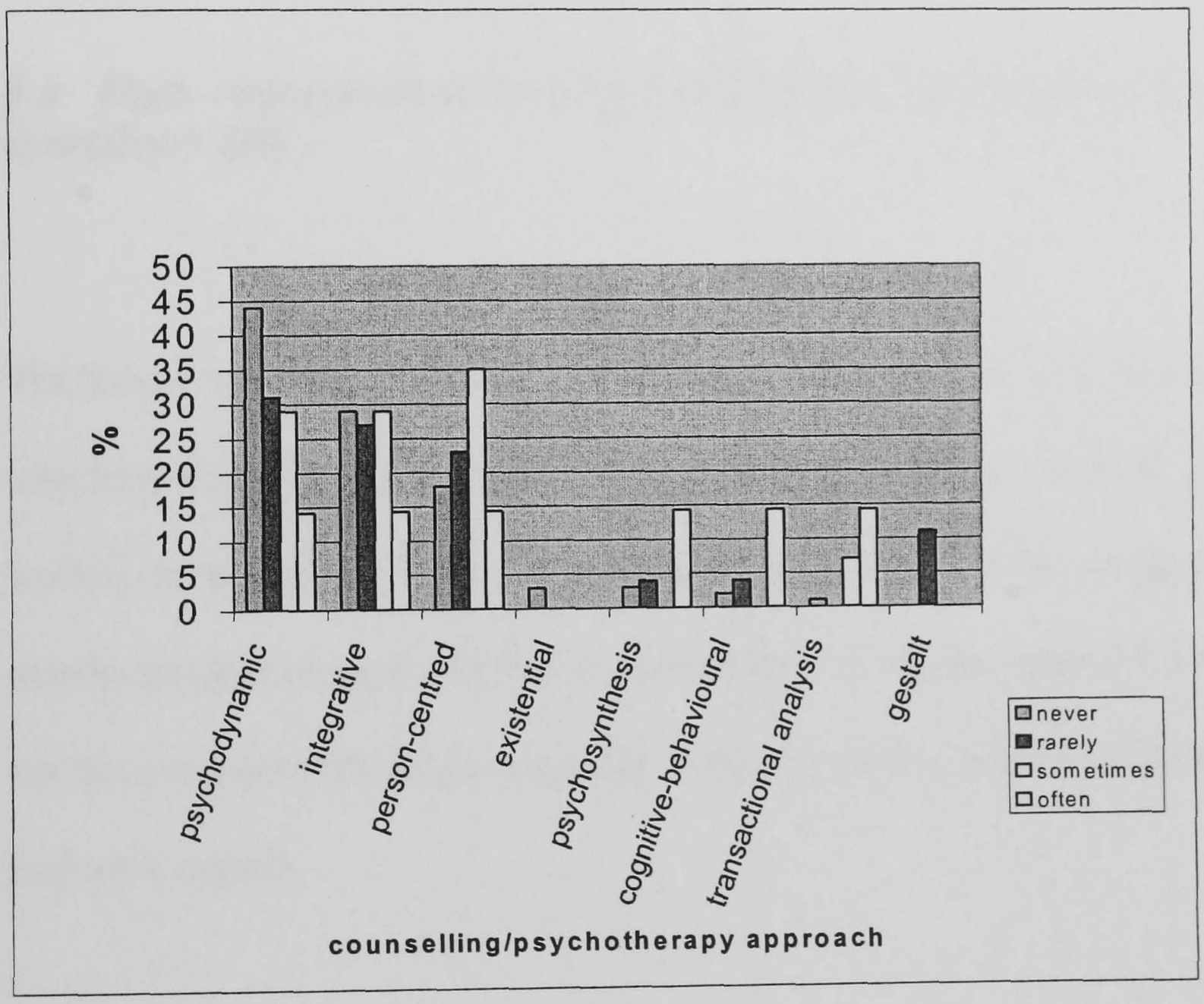


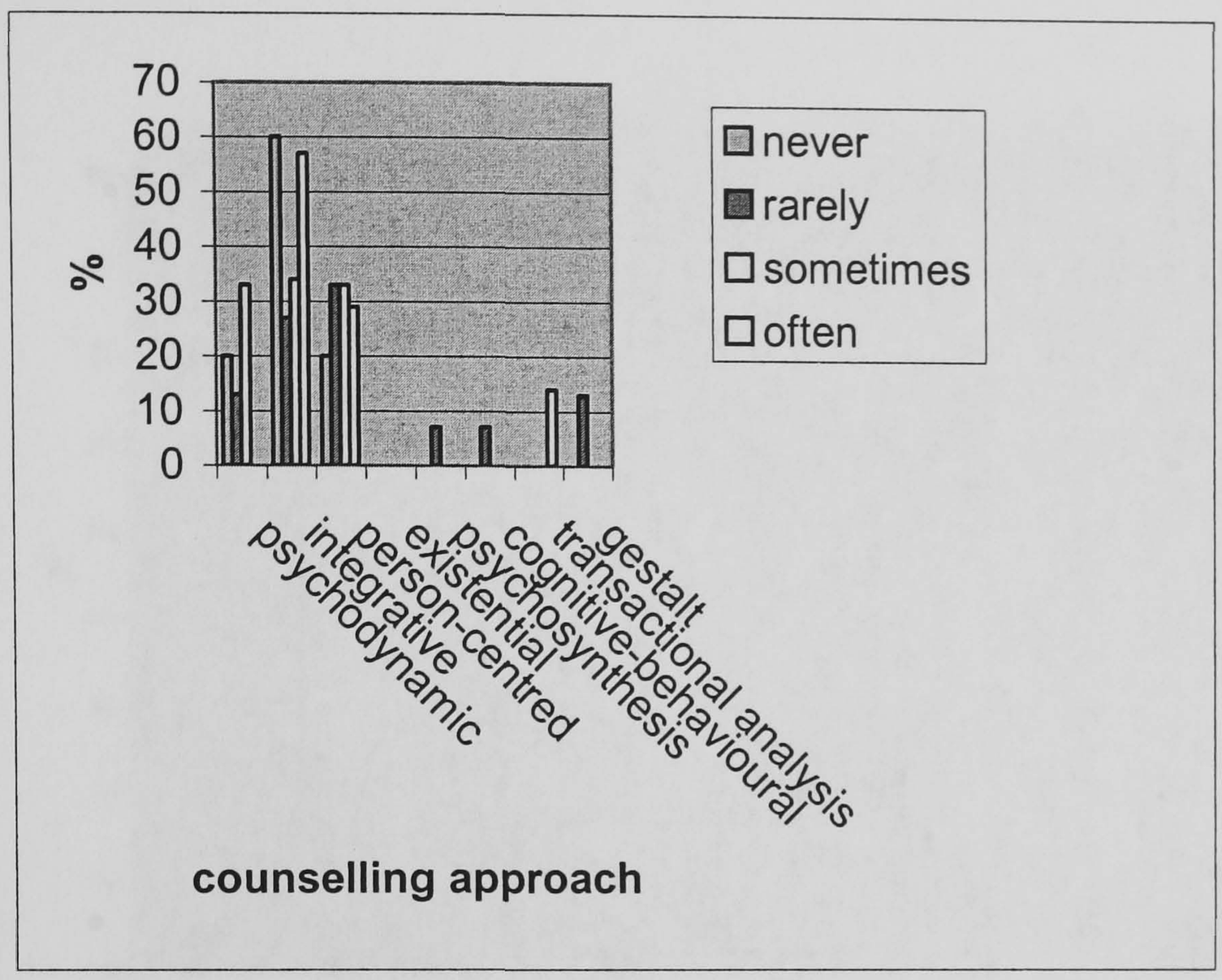
Figure 9: Percentage of counsellors affiliated to each approach

Counselling approach
Psychodynamic 37% Person-centred 26% Integrated 24% Gestalt 4% Cognitive-behavioural 3% Psychosynthesis 3% Transactional analysis 3%

6.4 Main occupational role and contact with client group (survey questions 3/4)

The following graph (figure 10) presents the results in relation to counsellors who have occupational roles other than counsellor. Such roles include social worker, nurse, teacher and support worker. Counsellors in this category who use the integrative approach appear more inclusive, whilst counsellors who do not have contact with this client group in their main occupational role are less inclusive overall.

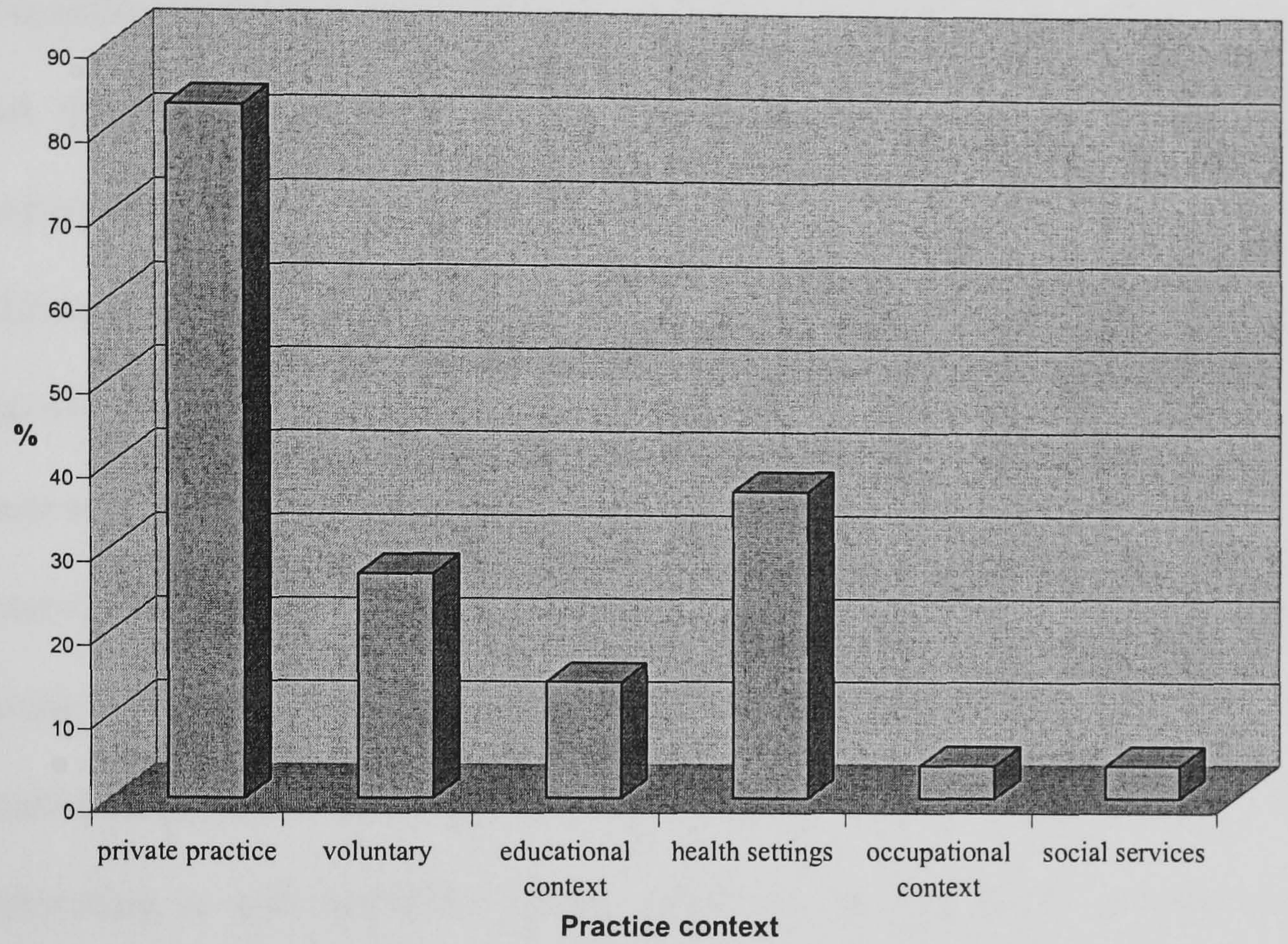
Figure 10: Counsellors who have contact with young people with learning disabilities in their main occupational role



6.5 Practice context (survey questions 5/6)

It is immediately apparent from the results of the survey (f, see figure 5, page 205) that the vast majority of counsellors (79%) are in private practice (fig. 3). This may indicate a range of private work in that counsellors may see just the occasional private client alongside their main employment or that most of their work involves private practice. The data collection methods do not allow for the differentiation of these results. Educational settings account for the practice context for 13% counsellors, with a range that includes schools, local education authorities (LEAs), college and university counselling services.

Figure 11: Counsellors' practice contexts



The results (f, survey, see figure 5, page 205) indicate that of the counsellors in private practice, 38% are affiliated to the psychodynamic approach. The second largest group of counsellors (34%) work in the health context; 27% work in the voluntary sector and 13% in educational settings such as colleges, universities and schools. A small number of counsellors work in occupational and social services contexts (13%) in each. Working within the various practice contexts is not mutually exclusive with some counsellors working in a variety of settings.

6.6 Organisational context (survey question 7)

The results (f, survey, see figure 5, page 205) indicate that the majority of counsellors are not affiliated to any particular organisation. This may suggest that they work in private practice or as freelance practitioners on a self-employed or sessional basis. Unfortunately the data collection method has not allowed for differentiation of this group. Counsellors (27%) indicate that they provide volunteer counselling for organisations such as MIND, women's' centres, CRUSE, Relate, religious organisations and charitable trusts (fig. 12). Interviews with volunteer counsellors from Cruse Bereavement Care show that young people with learning disabilities are referred occasionally for counselling, and almost always by a parent, carer or teacher. It is also interesting to note that these young people are usually in the care of social service departments as 'looked after' children or young adults in community homes with no access to counselling services other than those provided by the voluntary sector. Data from interviews (a, b, c, e, see figure 5, page 205) and feedback from awareness raising and training workshops (d, see figure 5, page 205) with voluntary counselling agencies in relation to increasing access to counselling for young people with learning disabilities indicate that counsellors in the voluntary sector are motivated towards working with this client group but would like some further skills, knowledge and support in order to build up their confidence.

Figure 12: Counsellors' organisational contexts

Organisational context	Percentage
No organisational affiliation	61.0
MIND	11.0
CRUSE	6.0
RELATE	3.0
Religious organisations	2.0
Women's centres	2.0
Employer Assistance Programmes	2.0
Independent counselling centres	2.0
NHS trust	2.0
Post-adoption services	1.5
Brooke Advisory Services	1.5
Royal College of Nursing	1.0
Police constabulary	1.0
University counselling service	1.0
LEA	1.0
Charitable trusts	1.0
Substance misuse organisations	1.0

A significant proportion (11%) of counsellors are employed by MIND, (a provider of help for individuals with mental health problems and their families), either in a paid or voluntary capacity (the data does not provide the

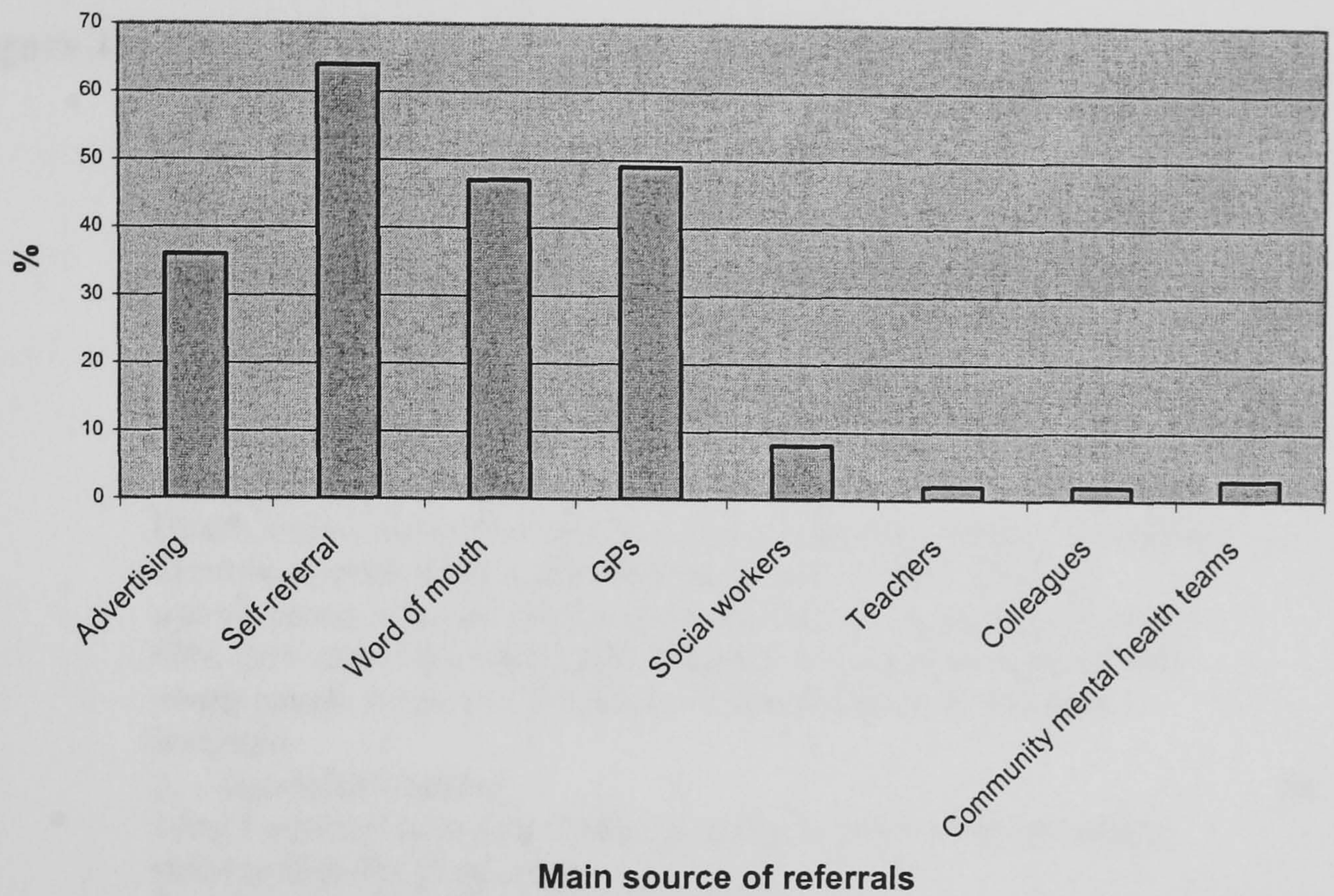
means to differentiate) and a further 6% counsellors work for CRUSE Bereavement Care, almost exclusively as volunteers. The percentage of counsellors working for other organisations is relatively small and spreads across the range presented in fig. 12.

The relationship therapy service, Relate, employs 3% of counsellors from the sample (n=396) and an equal number of counsellors provide their services to religious organisations. Women's centres and independent counselling centres together account for 4% of the organisations employing counsellors. Although only 2% counsellors work for Employee Assistance Providers there is evidence that this is an area of counselling that is increasing (McLeod, 2001b). Other organisations such as the police force, post-adoption services, charitable trusts and Brooke Advisory Services account for the remaining (5%) of counsellor's employment.

6.7 Main source of referrals (survey question 8)

Data collected on the main source of counselling referrals is related to general referrals rather than young people with learning disabilities specifically. Figure 13 presents the results from survey question 8. Self-referral, word of mouth and general practitioners are clearly identified as the major sources of counselling referrals.

Figure 13: Main sources of counselling referrals



6.8 Counsellors' suggestions for increasing access to counselling services (survey question 9)

Seventy-four percent of counsellors surveyed responded with their ideas on increasing access to counselling. Eight categories of ideas for increasing access have been identified from the survey and interview data (e, f, see figure 5, page 205) and are presented in chart form (fig. 14). They include: raising awareness, specialist training, an integrated partnership approach, expert supervision, financial support for clients, counselling practice sympathetic to special educational needs, advocacy and health promotion. Of these eight categories, the majority of counsellors (60%) suggest that counselling could be made more available to young people with learning disabilities if specialised

services, parents, carers and the young people themselves were made more aware of available counselling provision.

Figure 14: Counsellors' ideas for increasing inclusion

Hierarchy of the nine major categories of counsellors ideas for increasing inclusion of young people with learning disabilities in counselling (examples in counsellor's own words from semi-structured interviews)	%
1. Raise awareness of service Through contact with Learning Disability Directorates of Community Health Trusts, mental health link workers, appropriate learning disability charities, special schools, mainstream schools, service users and parents/carers, raise the profile of counselling in the community, visit GPs, give talks, visit youth clubs, Gateway clubs and other places that young people frequent. Advertising in BACP Directory and other literature.	**60**
2. Specialist training I feel I would plan to train further to equip myself with the necessary skills to help this client group.	**20**
3. Integrated/partnership approach It needs an integrated approach plus involvement with families and carers, but with the young people having as much control as possible.	**4**
4. Experienced supervision Supervision from an experienced practitioner who is aware of the dilemmas that such work may bring.	**4**
5. Financial support Financial support to enable clients to take up the service.	**4**
6. Practice sympathetic to SENS The practice should be sympathetic to the young person's needs i.e. access, toilet facilities etc., many of these young people have multiple disabilities.	**4**
7. Advocacy The use of advocates would be appropriate. The counselling service could be publicised to local advocacy services.	**2**
8. Health promotion work with care staff Care staff do not seem to recognise the earlier signs of emotional distress in these clients, they need to attend for training in this and on how to refer for counselling help.	**2**

Specialist training is the second significant category extracted from the data using quantitative analysis (20%). In qualitative data counsellors suggest that further training and skills may lead to increased levels of inclusivity. Although the remainder of the categories represent a minority of counsellors, they appear to be significant enough to individual counsellors to prompt quite full responses to questions in the survey and interviews.

6.9 How young people with learning disabilities find out about services (survey question 10)

The results show that there are five main ways in which this client group find out about counselling provision:

- GPs (10%)
- Social workers (10%)
- Community mental health teams/care managers (60%)
- Teachers/support staff (20%)

Counsellors have cited these as the least likely way to get referrals in mainstream counselling, with the exception of GPs.

6.10 Barriers to inclusion (survey question 11 and interview data)

Difficulties surrounding the appropriateness of counselling for individuals may present barriers to inclusion in counselling, however, this appears to locate the reasons for such difficulties solely in the individual. Qualitative analysis of the data (e, see figure 5, page 205), along with the use of simple quantitative, descriptive statistics has identified three main areas where barriers to inclusion may be located: the ***system*** (health, social care, education, voluntary sector, criminal justice, employment services), the ***counsellor*** and the ***individual with learning disabilities***. These areas of significance are presented in (fig. 15) in relation to themes identified from the data. Some themes cut across more than one area and are depicted as such. Comments and themes in each area are taken directly from qualitative data in survey questionnaires and interview transcripts. Several main themes are extracted from the data and used as part of the evidence to suggest ways in which counsellors can make their practices more inclusive and work towards removing barriers to inclusion.

Figure 15: Barriers to inclusive counselling: main themes and their location

Main Theme	Counsellor	Potential Client	Parents/carers/ teachers/health and social care professionals	System
Lack of awareness of counselling and counselling services		❖	❖	❖
Lack of awareness of the needs of young people with learning disabilities	❖		❖	❖
Lack of knowledge and experience of young people with learning disabilities	❖		❖	❖
Lack of awareness of wider issues related to disability.	❖	❖	❖	❖
Lack of resources	❖	❖	❖	❖
Lack of knowledge and awareness of counselling		❖	❖	❖
Failure to operationalise equal opportunity policies.	❖		❖	❖
Failure to prioritise young people with learning disabilities	❖		❖	❖

It is significant that, on closer inspection, the barriers to inclusion appear to be embedded in systems, counsellors and people who care for this client group rather than the individual with learning disabilities. The results (e, f, see figure 5, page 205) identifying the difficulties experienced by counsellors in their work with individuals who have learning disabilities are therefore significant in terms of potential barriers to inclusion in counselling. These results link the

difficulties experienced by counsellors to four main phenomena including clients' dependency on others and the major role that carers have in their lives; carers perceptions of learning disabilities, special educational needs and disability in general; clients' cognitions and perceptions of counselling and counsellors' lack of knowledge and experience of learning disabilities (fig. 16).

Figure 16: Difficulties experienced by counsellors in their therapeutic work with young people who have learning disabilities

Categories of difficulties (in clients' own words)	%
1. Dependency on others These young people are often dependent on carers for their mobility and support and may have a fear of rejection or abandonment.	**40.0**
2. Client cognition and perceptions of counselling Some clients treat counselling as a trip out and others expect the counsellor to solve all their problems. A lack of awareness of their situation and a difficulty in understanding the work we do.	**29.0**
3. Others' perceptions of special needs and disability Care staff may dismiss young people with learning disabilities as having a limited capacity for counselling.	**17.0**
4. Counsellors' lack of knowledge of learning disabilities I need to know more about clients' backgrounds in order to help them. I need to know about medical conditions such as epilepsy because 'absences' can affect counselling.	**14.0**

6.11 Strategies and techniques in counselling young people with learning disabilities (survey question 12)

Qualitative analysis of the data (e, see figure 5, page, 205) has identified four main categories in relation to counsellors' use of techniques, strategies and approaches to increase the inclusion of young people with learning disabilities in counselling. These are presented in fig. 17 below.

Figure 17: Strategies and techniques used by counsellors

Categories of strategies/techniques (in counsellors' own words)	%
1. Creative techniques I found visualisation works well with all young people and art therapy for those who have difficulty with speech.	**32.5**
• 2.Therapeutic relationship I try to meet with the client where they feel comfortable and work on building up the relationship, offering the core conditions.	**32.5**
3. Simplification of language Simple sentences, less use of complex speech, checking understanding. Repetition, emphasis to extra emphasis on points where there appears to be ambiguity or risk of misunderstanding on my part.	**27.5**
4. Non-verbal communication Acceptance of limitations in verbal communication, more mirroring of client's movements and the use of body language.	**7.5**

When the statistical information (f, survey, see figure 5, page 205) is broken down into counsellor sub-groups of *'rarely'*, *'sometimes'* and *'often'* a clearer picture emerges (see fig. 18). Membership of the four main categories of

helpful strategies/approaches increases with the frequency that counsellors have therapeutic contact with learning disabled young people in therapy. The use of creative techniques shifts from 16% (rarely) to 61% (sometimes), reaching a huge 83% in counsellors who 'frequently' counsel such young people. A similar pattern is observed in the category 'emphasis on therapeutic relationship', which begins at 23% in the group who rarely counsel this client group, a significantly higher percentage in the 'sometimes' (46%) and 'often' (79%) categories than those who use creative techniques. A possible explanation for this discrepancy is that counsellors are familiar with focusing on their relationship with clients (with the exception of counsellors adopting a purely behavioural approach). Therefore, the therapeutic relationship is also at the heart of most professional counsellor training programmes, whereas the use of creative techniques in counselling may not form part of training and may therefore be more dependent on counsellors' personal/professional development of their creativity. This may have implications for counsellor training and these issues are explored more fully in the discussion chapter.

Figure 18: Counsellor sub-groups in relation to the frequency of counselling and the use of techniques and strategies

	Often %	Sometimes %	Rarely %
Creative techniques	83	61	16
Emphasis on therapeutic relationship	79	46	23
Simplification of language	63	22	6
Non-verbal communication	24	0	0

My results (e, f, see figure 5, page 205) indicate that the counsellors who most often counsel young people with learning disabilities use creative techniques, put a greater emphasis on the therapeutic relationship, use simple adapted language and are more likely to use non-verbal communication. Figs. 19, 20, 21 visually depict counsellor profiles in each sub-group (rarely, sometimes and often) in relation to the four areas of significance referred to above (use of creative techniques, emphasis on therapeutic relationship, use of simple language and non-verbal communication) and provide an exploration of the way forward in building a model of good practice in counselling young people with learning disabilities. The results indicate that an increase in each of the areas of significance could lead to counsellors being more inclusive of this group of young people. The hypothesis being that in each case the shaded areas could be increased and the white areas correspondingly decreased.

Figure 19: 'Often' sub-group

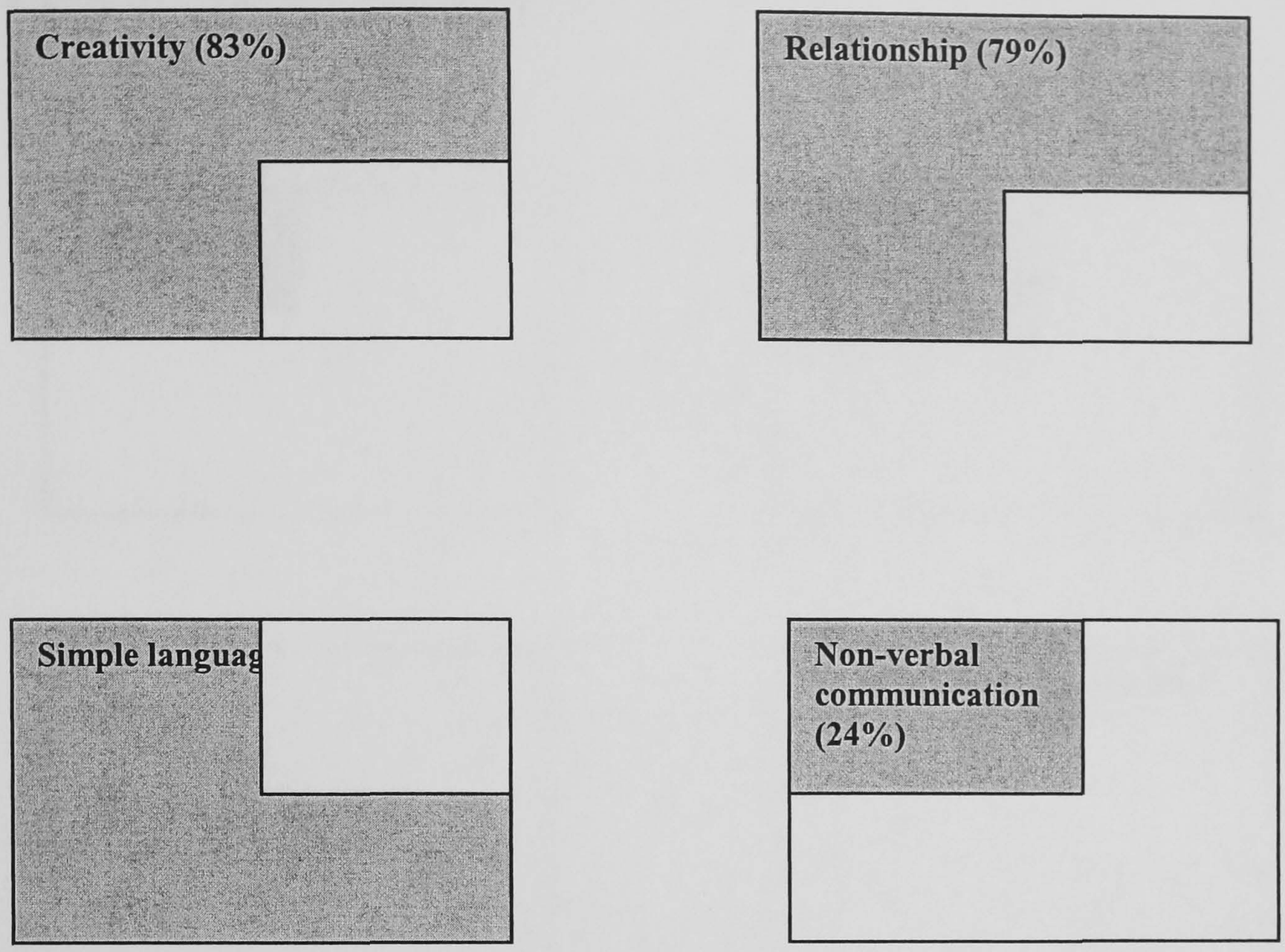


Figure 20: 'Sometimes' sub-group

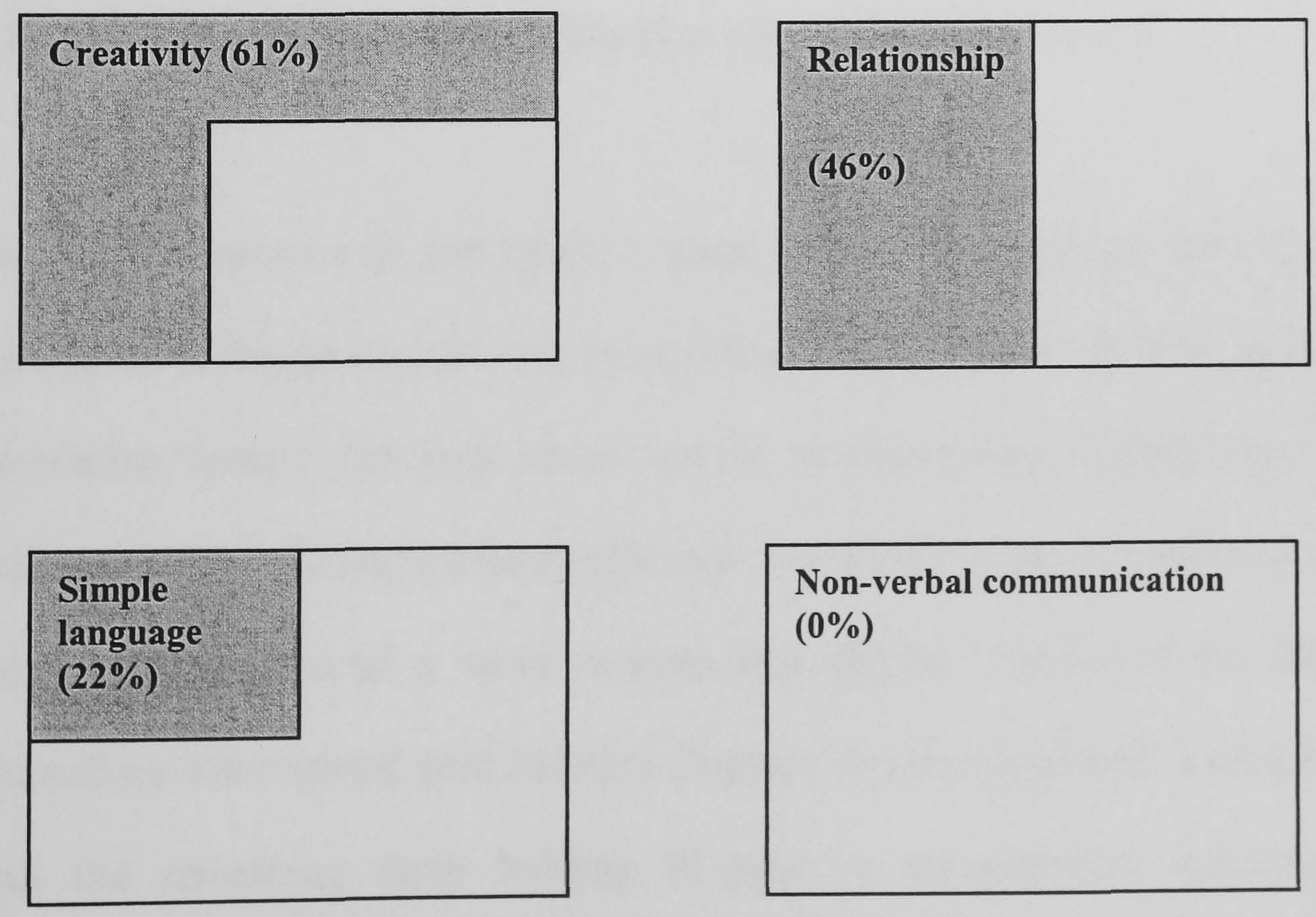
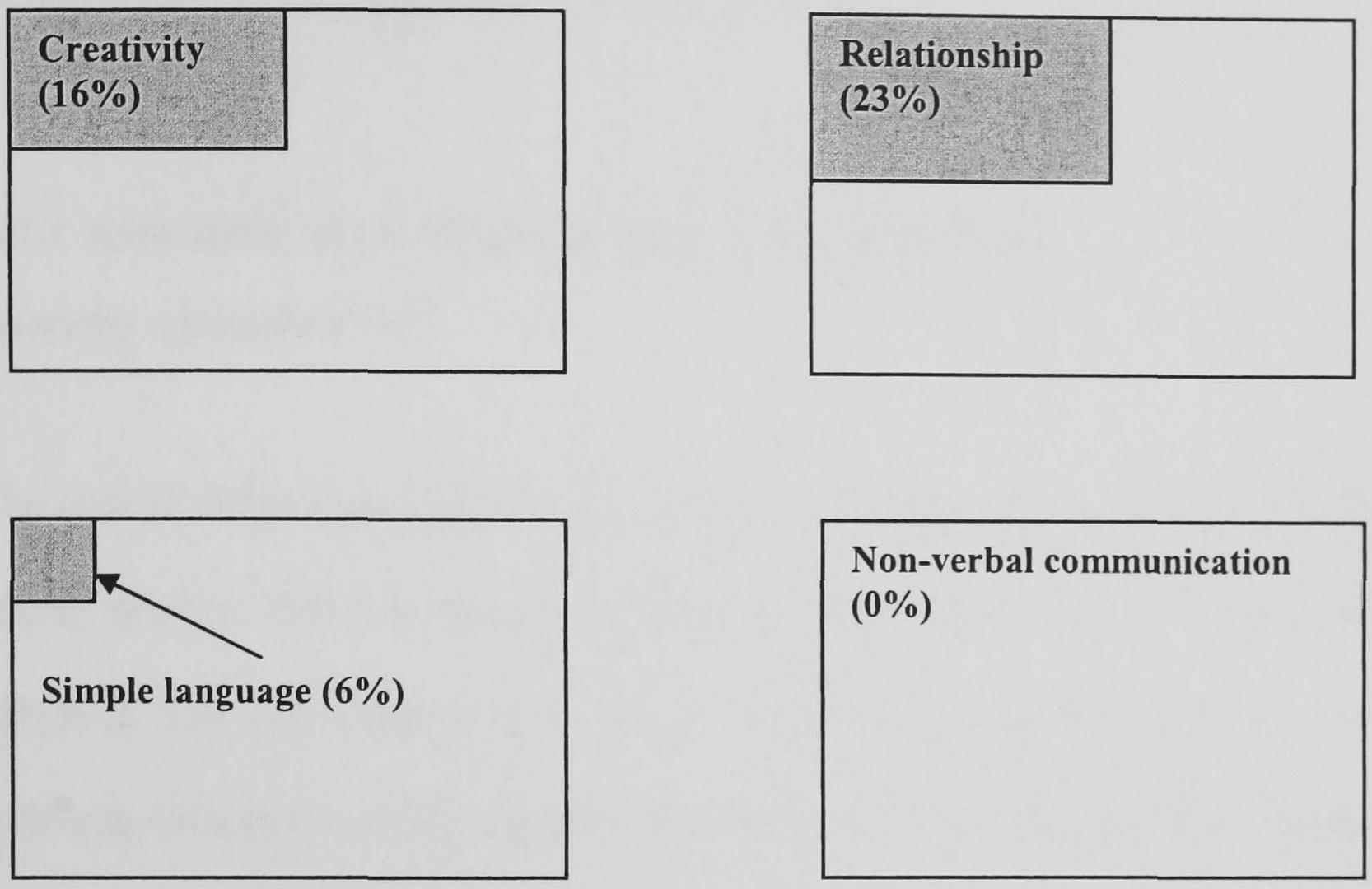


Figure 21: 'Rarely' sub-group



6.12 Qualifications and training (survey questions 13/15)

Data from interviews (e, see figure 5, page 205) with counsellors (n=15) who sometimes or frequently provide counselling for young people with learning disabilities reveals that they share certain characteristics. Firstly, they are qualified to Masters Degree level with over two thirds of these counsellors also being in possession of a social science first degree. Twelve of the fifteen counsellors interviewed held Masters Degrees in person-centred counselling, with the remaining three holding Masters in transpersonal approaches. However, this data is not statistically valid and could not be said to be

representative of counsellors in general because the provision of person-centred courses is most prevalent in the population interviewed. The interviewees in the qualitative part of this study also held a diploma in counselling, the accepted professional qualification.

6.13 Attempts to increase access to counselling (survey question 14)

The data (f, survey, see figure 5, page 205) shows that access to counselling for young people with learning disabilities is limited and that 18% counsellors surveyed and interviewed have recognised this and in response have made attempts to increase access for these clients. Fig. 22 presents the five categories into which these attempts fall. I have extracted these results from the data through firstly, qualitative, followed by quantitative analysis.

Figure 22: Categories of counsellors' attempts to increase access to counselling

Hierarchy of the five major categories of attempts that counsellors have made to increase access to counselling for young people with learning disabilities (examples in counsellor's own words from semi-structured interviews).	%
1. Relationship The most effective factor has been developing rapport with those people who enable the clients to attend. An overtly warm, friendly approach. I have given talks to groups and become known as a friendly, supportive person in their environment (college).	**39**
2. Proactive approach I mail-shot appropriate agencies. I give to talks to groups giving students chance to ask questions about what happens in counselling, for example, confidentiality, in a general informal atmosphere. This has been successful.	**22**
3. Imaginative and creative approach I use art materials when it seems appropriate and this helps to make the counselling process more accessible.	**15**
4. Eclecticism I work in an eclectic way and whatever works with these young people, I use.	**12**
5. Flexibility I make my practice flexible regarding times and appointments and accommodate carers where necessary, this means clients feel more welcome.	**12**

A significant finding (f, survey, see figure 4, page 2004) is that 39% of counsellors propose the building of relationships with the client group, their carers and other professionals as being the strategy that has been most effective in increasing access to counselling. The success of being proactive in the promotion of services is also an important finding with 22% counsellors citing

this as a good strategy for increasing inclusion. The remaining categories, the use of imaginative and creative approaches, eclecticism and flexibility, also warrant attention and together form 39% of all attempts to make counselling more inclusive.

6.14 The inclusive counsellor and indicators of inclusive counselling practice (survey question 16)

The results reflect (e, f, see figure 5, page 205) counsellors' views on what they believe to be the characteristics of inclusive counselling practice. These results are presented in fig. 23 and cite relationship building in 30% of responses. A significant proportion (21%) of counsellors believe a proactive approach to raising awareness is essential, whist 18% indicate inclusive practices would have equal opportunities policies in place. It is significant that 20% counsellors believe eclecticism, flexibility and the use of imagination and creativity to be connected with inclusivity in counselling. Counsellors (18%) cite knowledge and experience of young people with learning disabilities as being characteristic of inclusive counselling practice.

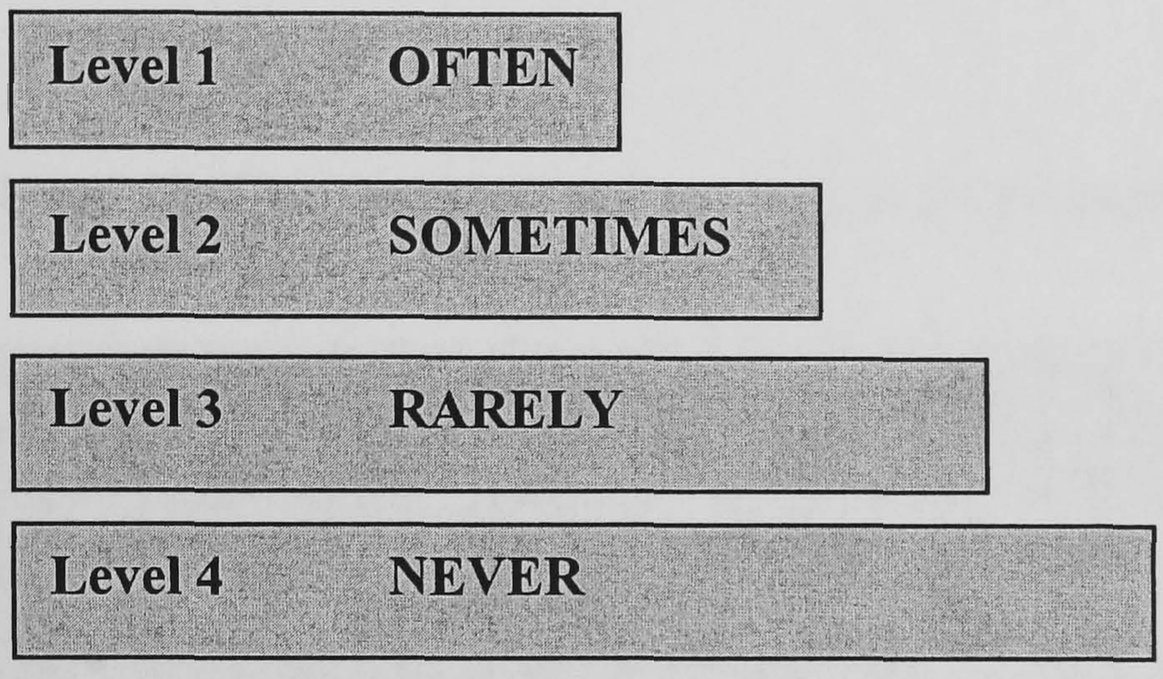
Figure 23: Categories of counsellors' views on what makes an inclusive counselling practice

Counsellors views on the characteristics of an inclusive counselling practice: 6 categories of responses with examples in counsellors own words (in hierarchical order)	%
1. Relationship building	**30**
Open, welcoming, accessible in every way.	
Such a practice would have to be warm and friendly and overtly welcoming.	
Simply find a way of being with the client.	
A practice where relationship building is paramount and the client is valued and respected.	
2. Proactive approach	**21**
Service advertised and promoted in areas likely to be frequented by young people and their carers.	
Proactive approach to developing rapport and trust with those who can refer clients and those in the client's personal life, if appropriate.	
Networking is important.	
Discuss referrals with GPs.	
3. Flexibility and Eclecticism-use what works/imaginative and creative approaches	**20**
One where the counsellor can match and utilise resources to meet the needs of clients, drawing on a wide range of theory and experience.	
Assessment is important to see what best fits the client's needs.	
Times of each session can vary to suit the client's attention span.	
Be able to adapt to the needs of the client. Creative ways of working in counselling would help to include these young people.	
Being imaginative and creative in your approach to counselling.	
4. Operates equal opportunities policy/include all	**18**
Inclusive, not an expression I am familiar with but I operate an equal opportunities policy and exclude no one.	
Counsellors must follow equal opportunities policies.	
5. Knowledge and experience of learning disabilities	**11**
Knowledge and experience of learning disabilities and the client group can be beneficial.	

The survey data (f, see figure 5, page 205) related to the frequency of counselling young people with learning disabilities can be assigned hierarchically to four levels of inclusiveness (see fig. 24). By presenting the results in this way the concept of inclusion in counselling be seen as a process

rather than as a static entity, with the most inclusive counsellor being represented by level 1 and the least inclusive counsellor by level 4. It may also be perceived that the most inclusive level (level 1) may be an ideal to aim for.

Figure 24: Hierarchy of inclusivity



The data (e, f, see figure 5, page 205) in relation to the following variables is presented and positioned in relation to the above four levels of inclusiveness in order to identify any differences between the various groups of counsellors and highlights characteristics of the more inclusive counsellors (fig. 25). The results show that the most inclusive counsellors are integrative, person-centred or psychodynamic in their theoretical approach. The psychodynamic approach is also, paradoxically, a characteristic of the least inclusive counsellors. The most inclusive counsellors counsel as their main occupational role. Counsellors within the highest inclusion category of level 1 work in health settings for NHS trusts. Their referrals are through word of mouth (care managers, teachers, carers and GPs). At first glance it appears significant that the least inclusive counsellors (level 4) are clinical psychologists. However, this may be

explained by the specialist nature of many clinical psychology practices resulting in many young people with learning disabilities being referred to the clinical psychologist responsible for this client group. Those counsellors reliant on self-referrals are the most exclusive in their practices. Care managers, GPs and teachers appear to provide the greatest number of referrals to the most inclusive counsellors.

Figure 25: Characteristics of inclusivity in relation to levels

Counsellors' level of inclusivity in relation to the variables (see Fig. 13)				
	More inclusive		Less inclusive	
Variable	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Theoretical approach	Integrative Person-centred Psychodynamic	Person-centred	Psychodynamic	Psychodynamic
Main occupational role	Counselling	Educational support work	Social work	Clinical psychology
Practice context	NHS Trusts	Education Health	Social services Voluntary (e.g. Cruse, Relate, Rape Crisis)	Workplace (EAPs) Private practice
Main source of referrals	Carers GPs Care managers Teachers Active promotion of service	Carers GPs Teachers Care managers Social workers, Voluntary agencies Specialist consultant psychiatrists Community psychiatric nurses Parents FE colleges Active promotion of service	GPs Self-referral Teachers Care managers	Self-referral Advertising

6.15 Interview data

Semi-structured interviews (n=15) were recorded and extensive notes were taken around the main points (see interview schedule in appendix). Themes and categories were grouped together and collapsed into clusters within the main areas used in the structure of the interviews. The data are presented in the form charts and direct quotes. The purpose of this data is to enrich the survey results and provide examples from practicing therapists. The main themes identified from interview data are presented in the following figure 26.

Figure 26: Main themes identified from interview data

Main themes identified from interview data
Appropriateness of counselling for young people with learning disabilities
Indicators of inclusive counselling practice
How counsellors have tried to be inclusive/strategies and techniques
Difficulties experienced when counselling young people with learning disabilities

6.14.1 Appropriateness of counselling for young people with learning disabilities

The data collected from interviews (e, see figure 5, page 205) with counsellors (n=15) who have experience of counselling young people with learning disabilities has been subjected to qualitative analysis, producing four main categories of responses that can be aligned to the survey data. These results are presented in tabular form below (fig. 27) and offer support for the hypothesis

that counselling is not an appropriate intervention for all young people with learning disabilities. The results show that counsellors believe there to be four main qualifying categories that need to be taken into consideration when assessing the appropriateness of counselling for individuals with learning disabilities.

Figure 27: Assessing the appropriateness of counselling

	Appropriateness of counselling – Qualifying Categories
1	Communication
2	Ability to process information
3	Ability to engage with the counselling process
4	The level of learning disability

It is significant that deficits in two of the categories, communication and the ability to process information, are also the main concomitants of learning disabilities. One interview gave the following response when asked what her views were on the appropriateness of counselling for young people with learning disabilities:

> …I have only counselled one girl who had learning disabilities
> …I feel ashamed to say that I found it really hard going…..
> I found myself thinking that this wasn't appropriate for her but really I just don't know…..how I am I supposed to know whether counselling is working for such clients when I don't even know if counselling is right for anybody I see… .its just my judgement, isn't it? I don't feel qualified to judge basically. I suppose if they can really engage with the process, however they do this, counselling might be ok for them.

Another counsellor was very specific about the appropriateness of counselling:

> I think it depends on the level of learning disability, therefore it's a very individual thing. Some kids have such severe problems that counselling just would not be appropriate. I would say that kids with milder learning disabilities would manage well in counselling, so long as they could take part in reciprocal communication and understood what was going on.
> (Interviewee 7)

The ability to connect with the counselling process may be dependent upon the first two categories. The second significant result is that the appropriateness of counselling is reported to depend on the level of learning disability present in the individual. The level of learning disability directly affects the individual's ability to communicate and to process information. Moreover, the level of learning disability is actually classified by the ability to both communicate and to process information (DSM-VI; ICD-10).

6.14.2 Indicators of inclusive counselling practice

Five indicators of inclusive counselling practice that corresponded with the survey responses were identified and a direct quote from the data is given in each category:

- Relationship building

> ...such a practice would be warm and friendly and overtly welcoming...a practice where relationship building is paramount and the client is valued and respected.
> (Interviewee 9)

- Proactive approach

> An inclusive counsellor would need to take a proactive approach, especially towards developing rapport and trust with those who can refer clients and be proactive with others in the client's personal life, if appropriate.
> (Interviewee 4)

- Eclecticism

> The counsellor would need to match and utilise resources to meet the needs of such clients, drawing on a wide range of theory and experience and basically just using what works without being precious about their therapy approach.
> (Interviewee 7)

- Equal opportunities policies

> I think that any counsellor claiming to be inclusive would be laughed at if they didn't have an equal opportunities policy. ....but in reality they might appear inclusive without actually including diverse clients groups...lip service...lots of big organisations are the same...employing the nominal black or disabled person....
> (Interviewee 11)

- Knowledge and experience of learning disabilities

> Counsellors would have knowledge and experience of learning disabilities and the client group...most people don't and counsellors are no different to the rest of the population. Lack of knowledge and awareness leads to prejudice and assumptions.
> (Interviewee 14)

By being proactive counsellors may also raise awareness of counselling. Data relating to this is presented in figures 28 and 29.

Figure 28: Targets for raising awareness of counselling services for young people with learning disabilities

Suggested by interviewees:
❑ Young people with learning disabilities ❑ All young people ❑ Parents/carers ❑ Primary care professionals, including GPs, health visitors, district nurses, community psychiatric nurses, occupational therapists ❑ Young people's organisations and projects, e.g. National Children's Homes, 'Place to Be' project. ❑ Voluntary and statutory counselling services, e.g. Cruse, Relate, MIND, Rape Crisis, and occupational counselling providers. ❑ Counsellors in private practice

Figure 29: How awareness may be raised

Suggested by interviewees:
❑ Give talks to groups, e.g. young people (with and without learning disabilities), parents/carers, professionals, organisations. ❑ Drop-ins –regularly to day centres ❑ Outreach work ❑ Disability Awareness sessions ❑ Advertising and promotion in areas likely to be frequented by young people with learning disabilities and young people in general. ❑ Advertising in BACP directory/specialist areas ❑ Mail-shot appropriate agencies and organisations ❑ Discussions with GPs and Primary Health care teams ❑ Workshops and training sessions for counsellors ❑ More specialist training at baseline/within counselling training programmes

6.14.3 How counsellors have tried to be inclusive: techniques and strategies

The results from a qualitative analysis of interview data are presented below, showing the four main areas of response that correspond with responses to the survey and direct quotes from interviewees:

- Creative techniques

  I have found visualisation works well with all young people, they usually really enjoy it and become motivated towards change. Art therapy works well for those who have difficulty with speech.

  (Interviewee 5)

- Therapeutic relationship

  I work on building up the relationship right from the beginning, offering the core conditions and really accepting the client. Young people often have such negative views of themselves, its such a shame.

  (Interviewee 9)

- Simplification of language

  I have found that by using simple sentences and less complex speech, along with checking The client's understanding helps. Repetition, extra emphasis on important points and checking out where there appears to be ambiguity or risk of misunderstanding on my part is part of counselling anyway.

  (Interviewee 12)

- Non-verbal communication

  It would be better if the counsellor could just accept the client's limitations in verbal communication and make more use of non-verbal communication. more mirroring of client's movements and the use of body language.

  (Interviewee 8)

6.14.4 Difficulties experienced when counselling young people with learning disabilities

Counsellors indicated difficulties that they had encountered when counselling this client group. These difficulties could be assigned into four categories that corresponded with data from the survey and are presented below along with direct quotes from interviewees:

- Dependency on others

> These young people are often dependent on carers for their mobility and everyday personal care support and they might try to please carers and their counsellor. The may be very dependent on the counsellor for guidance and advice and may not be used to making their own decisions and having ideas that they share with others. They may also have a fear of rejection or abandonment if they speak out with their own views. I have found difficulties around these areas.
>
> (Interviewee 6)

- Client cognition and perceptions of counselling

> Its really annoying because some clients treat counselling as a trip out, like going shopping or to the swimming baths. Others expect me to solve all their problems, though I suppose there are other clients who also do that, and they don't have learning disabilities. A lack of awareness of their situation and a difficulty in understanding the work that counsellors do is also problematic at time.
>
> (Interviewee 11)

- Perceptions of special needs and disability in others

  In my experience care staff can dismiss young people with learning disabilities as having a limited capacity for counselling and in need of behavioural management rather than emotional support.

  (Interviewee 14)

- Counsellors' lack of knowledge of learning disabilities

  I need to know more about clients and their specific type of learning disabilities in order to help them. I don't feel as if I know very much about learning disabilities at all and this feels dangerous regarding my counselling practice.

6.15 Rationale for making counselling more inclusive of young people with learning disabilities

The evidence in support of the hypothesis that counsellors should make their practices more inclusive is to be found in the literature on social inclusion/exclusion and rests on the issue of human rights and particularly the human rights legislation that underpins equal opportunities policies. A list of relevant policy documents and legislation is presented in chart form in fig. 30 below. Data from research on mental health problems in young people with learning disabilities and dual diagnosis along with counselling efficacy studies

provides support for a greater level of inclusiveness in counselling practice (DoH, 2001; Prosser, 1999).

Figure 30: Documents to support inclusion

	Human Rights documents and legislation
2001/2	Mental health policies
2001	Family Matters: Counting Families In (DoH)
2001	Valuing People: A New Strategy for Learning Disability (DoH)
2001	From Words into Action: The London Strategic Framework for Learning Disability Services, NHS Executive
2000	Connexions: The Best Start in Life for Every Young Person, HMSO, London
1999	Saving Lives: Our Healthier Nation (DoH)
1999	Human Rights Act (HMSO)
1999	Disability Rights Commission Act, HMSO
1999	Facing the facts: Services for People with Learning Disabilities: Policy Impact Study of Social Care and Health Services (DoH)
1999	All Our Futures, Creativity, Culture and Education, National Advisory Committee on Creative and Cultural Education (DfEE)
1998	Meeting Special Educational Needs: A Programme for Action (DfEE)
1998	Signposts for Success in Commissioning and Providing Health Services for People with Learning Disabilities, Dept. of Health, HMSO, London.
1997	Maastricht Guidelines on Violations of Economic, Social and Cultural Rights
1996	Disability Discrimination Act, DfEE, HMSO, London
1994	Policy Statement on Inclusion, Council for Disabled Children, London
1994	The Salamanca Statement (UNESCO)
1993	United Nation's Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, Disabled Person's Unit, Department for Policy Co-ordination, New York.
1992	Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs, Dept. of Health, HMSO, London
1992	Health Services for People with Learning Disabilities, Circular HSG, 92, 42, Dept. of Health, HMSO, London
1992	Social Care for Adults with Learning Disabilities, Circular LAC, 92, 15, Dept. of Health, HMSO, London
1992	Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services, Dept. Health and Home Office, HMSO, London
1990	European Convention for the Protection of Human Rights and Fundamental Freedoms
1989	The UN Convention on the Rights of the Child, Articles 2, 23, UNICEF, London
1975	The UN Declaration on the Rights of Disabled People, Disabled Person's Unit, Dept. for Policy Co-ordination, London.
1971	UN Declaration of Rights for Mentally Retarded Persons (UN)
1969	Declaration of Social Progress and Development (UN)
1948	Universal Declaration of Human Rights

Inclusion is high on the political agenda both nationally and internationally. There is a progressive move towards policies on human rights issues, a movement that has accelerated since the Second World War. National policies and related projects include:

- Social democracy and Third Way politics
- The Social Exclusion Unit
- New Deal
- Sure Start
- Literacy and numeracy programmes
- National Curriculum for Citizenship

The mental health needs of those with learning disabilities have become increasingly visible as a result of policies to move individuals from institutions into smaller homes in the community or from special schools and colleges, often residential, into mainstream education. Recent research has also prompted a growing awareness of the prevalence of psychiatric disorders in this population (Prosser, 1999).

6.16 Summary

This chapter has presented results from quantitative and qualitative analysis of the data. These results have related directly to the research questions, survey questions and interviews and provide the evidence to be used as a basis for analysis and discussion in the next chapter. However, not all results will be referred to in the discussion, choices will be made regarding the value of the results to building a model for good practice. The intention has been to present data that can challenge my hypothesis that counsellors can make their practices more inclusive of young people with learning disabilities. It appears from the

results that mainstream counselling does largely exclude this client group and that there are identifiable differentials in the variables of counsellors who include and those who exclude. The data has shown that by raising awareness of counselling amongst the client group, their carers and professionals; also through awareness-raising regarding learning disability in counsellors and health/social care professionals it may be possible to increase inclusivity in counselling. The results of documentary research situate the reasons for increasing inclusion in the human rights movement, policies and legislation. It is significant that the results identify inclusive counselling practice as a process rather than a static entity or phenomenon, indicating four levels of inclusivity. It is apparent from the data that counsellors working in health settings are the most inclusive with the majority of their referrals coming from care managers, GPs and teachers. Clinical psychologists and counsellors relying on self-referral appear more likely to exclude young people with learning disabilities. Four areas of assessment of the appropriateness of counselling have been identified from the data. The results show that the main barriers to inclusive counselling practice are linked with a lack of knowledge and experience of young people with learning disabilities, their needs and wider issues related to disability. There is also a failure to operationalise equal opportunities policies and a general lack of awareness of counselling amongst the client group and health and social care professionals. The results indicate that the difficulties counsellors face in their work with these young people can also provide barriers; these include the dependence of individuals with learning disability on others and their misconceptions and lack of understanding of counselling.

Finally four areas of significance that can be increased to improve the level of inclusivity in the counselling process have been highlighted, namely, the use of creative techniques; an emphasis on the therapeutic process; the simplification of language and non-verbal communication. In the following section I evaluate the results in relation to the literature and develop a model for inclusive counselling practice.

Chapter 7: Discussion and Model for Inclusive Counselling Practice

7.1 Introduction

This following discussion presents, explores and evaluates the results derived from survey and interview data relating to counsellors and their practices in three major contexts in order to build of a model of inclusive counselling practice in relation to young people with learning disabilities. This process involves examining inclusion in counselling and the potential for change; the case for inclusivity and the appropriateness of counselling individuals with learning disabilities; removing barriers to inclusion and increasing access to counselling. Firstly, information regarding the characteristics of counsellors and their practices is examined. This involves identifying characteristics that may prove useful in developing indicators for making counselling more inclusive. Secondly, information regarding counselling practices and data that may provide new insights into the organisation and running of counselling services in relation to inclusion is evaluated. The research problem addressed in the study is concerned with the inclusion of young people with learning disabilities in the counselling practices of counsellors advertising their services in the BACP directory and, by implication in counselling generally.

Specifically, the study has identified indicators of inclusive counselling practice, the potential of increasing inclusion of this particular client group in counselling and barriers that may exist to prevent this process from taking place. The results may also infer that barriers to the inclusion of other marginalised individuals and groups may be detected and addressed. Evidence to support the thesis that counsellors can make their practices more inclusive of young people with learning disabilities is critically examined and discussed in this chapter and a framework or model of good practice in counselling these individuals is constructed and presented.

Counsellors, although providing services to the public, by the very nature of the confidential quality of their work, carry out their practices in a private, rather than public arena. Moreover, counsellors are responsible for assessing whether therapy is, in fact, appropriate for individual clients. They have a great deal of autonomy over the type of therapy they use with individual clients and within organisational limits may control the number of sessions each client is offered. This study places the issue of inclusion of young people with learning disabilities in the counselling context under scrutiny in the public domain and examines practices and processes that either include or exclude these young people.

Some counsellors do provide counselling to young people with learning disabilities, this has been identified from the data. However, it has been necessary to explore the degree of exclusion/inclusion of this counselling

provision in order to identify any characteristics that may be indicative of more inclusive counselling practices. The quantitative and qualitative differences and similarities between the various groups of counsellors in relation to the variables will be discussed. During the data collection process pre-pilot work highlighted the difficulties involved in asking counsellors to quantify their counselling provision to young people with learning disabilities. Only those counsellors who did not make such provision were able to answer this question with any degree of accuracy ('never'). However, the pre-pilot study identified several words used by counsellors in relation to the frequency of counselling that I have adapted and used in the survey: ***'never'***, ***'rarely'***, ***'sometimes'*** and ***'often'***. Whilst accepting the scientific limitations of this measurement tool and its subjectivity, the scale provides a useful indication of a phenomenological perception and demarcation in frequency of counselling by counsellors themselves. This demarcation has enabled the identification of the two main groups and three sub-groups of counsellors at different levels of inclusivity. I will discuss characteristics that are similar or different in these groups, which seems more relevant to this study than measuring the frequency of counselling in a statistically accurate way. Therefore the subjectivity of the measurement tool and its effects upon potential generalisation of the findings may be of lesser consequence.

7.2 *Inclusion in counselling: potential for change*

The findings of this study need to be interpreted with some degree of caution. It could be argued that willingness to participate in a research study of this nature might be influenced by whether or not the respondent had been involved in counselling this client group. Therefore, it may be expected that the results be skewed in favour of over-representing those who do counsel these young people. However, the evidence suggests otherwise, that the majority of counsellors who took part in this project (n=396) do not counsel young people with learning disabilities. Moreover, the weight of evidence suggests that counselling is an intervention that excludes these young people, reflecting the views of Lindsay (1999) and Prosser (1999) in that people with learning disabilities are often excluded from therapeutic help for psychological problems. A report produced by the Royal College of Psychiatrists (2004) found that people with learning disabilities do not have parity of access to mainstream psychological services. Although at first glance the results of this research study may seem negative in their claim that counselling excludes, they indicate that there is a hierarchy of inclusivity/exclusivity with the potential for positive change. Mackay *et al.,* (2000) highlight the difficult processes that some counsellors may go through when making significant changes to their practices and there are parallels here with processes involved in inclusive schooling (Dyson *et al.*, 2004). As suggested by (Visser, 1999) inclusiveness can therefore be described as a dynamic process rather than a static entity and despite the patchy and variable nature of inclusion in counselling practices, it

has been possible to place inclusion on a continuum or scale. Although this research study can only provide a snapshot of inclusivity at the time the study took place, the dynamic influence of the research process itself has been the catalyst for positive change in counselling practice. Feedback from counsellors taking part in the interviews indicates that a greater level of awareness of the needs of this client group has motivated them to change their practices leading to increases in inclusion, this represents a process of reflexivity as referred to by McLeod (2001b).

The results of this study make the distinction between two main groups of counsellors, firstly, those who counsel young people with learning disabilities and secondly, those who do not have any therapeutic counselling contact with this client group. A comparative study of these counsellors along with an exploration of differences between counsellors providing different levels of inclusion has provided useful information that has enabled me to build up profiles of counsellors and counselling practices at four different levels of inclusivity. I have also used this information to produce a model of good practice for the inclusion of young people with learning disabilities in counselling. There is the potential for building on this work and developing a code of practice and guidelines for inclusion in counselling.

However, to return to the issue of exclusion in counselling and a critique of the results of this study the primary difficulty in accepting the findings at face value seems to lie in a flaw in the data collection. Although the majority of

respondents indicated that they did not counsel young people with learning disabilities the survey question relating to this did not allow for respondents to indicate that they did not counsel ***young people*** regardless of whether the young person had learning disabilities. Although I believe this to be significant with regard to the survey data, the findings from interviews and workshop feedback are not flawed in this way, thereby giving me greater confidence in using the survey results.

7.3 The case for inclusivity and appropriateness of counselling for young people with learning disabilities

It is implicit in the thesis that counsellors should make their practices more inclusive of young people with learning disabilities. However, it is imperative to ask the question: 'Why should counsellors include this group of young people?' in order to begin an exploration of the appropriateness of counselling for these young people. This study shows that therapists believe counselling not to be appropriate for all young people with learning disabilities, this is also a finding by the Royal College of Psychiatrists (2004). Suitability is dependent on four main qualifying categories: communication (DSM-IV); ability to process information (Numminen *et al.,* 2000); ability to connect with the counselling process and relationship (Sinason, 2002; Borgatti, 2001; Ratiasuo, 2001) and the level of learning disability (WHO, 1996). Although this research found that the ability to process information was important for clients, Sinason (1994) suggests that emotional intelligence is a more important quality to enable therapy to be successful. Hornby (2003) provides useful suggestions regarding inclusion through counselling. This information could prove useful

in the initial assessment of clients and help counsellors to allocate resources appropriately on behalf of statutory and voluntary agencies. Due to the ill-defined and ambiguous nature of the four qualifying categories it would be necessary for the counsellor to make judgements based on concepts that are by their very nature difficult to define precisely. Whilst accepting that counselling may not be appropriate for all potential clients, the assessment of the appropriateness of counselling based upon such indistinct qualifying categories could in itself become an excluding practice. According to the results of this study such assessments could only be classed as inclusive practices if the individual's level of communication was assessed by a counsellor who was able to build up enough of a relationship with the client in order to recognise and make the best use of whatever level of communication was present. In order to engage in the counselling process it appears necessary for the client to be able to process information (WHO, 1996). However, difficulties with communication and cognitive processing are concomitants of learning disabilities (WHO, 1996; DSM-IV, 1994), making the ability to communicate only the first step in assessing the appropriateness of counselling for the individual.

At this point in the discussion it seems prudent to return to the issue of exclusion in counselling. The results show that young people with learning disabilities do appear to get a raw deal when it comes to accessing counselling, especially when counselling is described as an effective therapeutic intervention for individuals with psychological problems (DoH, 2001).

However, the results of this study are encouraging in their indication that there is the potential for increasing inclusiveness in counselling practice, some practitioners do provide inclusive strategies and techniques (Hornby, 2003). Higher levels of mental illness in people with learning disabilities (Prosser, 1999; Lindsay, 1999), the phenomenon of dual diagnosis along with the results of social factors such as: bullying (DfES, 2001a), pressure to achieve academically, negative attitudes to disability, vulnerability, emotional, physical and sexual abuse can cause low self-esteem, lack of confidence, psychological and behavioural symptoms leading to an even greater need for counselling provision (Hard and Plumb, 1987; James, 1988; Elvick *et al.,* 1990; Buchanan and Wilkins, 1991; Finkelhor, 1994; Sobsey, 1994; Brown *et al.,* 1995; Etherington, 1995; Chenowith, 1999, 2000). Why is it so important to include young people with learning disabilities in counselling? Why now? These questions also apply to inclusive schooling (Dyson *et al.,* 2004) and much can be learnt from the processes and practices of inclusion that have been developed in this field. Human rights issues and the movement towards social inclusion coupled with educational policies supporting the inclusion of children and young people with disabilities in mainstream education make the issue of inclusion in counselling more timely (DfEE, 1998; DoH, 2001). The increasing provision of school counselling indicates that strategies may need to be put in place in order to ensure a parallel process of inclusion for children and young people with learning disabilities, as promoted by Hornby *et al.,* 2003). It is encouraging that counsellors have identified ways of increasing access to counselling. This indicates at least a willingness and motivation to increase

inclusivity. Moreover, such improvements appear to be achievable, at least to some degree.

7.4 Removing barriers and increasing access

The main research findings are focused in two areas, firstly on the identification of counselling as excluding rather than including young people with learning disabilities and secondly, on the notion of inclusion as a hierarchical process with counselling having the potential for positive change. It seems useful at this point to explore exactly what it is about counselling that excludes young people with learning disabilities. The word exclude comes from the Latin word *claudere*, which means closed or shut. What happens to close off counselling to these young people? Where does the responsibility for exclusion lie? The counsellor forms a necessary part of the whole picture and is reported to be of great consequence in the therapeutic process (Smail, 2000; Corey, 2001; Rogers, 1951, 1962), therefore it seems imperative to explore the sphere of influence that counsellors have regarding the inclusion of young people with learning disabilities in their practices. It is possible to use these results to build up a profile of an inclusive counselling practice. The results of this study locate the reasons for exclusion in four major domains, the counsellor, the system, the individual with learning disabilities and significant others such as carers, parents, health and social care professionals. This information can be used to find ways of removing barriers to inclusion, beginning with the counsellor.

7.4.1 Counselling in primary care

Time is a resource that seems to be in short supply for the counsellors taking part in this research study. Paradoxically, the results show that the counselling practices most likely to include young people with learning disabilities may also, by the very nature of the type of provision, be more likely to exclude. According to the survey findings counsellors in primary health care are amongst the most inclusive of young people with learning disabilities. However, counsellors report that the type of therapy usually offered is brief therapy, lasting around six sessions. These findings are supported by my supervision work with counsellors in primary care and by the literature (DoH, 2001). Initially, I was encouraged to find that counsellors working in primary care were inclusive of young people with learning disabilities. However, these initial results were based on a statistical analysis of the survey data alone, unfortunately, it was only when the qualitative data from interviews was examined that the potentially excluding nature of counselling in primary care was apparent. The following quote from a counsellor in primary care encapsulates the problem well:

> There is no time to counsel these young people because appointments are limited to six sessions and they need more time. I'm told to refer on in order to clear the waiting list, so they are effectively shunted elsewhere, to social workers and psychologists, where they receive 'management', a behavioural programme rather than counselling.

One could locate the barriers to inclusion in this case within the health care system, in spite of the results showing that counsellors in primary care are most experienced and inclusive in working with young people with learning disabilities. Putting the difficulties with time-limited therapy aside, counsellors in primary care also report that they have little time to be proactive in promoting counselling for this client group because many of them are paid sessional rates, restricting their time to face to face contact with clients only. This seems to negate international and national health targets aimed at improving mental health, especially when mental health problems have been shown to be higher amongst individuals with learning disabilities (Lindsay, 1999; Prosser, 1999). Part of the problem may lie in the organisation and management of primary care, which is decentralised into Primary Health Care Trusts, each setting their own priorities for health care based upon local needs as well as national targets. In order to attract higher levels of funding counsellors would need to be more proactive in their approach, becoming more visible and putting themselves in better positions to represent both counselling and young people with learning disabilities. In order to attract more funding it would be necessary to put forward a strong case based on some form of evidence. Although this research may be useful to counsellors who are motivated towards taking the case forward, without adequate time resources it may be an impossible task. As a supervisor of several counsellors working in primary care, it appears that in spite of having the motivation, the lack of time due to the nature of their employment contracts remains an insurmountable barrier. These counsellors, who may not be representative, work in several

different GP practices, alongside other types of counselling or health and social care work in order to earn a reasonable salary. Moreover, they often work in isolation, making access to the systems associated with the allocation of funding more difficult. This process in some way seems to mirror the marginalisation experienced by many young people with learning disabilities. What at first glance seems a fairly simple way of increasing access to counselling is therefore more complex and difficult to achieve without first addressing the issues related to the employment of counsellors in primary care and the restrictive nature of employment contracts based upon payment for sessional work.

Counselling could be made more accessible by raising awareness of available counselling provision amongst the young people themselves, their parents, carers and the agencies that provide their education, health and social care. Concrete, practical ways of raising awareness include giving talks, running disability awareness sessions, advertising and promotion, such as mail-shots and posters, discussions with appropriate professionals and workshops/training sessions for counsellors. However, if such simple measures would help to increase levels of inclusivity in counselling, why are they not happening already? Who would be best placed to promote counselling in these ways? Counsellors? Counsellors are such a disparate group and the results of this study indicate that few are experienced enough with this client group to take on the role of increasing awareness in others. However, it is interesting to note that some counsellors in private practice are having success in promoting their

practices and increasing access to this group of clients by mail-shots to appropriate agencies and by increasing the flexibility of their practices. When interviewed for this study one counsellor in private practice said:

> I increase access by making my practice flexible regarding times and appointments and accommodate carers where necessary, this means clients feel more welcome.

By being self-employed and negotiating contracts with a local social services department this counsellor had the flexibility, the freedom and the financial motivation to be proactive and increase accessibility. Counsellors in primary care do not usually have such control over times and appointments, having to fit into already busy practice schedules regarding availability of rooms and times. Who else is well placed to raise awareness of counselling services?

7.4.2 Counselling in education

Counsellors working in education may be well placed to raise awareness and promote counselling amongst teachers, children and young people with learning disabilities and their parents/carers. According to the results of this study, counsellors working in educational settings are already reasonably inclusive in their practices. One college counsellor was already promoting her service:

> I have given talks to groups and become known as a friendly, supportive person in their environment.

Another counsellor in further education said:

> I give talks to groups, giving students chance to ask questions

> about what happens in counselling, for example, confidentiality, in a general informal atmosphere. This has been successful (in increasing access).

Nevertheless, in this study school counsellors have expressed lack of knowledge, skills and confidence in counselling these young people. This research highlights counsellors' perception that specialist training would increase their confidence in working with this client group, thereby increasing their ability to make their practices more inclusive. I provide supervision for counsellors working in schools and my experience includes children's and young peoples' counselling projects. Feedback from these supervisees validates the evidence from this research study that is suggestive of specialised training leading to a greater level of confidence in counsellors working with this group of clients. It would therefore seem logical to provide counsellors in education settings with such training, thereby motivating and equipping them with the knowledge and skills necessary to both counsel children and young people with learning disabilities and promote their services, resulting in a greater level of accessibility for these clients. School counsellors are often employed by Local Education Authorities (LEAs) under different terms and conditions to those working in primary care. LEAs follow national education policies regarding increasing inclusion in mainstream schools and funding is likely to be available for the continuous professional development of school counsellors. This study indicates that although counsellors working in the voluntary sector are amongst the least inclusive of young people with learning disabilities, some have worked at increasing access to counselling. One counsellor in this study said:

> The most effective factor (*in increasing access*) is developing rapport with those who enable the client to attend.

This simple strategy could be used by all counsellors, for example: school counsellors in developing rapport with teachers and classroom assistants who help children to attend; counsellors in primary care developing rapport with all members of the team and through these relationships promote a greater awareness of counselling in relation to the needs of the client with learning disabilities. The implementation of current education policies on inclusion mean that many special schools have closed or are in the process of closure and children with disabilities are being integrated into mainstream education (DfES, 1998). Some children are being educated in mainstream classrooms with support and others are educated in special units attached to mainstream schools with some integration into mainstream activities (DfES, 1998). The results of this study indicate that although training in counselling children and young people may be provided in the educational context, the perspective of special educational needs and learning disabilities is not addressed. This may leave counsellors unprepared and lacking in knowledge, skills and confidence with this client group.

7.4.3 Counselling in the voluntary sector

According to Lindsay (1999) a dual diagnosis of mental illness and learning disability is relatively common in psychiatric practice; therefore it appears logical to assume that counsellors working for MIND are more likely to have

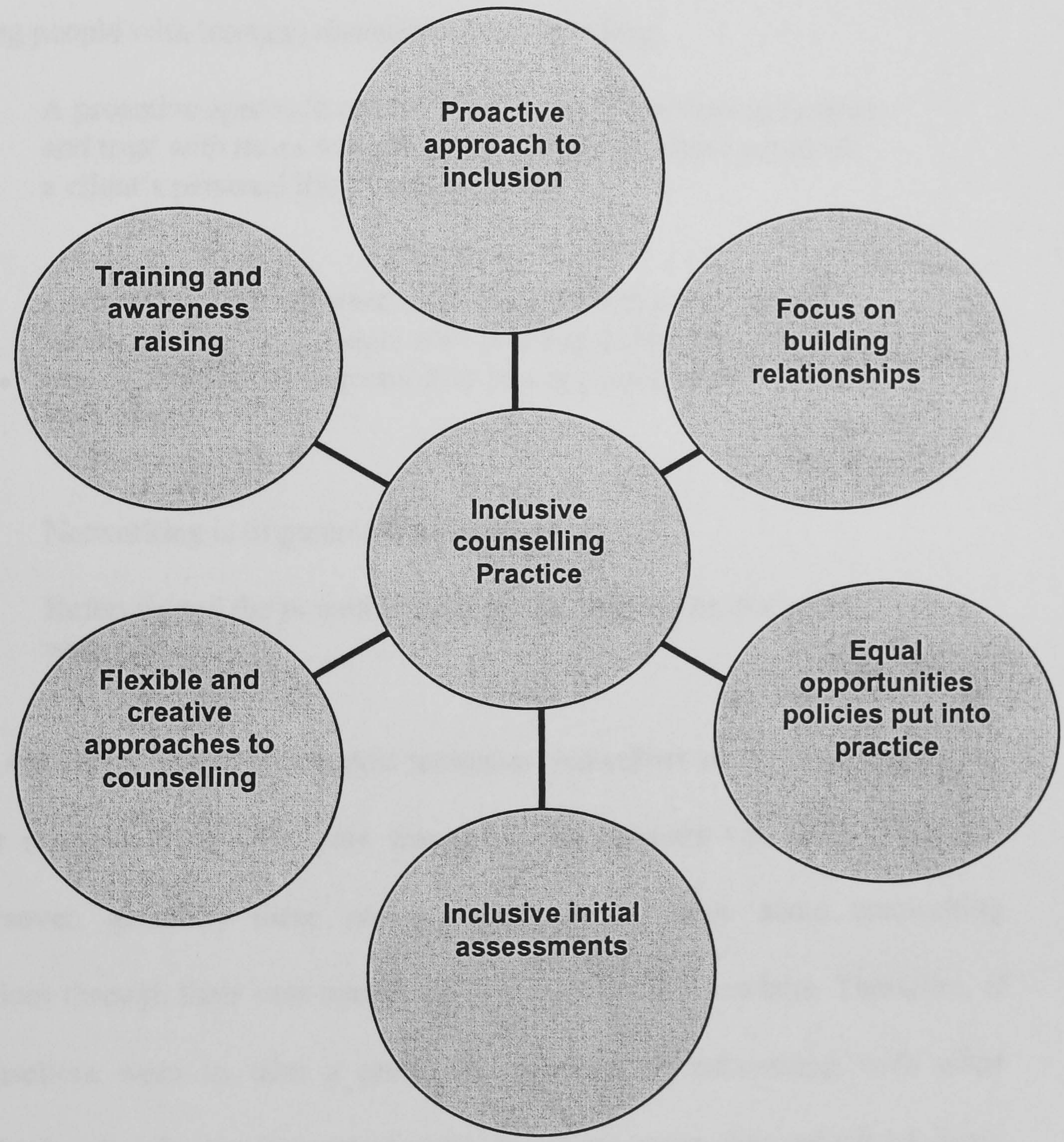
contact with people with learning disabilities than those working for other voluntary organisations. However, one counsellor from MIND when interviewed for this study stated that she had no contact with young people with learning disabilities, although she did have contact with young people. During the interview she had observed that she did in fact counsel clients with learning disabilities, she realised that they were different in some way but had not identified learning disabilities as the main feature. Difficulties with communication and awareness had been attributed to the diagnosis of mental illness. This indicates a lack of awareness of the nature of learning disabilities and the difficulties in diagnosing mental health problems correctly in this client group (Lindsay, 1999).

The voluntary sector has an impact on counselling training through the provision of placements for student counsellors. Some organisations such as CRUSE and Relate provide their own training for counsellors; therefore they only accept students who have also completed their specific training within the organisation's theoretical framework. Other voluntary organisations, for example, MIND, accept counsellors in training from a variety of theoretical approaches, so long as the approach is compatible with the philosophy of the organisation. Therefore, there are opportunities to increase awareness and knowledge of learning disabilities through the voluntary sector.

7.5 Model for inclusive counselling practice

I have identified six indicators of inclusive counselling practice from the results: a proactive approach including networking; relationship-building; operationalisation of equal opportunities policies; inclusive initial assessment; flexible and creative approaches to counselling; training and awareness-raising. Although the data appears to place these indicators in hierarchical positions, on closer examination they are intrinsically connected to each other. I explore each of these indicators in turn and in relation to each other in order to present a model of good practice for inclusive counselling. A graphical representation of the model is presented in fig. 31 overleaf.

Figure 31: Model for Inclusive Counselling Practice



7.5.1 A proactive approach to inclusion

Some of the comments made by counsellors participating in this study encapsulate the importance of taking a proactive approach to the inclusion of young people with learning disabilities in counselling:

> A proactive approach can be taken towards developing rapport and trust with those who can refer clients, and those people in a client's personal life, if appropriate.
>
> Counselling services need to be advertised in a way that is accessible to young people with learning disabilities and in places likely to be frequented by young people and/or their carers.
>
> Networking is of paramount importance.
>
> Referrals and the potential for referrals needs to be discussed with GPs.

The results indicate that the most inclusive counsellors receive the majority of their referrals from GPs, care managers and teachers via word of mouth. Moreover, generally these young people get to know about counselling services through their care managers, link workers and teachers. Therefore, if counsellors were to take a proactive approach to networking with other professionals who are in contact with this client group they would be likely increase the level of awareness of counselling and facilitate referrals. It is evident from the data that the majority of all clients self-refer. Self-referral is a source of potential difficulty for young people with learning disabilities. They

are unlikely to self-refer due to their lack of knowledge and information about services and dependency upon others.

A proactive approach may be taken towards advertising and promoting the service. The majority of counsellors taking part in this research suggest that counselling could be made more available to young people with learning disabilities if specialised services, parents, carers and the client group were made more aware of what was available to them. However, even if counselling services were accessible to clients with regard to referrals the issue of cost remains. According to the results of this study there appear to be several potentially accessible mainstream counselling services available for young people with learning disabilities. They include: GP and Primary Health Care Trust counsellors, school counsellors and voluntary counselling organisations, along with several voluntary agencies, for example, Cruse Bereavement Care, Rape Crisis and Relate. Specialist counselling services include Voice UK and Respond. Due to the nature of learning disabilities and the ensuing potential communication difficulties (WHO, 1998) coupled with the observed help-seeking behaviour of young people in general (Everall and Paulson, 2002), these avenues of finding counselling help may not be available to young people with learning disabilities. Many people with learning disabilities have problems with literacy skills and the BACP directory can only be accessed through written information. Some organisations produce information in forms that are more readily accessible to disadvantaged groups of people, for example, publicity material in Braille for visually impaired people and leaflets written

using simple language and graphical information. Audio-taped information may be of use to some potential clients who have difficulties with literacy. However, problems with cognitive processing is a major feature of learning disabilities (Numminen *et al.,* 2000), therefore information may not be interpreted correctly or may be used in inappropriate ways (BILD, 2004; Valuing People: A New Strategy for Learning Disabilities, 2001). Moreover, many people with learning disabilities require help in managing their daily lives (Borgatti, 2001; WHO, 1998), in areas such as transport, personal care and budgeting, making the complex task of locating a counsellor totally inaccessible, except for the most mildly learning disabled individuals. In order to be inclusive of young people with learning disability counsellors may need to be proactive in promoting the service, network and liaise with other professionals and have direct contact with carers and the young people themselves. The Royal College of Psychiatrists (2004) and Sinason (2002, 1994) refer to multi-disciplinary ways of working with a cautionary note regarding confidentiality for clients. Proactive inclusive practices identified in this study comprise encouraging the use of advocates and communication support workers; welcoming carers and support staff who may accompany the client and provide transport.

7.5.2 Focus on relationship building

According to the results of this study more than ¾ of the most inclusive counsellors place an emphasis on the therapeutic relationship as opposed to ¼ of the least inclusive counsellors. The level of inclusivity rises in direct relation to the emphasis placed on the therapeutic relationship, referred to as the 'therapeutic alliance' by psychodynamic therapists (Sinason, 2004, 2002, 1994). The most inclusive counsellors are also more likely to use creativity, simple language and non-verbal communication. One counsellor reports that the most inclusive counsellors are more likely to:

> Accept limitations in verbal communication, more mirroring of clients' movements and the use of body language

Another counsellor claims that inclusive counsellors should:

> Adopt an overtly warm approach…

Almost half of the counsellors participating in this study who have tried to increase access for young people with learning disabilities identify the most effective factors in the category of relationship building or:

> Developing rapport with people who enable clients to attend.

Therefore a greater emphasis on building relationships seems a valuable component of a model for inclusive counselling practice. Contemporary research agendas explore the characteristics of the counsellor and the counselling relationship that best provide help for distressed clients (McLeod,

2002). I return to Smail's (2000:4) quote in support of the counselling relationship:

> Having someone to talk to, someone to listen, is in itself 'therapeutic', it doesn't take a genius to establish this – its part of everyday human experience. Of course some people are more comforting and reassuring to talk to at such times than others.

McGuiness (1998:19/1982:79) claims that the therapeutic relationship is:

> ...just another type of helping relationship – not always clear-cut.

The BACP align the notion of relationship to good practice in counselling and in doing so support the results of this study in that the relationship is fundamental to inclusive counselling practice:

> Good standards of practice and care require professional competence, good relationships with clients and colleagues...

Results from this study indicate that a warm, friendly approach towards clients, their carers and other professionals is successful in increasing access to counselling. It is significant that the results from this study locate the person-centred approach to counselling at Level 1, the most inclusive. This approach requires counsellors to build up therapeutic relationships within an atmosphere of warmth and trust based on Rogers' (1951) core conditions of:

1. Unconditional positive regard (non-judgemental acceptance)
2. Empathy
3. Congruence

This type of relationship appears essential for effective therapy, in spite of differences in theoretical approach (DoH, 2001). The BACP (2002: Section 3.1) refers to the concept of variations in the counselling relationship:

> The objectives of particular counselling relationships will vary according to the clients' needs.

It could be argued that in the case of young people with learning disabilities the need for the relationship is greater due to difficulties with communication and understanding. The notion of positive discrimination could apply with counsellors working within a model of inclusive counselling practice by working harder at building a therapeutic relationship and allocating more time and resources to this process. Raz (1986:86) makes a case for positive discrimination:

> ...their need is more pressing, their suffering more hurtful and therefore it is our concern for equality that makes us give them priority.

This fits with the results from this study suggestive of counsellors giving greater priority to young people with learning disabilities in order to increase inclusivity. However, there may be difficulties in applying a model of inclusive counselling practice due to potential barriers. For example, Smail (2000:4) predicts that:

> The nature of the association between client and counsellor will be changed from a relationship into a time-limited contract.

This study has identified the NHS at the highest level of inclusivity. However, in spite of recommendations that around sixteen sessions are generally needed

in order to promote therapeutic change in clients counselling in primary care in practice consists of only 6-8 sessions and is likely to follow a brief therapy model (DoH, 2001). Therefore counselling provision may be driven by market pressures rather than client needs or well-being (Smail 2002, 2001, 1995). It may be necessary for practices adopting an inclusive counselling model to overtly prioritise this client group and negotiate further resources in terms of time and number of sessions available for learning disabled clients in order to take account of the diverse features of the condition as described by WHO (1996:1):

> ...a condition of arrested or incomplete development of the mind...especially characterised by impairment of skills...and social abilities...

Autism, hyperactivity, aggressive and anti-social behaviour, withdrawal and social marginalisation can all affect relationship building (Baird *et al.,* 2000; Smith, 2001; Beardsmore, 1998; Borgatti, 2001; Bonell-Pascall, 1999; DSM-IV; ICD-10; BPS, 2000). Moreover, young people with learning disabilities are used to rejection and the resulting low self-esteem (Zic and Igrac, 2001) and are more likely to have attachment difficulties and disrupted relationships (Pattar and Forrest, 1993; Bowlby, 1969/1975) due to a higher prevalence of physical problems resulting in repeated hospital admissions (Kivitic-Kallio and Norio, 2001; Rajogopalan, 2001) due to conditions such as heart defects associated with Down syndrome (Forster-Gibson *et al.,* 2001), liver damage (Dabora *et al.,* 2001), leukaemia and other forms of cancer (Forster-Gibson *et al..,* 2001).

Other reasons for prioritising this client group and allocating more resources, especially time, rest on the higher prevalence of communication problems. Physical communication difficulties include visual problems, gross and fine motor problems leading to dyskenetic movements making communication through non-verbal communication more difficult (Gemignani and Marbini, 2001; Di Cicco *et al.,* 2001; Cronenberger *et al.,* 2001). By making these clients a priority and allocating the time and resources based on client need counsellors would be working towards inclusive counselling practice. Counsellors interviewed for this study suggest that:

1. Inclusive practice is open, welcoming, and accessible in every way.
2. Such a practice would have to be warm, friendly and overtly welcoming.
3. Inclusive practice is one where relationship building is paramount and the client is valued and respected.

The type of relationship described does not seem to be different to effective relationships in counselling generally; it is the ***greater*** emphasis on relationship building that fits with the model of inclusive counselling practice.

It seems judicious at this point to focus on the components of the therapeutic relationship and how these fit with or apply to inclusive counselling practice. Although client's perceptions of therapy are increasingly being valued there is little research on young peoples' perspectives (Kazdin, 2000). Yet young people can contribute much to counsellors' awareness of their experiences of

effective counselling relationships (Docherty and Sandelowitz, 1999). The nature of the relationship required for counselling to be effective is well documented (McLeod, 2002; Mellor-Clarke, 2000; Martin *et al.,* 2000; Gelso and Carter, 1994). The BACP (2002: Section C.1) provides guidelines for the type of qualities a counsellor needs in order to work ethically:

> ...integrity, impartiality, respect...

Rogers (1951) claims that non-possessive warmth is an essential quality of the effective counsellor, whilst Smail (2000:4) introduces the polarities of good and bad therapists, assigning the following qualities to the 'good' counsellor:

> ...a tolerance of and affection for otherness...

Hanna *et al.,* (1999) claims that the relationship is essential in adolescent therapy, whereas Taylor *et al.,* (1986) and Everall and Paulson (2002) identify trust as an important component of the therapeutic relationship with young people. DiGuiseppe *et al.,* (1996) and Gil (1996) suggest that the development of trust is likely to require more work when counselling young people due to their general distrust of adults' motivations as a normal part of their adolescent development process. Everall and Paulson (2002:82) identify therapist openness and impartiality as:

> ...critical factors in the development and maintenance of the therapeutic relationship.

Therefore, to be inclusive of young people with learning disabilities is to be inclusive of young people generally with the added dimension of learning disabilities. This may also mean that the counsellor needs to address the power

differentials in the relationship in two domains. Firstly, in the age/generation domain, the older counsellor and the younger client may have issues around authoritarianism and secondly, the domain of learning disabilities where others may often be seen as the experts (Everall and Paulson, 2002). When the relationship is more egalitarian and the counsellor is seen as an ally there is likely to be a more positive therapy outcome (Diamond *et al.,* 1996).

Although Rogers (1951) positions skills as secondary it could be argued that skills are essential to building relationships. For example, listening and hearing what is being said and responding empathically, qualities claimed by Rogers (1951) to be essential to building therapeutic relationships, could be described as skills. The use of techniques and strategies (skills) have been identified in this study as components of inclusive counselling practice and along with flexible and creative approaches could be used to aid the building of relationships. Training and awareness raising sessions for counsellors could include knowledge, information and experiential training in relationship building with learning disabled clients. Knowledge and experience of relationship building with this client group could be used to provide an inclusive initial assessment process and more equal opportunities for accessing therapeutic psychological interventions.

7.5.3 Equal opportunities policies in practice

The results of this study indicate that equal opportunities policies are considered essential for inclusive counselling practice. Such policies developed by organisations providing counselling services, for example the NHS, are based on national policies and legislation such as: The Disability Discrimination Act (1995); Disability Rights Commission (1999); Saving Lives: Our Healthier Nation (1999); Valuing People: A New Strategy for Learning Disabilities (2001). Moreover, the results from this study indicate that not only should equal opportunity policies be part of the systems of counselling services but that they need to be operationalised and applied in ways that really work to increase the inclusion of marginalised groups. There may be inherent problems in the operationalisation of such policies as identified by participants in this study:

> Do counsellors understand what is meant by inclusive?
>
> What does operating an equal opportunities policy mean?

One participant responded in a way that highlights the problems of applying policies to practice:

> Inclusive? Not an expression I am familiar with but I operate an equal opportunities policy and exclude no-one.

On the one hand the presence of such a policy appears to indicate inclusivity, on the other it appears that there is a lack of knowledge and awareness of the term 'inclusion', making the application of an equal opportunities policy

problematic. It also seems that there is a certain naivety or lack of awareness present in the claim that the above counsellor 'excludes no-one'.

Although major organisations such as the NHS, LEAs and social service departments are required to operate equal opportunities policies regarding minority groups the results of this study show that the majority of counsellors (80%) are also in private practice to varying degrees and it is more difficult to be sure whether these private practices operate such policies. Inclusion means having access to services and in the case of private practice findings from this study indicate that self-referral is the most usual gateway to access and yet the least likely to be used by young people with learning disabilities, thereby being the least inclusive. Conversely, the results also indicate that although the above major organisations may have equal opportunity policies in place they may not be effectively putting them into operation. Following a model of inclusive counselling practice would involve counsellors communicating, networking and building up relationships with the professionals most likely to refer learning disabled young people for counselling, identified by this study as: GPs, care managers, teachers, social workers, voluntary agencies, community psychiatric nurses and specialist psychiatrists.

Making equal opportunity policies work in practice may also involve taking into account individual clients' physical needs because physical disabilities are more prevalent in this client group, for example, deafness and hearing problems (Di Cicco *et al.,* 2001); visual difficulties (Kivitie-Kallio and Norio,

2001; Dabora *et al.,* 2001); and mobility problems (Gemignani and Marbini, 2001; Dabora, 2001). The data suggests that a greater knowledge and awareness of these problems facilitated by training may help counsellors to understand that although physical access to services may be improved by wheelchair ramps, the use of literature in Braille, the provision of British Sign Language interpreters and hearing aid loop systems this does not necessarily mean that the client has access to the processes of counselling.

According to my findings a model for inclusive counselling also involves the inclusion of young people with learning disabilities in the processes of counselling. Counsellors' awareness of how clients may be affected by their learning disabilities means that genuine attempts can be made to increase inclusivity and go further towards meeting clients' very individual needs, acknowledging that such clients do not represent a homogenous group. Information from the WHO Internal Classification of Functioning and Disability-2 (WHO Draft, 1999) may help counsellors to gain a deeper knowledge and understanding of the range of effects of learning disabilities on the individual (Rajogopalan, 2001).

Mental health problems are more prevalent amongst the learning disabled population (Lindsay, 1999). Therefore, it is not surprising that the results of this study point towards the NHS providing counselling at the most inclusive level (Level 1) regarding young people with learning disabilities, especially considering the provision through child and adolescent mental health services

(CAMHS). However, counsellors indicate in this study that the NHS provision is through specialist counselling services and learning disability teams rather than in the mainstream. Mainstream NHS counselling services include primary health care trusts (PHCTs) and the results from this study show that counsellors working in primary care are the least inclusive of this client group due to time and resource constraints. Goss and Rose (2002) suggest that the NHS is the single largest single employer of counsellors in the UK and that the number of GP surgeries offering counselling has risen from 31-51% over the past few years. It is also shown that 86% GP patients would rather see a counsellor than have tranquillisers or antidepressants (MORI Poll, 1996). On this basis alone it appears that counsellors working in primary care have a firm rationale for increasing their inclusivity of young people with learning disabilities by using their equal opportunity policies as leverage to obtain further resources to enable services and processes to be effectively accessed.

Barriers to inclusion and the effective operation of equal opportunities practices can be identified from the results and show that such barriers are more likely to be located in systems, counselling practitioners, parents, carers, teachers, health and social care professionals rather than clients. Equal opportunity policies are developed and operationalised by individuals and groups working within systems and may reflect prejudices, stereotypes, lack of knowledge and awareness of those involved. Increasingly, clients of various health and social care organisations are being encouraged to have a 'voice'. User groups in the mental health arena provide a good example of this practice.

Putting equal opportunities polices into action can be more complex than it first appears. The nature, quality and processes of the service may be in need of closer examination and the involvement of user groups encompassing the notion of citizenship may need to be facilitated through the use of advocates, thereby giving clients their 'voice' (BILD, 2003). The Cruse Youth Project funded by the Princess Diana trust Fund (2003) provides a good example of how young people can be involved in the planning and provision of counselling services. Visser (1999) suggests that a paradigmatic shift can be made from the individual being seen as having the problem to organisations having to address issues which act as barriers to inclusion, this links with the differences between a medical and a social model of disability. Moreover, Visser (1999) refers to the compounding of the problematic nature of inclusion due to the lack of a definitive meaning of the term learning disabilities, in other words, how can a service work towards the inclusion of young people with learning disabilities when such individuals have not been identified? Therefore, identification and targeting of this client group may be an effective inclusive strategy.

When attempting to put equal opportunity policies into practice the literature shows that several processes need to be considered. Counselling is about processes such as relationship building, engagement, psychological movement and change (DoH, 2001; BACP, 2003). Firstly, the relationship is an important process where the client is understood through their internal frame of reference and a process of empathic understanding and relationship building (Rogers,

1951; BACP, 2002; DoH, 2001; Wolfe, 1997; Sanders, 1996; Nelson-Jones, 2003). Hanna *et al.,* (1999) claim that the relationship is essential in adolescent therapy. The BACP (2002) refers to another process, that of exploration in therapy.

Smail (2002) suggests that counselling doesn't take place in a social vacuum and Wolfe *et al.,* (1989:11) claims that counselling is part of the fabric of wider social life:

> Counselling is a social enterprise and cannot be divorced from the social, economic and political environment in which it is practised.

Lee (2003) maintains that equal opportunities relates to social inequalities and exclusion from the mainstream with social and economic deprivation leading to marginalisation. The effective delivery of services is synonymous with access to provision and equal opportunities equates to equal access (DfEE, 1995). Giddens (1998) claims that equality equals inclusion and inequality equals exclusion. Foucault (1982) refers to exclusion as dividing practices. Positive welfare and social investment could be interpreted as making resources available to enable learning disabled young people to access services. However, professional therapy fees can be in the region of £25-35 per hour forming an effective barrier to young people who do not generally have their own resources (Friery, 2003). Reeve (2002:13) in his reference to oppression in the counselling room has the following to say:

> Counsellors, like all other people in society, are fed a stream of negative images and stereotypes of disabled people from a very early age, these contribute to the continued

discrimination and exclusion of disabled people in society.

It appears that counsellors cannot afford to neglect the matter of including young people with learning disabilities in their practices because apart from moral and ethical issues legislation and policies demand that individuals are treated equally with regard to the provision of services. There is an issue with regard to discrimination and how anti-discrimination in counselling is monitored. One survey participant provided the following response: 'I do not want to work with this client group'. Should counsellors to be allowed to choose their clients according to their personal preference? In other areas of potential discrimination, for example, race, counsellors would be held accountable for their discriminatory practices. It seems very different to imply that counsellors need to develop knowledge and skills before taking members of this client group for counselling, other than merely stating a personal preference. However, if a counsellor really does not want counsel this type of client, in a therapy that relies upon the relationship between counsellor and client for therapeutic benefit, would being persuaded to take such clients be useful?

Although specific legislation applies to services providing specialist help to people with learning disabilities, the Human Rights Act (1998) and the Disability Discrimination Act (1996) apply to all providers of services. It could be argued that organisations offering counselling are complying with the legislation by having equal opportunities policies. Moreover, this study identifies that counsellors believe equal opportunities policies to be indicative

of inclusive counselling practice. However, in order for counselling to be inclusive such policies would need to be operationalised. My experience of working in a variety of voluntary and statutory contexts leads me to believe that such policies are not always translated into inclusive practices. Rather, the physical aspects of disability, such as auditory, visual and difficulties with mobility are considered. In discussion with voluntary agencies it is apparent that loop systems to help counsellors to deal with clients who have hearing impairments, literature promoting the service in the medium of Braille and ramps for wheelchair users are often provided. The results of this research indicate that there is a lack of awareness of the needs of young people with learning disabilities, in spite of equal opportunities policies, such policies do not appear to be generally put into practice in terms of young people with learning disabilities. Moreover, the response of one counsellor interviewed lends more weight to the argument:

> Inclusive? Not an expression I am familiar with but I operate an equal opportunities policy and exclude no-one. Counsellors must follow equal opportunities policies.

This counsellor had not counselled an individual with learning disabilities. Although there may be many reasons for this, I find this counsellor's lack of awareness and naivety inherent in her claim that she excluded "no-one" rather disturbing. Moreover, her lack of familiarity with the term 'inclusive' was of concern to me. This may be linked to a general lack of knowledge and awareness of social issues and their impact on individuals within society. Gilliland and McGuiness (1989) claim that clients are most likely to be helped by counsellors who have levels greater of self-awareness.

For those counsellors wholly in private practice, how far do they have the systems in place that can be supportive of greater inclusivity and access to counselling, for example, equal opportunity policies? How isolated are private practitioners? The cost of counselling in the private sector can be high, especially if long-term work is required. Results from the survey and interviews with counsellors regarding increasing access to counselling indicate that cost and lack of funding are barriers to counselling for young people with learning disabilities, both in the private and public sector. The question raised by one interviewee, 'who pays?' is central to the inclusion of this client group in all areas of counselling provision. These young people do not have access to the funds for private counselling unless a parent, carer or other advocate facilitates this. According to Giddens (1998) inclusion is one of the major reforms of the 20th Century. The results of this study indicate that a proactive approach to referral, allocation of appropriate resources, inclusive initial assessments and training are likely to increase inclusion. Putting equal opportunities policies into practice may mean approaching initial assessments through a positive inclusive frame rather than allowing the assessment process to exclude clients.

7.5.4 Inclusive initial assessments

The results from this study point to inclusive initial counselling assessments as integral to a model for good practice in counselling children and young people.

There appear to be three main issues in assessing young people who are learning disabled.

Firstly, there is the issue of appropriateness of counselling for the individual. Does a counsellor really need to know whether a person has learning disabilities? Would it make a difference to the level of help provided in terms of increasing access or would such knowledge increase the chances of exclusion? West (2004:22) has the following to say about prior knowledge of a client's condition:

> One is left feeling that the diagnosis has been made before the patient enters the consulting room on the basis of previously acquired prejudice.

How would a therapist know that they had a client with learning disabilities? As identified in the literature, people with learning disabilities are not a homogenous group; ICD-10 (WHO, 1996) and DSM-IV (1994) provide information regarding a hierarchy of effects leading to classification as having mild (IQ<75 but >50), moderate to severe (IQ<50 but>30) or profound learning disabilities (IQ<30 or immeasurable). In terms of the individual with mild learning disabilities the counsellor may have no definitive diagnosis relating to this unless the source of referral makes this information available or the client presents with obvious physical indicators as found in some of the syndromes, for example Down or Turner's syndrome (Di Cicco *et al.*, 2001). The counsellor may try to clarify the situation by asking the client if they have been 'statemented' at school. Although there is no evidence from this study to

support this proposition, in my experience as a counsellor and counselling supervisor this simple question is easily understood and able to be answered in the affirmative by young people who have gone through the statementing process. However, there are problems regarding some clients and their diagnosis of learning disabilities. Borgatti (2001) claims that psychopathology; psychological, intellectual and language delays can identify young people with learning disabilities. However, developmental disorders such as dyslexia, dysgraphia, dyscalcula, ADHD (Attention Deficit Disorder) and Autistic Spectrum disorders (Autism, Asberger's syndrome) do not signify that an individual has learning disabilities in terms of intellectual impairment. These conditions may be found in young people alongside learning disabilities and can mask learning disabilities or falsely indicate this (Kulkarni, 2001).

Regarding the question I posed earlier 'Does the counsellor really need to know whether an individual has learning disabilities?' the answer lies in the question 'Would it make a difference to the level of help provided in terms of increasing access or would such knowledge increase the chances of exclusion?' If the answer to this question is in the affirmative towards increasing inclusion and accessing resources that would provide psychological help for the client then it seems that knowledge of a client having learning disabilities would be useful and positive. However, if the answer to the above question points to the client having more chance of being excluded from services such knowledge may provide a barrier to accessing therapy. Therefore, in carrying out the initial

assessment of clients the therapist has the power to include or exclude clients with learning disabilities.

The results from this study indicate that there are four main issues to attend to when assessing the appropriateness of counselling for an individual with learning disabilities.

1. Level of communication
2. Ability to process information
3. Ability to engage in the counselling process
4. Level of learning disability

These issues may give the appearance that certain characteristics in relation to learning disabilities are situated in the client and to some degree this is the case. However, unless the client has severe learning disabilities (IQ<50) it is possible that counselling may be an appropriate psychotherapeutic intervention. The results from this study point to the systems involved in counselling, counsellors and health/social care professionals as being exclusionary and providing barriers to counselling rather than the nature of the learning disabled client. However, it appears from the results of this study and the literature that under certain conditions counselling may not be appropriate for some young people with learning disabilities, even if they are able to communicate, process information and actively engage in the counselling process. Such instances may include referrals for problems associated with learning disabilities that the individual has no control over, for example obesity in Turner's syndrome that is caused by hormone imbalance and pica (obsessive eating of strange substances, behavioural problems that are inherent in the

client's condition and obsessive compulsive symptoms caused by the client's disorder.

Secondly, resource management is likely to be an issue. The initial assessment is usually the first meeting that a client has with a counsellor and one of the functions of assessment is to determine the appropriateness of counselling for the individual and how psychotherapeutic needs of the client may be met within the limits of available resources (Mellor-Clark, 2001). Moreover, the initial assessment, particularly where the CORE system is used (Mellor-Clark, 2002), may identify client goals and use these to evaluate outcomes from therapy. The results of this study indicate that the assessment process may prove more difficult in the case of individuals with learning disabilities due to factors related to communication, levels of understanding and problematic behaviour. The WHO (ICD-10, 1996) highlights impairment of social skills and cognitive language as concomitants of learning disabilities. Prosser (1999) and Lindsay (1999) suggest that the high prevalence of mental illness (dual diagnosis) in such individuals can cause behaviour that could be attributed to either, making assessments of mental health difficult or impossible.

Inclusive initial assessments require the resources of time to allow the client to reveal their problems and issues; time to enable the counsellor to get to know the client well enough to access the way that they best communicate and build up a relationship with the client; time to liaise with other professionals involved with the client if appropriate and the client's carer; a variety of

creative materials that can be used in the first session if necessary; and access to specialist supervision so that that difficulties in making decisions regarding the provision of counselling can be talked through without erring on the side of exclusion when in doubt. Participants taking part in this study highlight flexible and creative approaches to counselling as inclusive practices and these approaches can be adapted for use in the assessment process.

7.5.5 Flexible and creative approaches to counselling

This section looks at the results from the research carried out for this study and the literature in order to explore the place of flexibility and creative approaches to counselling in relation to my model of inclusive counselling practice. I have identified four main concomitants of inclusive counselling practice that can be used in this section: adapted simple language, imaginative and creative therapeutic techniques, non-verbal communication, flexibility in counselling practices and eclecticism. A report produced by the Royal College of Psychiatrists (2004) suggests that creative therapeutic approaches, eclecticism and relationships are of paramount importance in providing accessible services to people with learning disabilities.

Flexibility in counselling practices may make a difference between a client being able to attend for counselling or being excluded at an early stage. The organisation of counselling appointments may be arranged to make times available when carers or support workers are able to attend with the client or

transport requirements can be more easily met. Flexibility may mean including a carer in the session if that is what the client really wants and comments from counsellors interviewed for this study substantiate this:

> I make my practice flexible regarding times and appointments and accommodate carers where necessary, this means clients feel more welcome.

Carers may be included in the initial assessment where the establishment of the client's communication abilities and levels of understanding are required. However, the downside of this may involve difficulties around confidentiality.

Establishing communication and through the building of a relationship and a working rapport may be possible if the client's level of language ability is assessed, enabling the counsellor to adapt their own language. Difficulties with language are integral to learning disabilities (Chomsky, 1957) and therefore the adaptation of language is likely to be one of the most useful approaches that a counsellor can take in order to include such clients. The adaptation of language may include the use of simple sentences, less use of complex speech, repetition and emphasis on points of ambiguity or risk of misunderstanding (Griffiths, 1996; Galloway and Richards, 1994; Mahoney and Sealey, 1976). Clarification of ambiguities and shared meanings are precursors to the building of empathic relationships (Gass and Veronis, 1991). Counselling involves reciprocal communication and therefore linguistic flexibility may be necessary on the part of the counsellor (Chin and Bernard-Opitz, 2000). Verbal language is also the basis of communication between counsellor and client and is

therefore of paramount importance to the psychotherapeutic process (Hyme, 2000).

According to Geldard and Geldard (1999:97) young people tend to use metaphorical language such as 'a black cloud seems to follow me wherever I go'. However, learning disabled young person may not have the cognitive understanding of abstract ideas or the linguistic abilities that enables them to use metaphorical language (Piaget, 1970; Vgotsky, 1962) and may require the use of art or other creative materials to communicate their thoughts and feelings. On the other hand, these difficulties in expression may not be confined to young people with learning disabilities, as Lynch (1998:531) claims:

> We need to acknowledge that it (language) cannot of itself fully depict the true nature of an existence.

Reiffe *et al.,* (2000) claim that individuals with learning disabilities often have great difficulty in understanding emotions in themselves and others. This information may be useful in that whilst there are difficulties in understanding emotions the actual feeling or experiencing of emotions may not be affected and may be accessed as part of the counselling process through artwork or other creative medium.

7.5.6 Training and awareness raising

The results reveal that the most inclusive counsellors are qualified to the level of Masters Degree with over two thirds also being in possession of a social science Batchelor degree. Although the data are not sufficient to scientifically identify the possession of a social science degree as a causal factor in the more inclusive counsellors it is reasonable to expect that such counsellors are more aware of how social issues impact on individuals and groups. Smail (2000) highlights the impact of social issues upon clients making it appear that the individual is responsible in some way for his/her circumstances and has the power to initiate change, when in fact the individual is largely powerless against social forces. Therefore a greater awareness of issues such as race, gender, disability, power, social exclusion, social and economic deprivation on the part of the counsellor may enrich the counselling process and be an integral component of the model for inclusive counselling practice. Sinason (2002) claims that training is a real issue for therapists who want to want with people who have learning disabilities. Psychodynamic training programmes often do not accept this type of client as training cases, perceiving that they are too emotionally disturbed or unstable, therefore high risk (Sinason, *ibid.*)

How may this information be of significance to counsellors in their work with young people with learning disabilities? Masters level study requires commitment and a willingness to go through a process of learning and development above that needed for diploma level study. This involves close

examination and critical analysis of the field of study; an understanding and differentiation of the main concepts and eventually integration and wider understanding reflected upon in the context of individual practice. The literature regarding the developmental process of studying in higher education and its effects upon the individual identifies this process. In other words, the possession of a higher degree may be indicative of a more open-minded, reflective approach to counselling, with the counsellor being less accepting of the so-called norms of society and the profession and may be more willing in a pragmatic sense to try out different techniques and strategies to see what works with individual clients.

By the very nature of their training and the type of work that counsellors do it could be assumed that counsellors have a greater influence over their own behaviour than the general population (Smail, 2000). Counsellors undergo personal development and work towards higher levels of self-awareness in order to be able to help their clients in therapeutic situations more effectively (McLeod, 2001b; Rogers, 1962). Increased levels of counsellor knowledge and awareness may hold the key to increasing inclusivity in counselling. A lack of knowledge and awareness of the counselling needs of young people with learning disabilities and available services appears to be embedded in systems (health, education, social care, employment, criminal justice, voluntary sector). According to the results of this study even counsellors are unsure of where to refer these young people if they feel unable to offer therapy themselves.

The results indicate that counsellors would be more able to change their practices if they had a greater awareness of the needs of young people with learning disabilities and how to address these needs, along with having a greater knowledge of the nature of learning disabilities as demonstrated in the words of one counsellor interviewed for this study:

> I feel I would plan to train further to equip myself with the necessary skills to help this client group.
>
> Knowledge and experience of learning disabilities and the client group can be beneficial.

A raised awareness and greater knowledge may also enable counsellors to re-examine their equal opportunities policies critically and find ways of putting these policies into operation more effectively. Counsellors also appear to be in a good position to raise awareness of counselling in the client group, parents, carers and other health and social care professionals.

7.5.7 Overview of the model

The model of inclusive counselling practice is intended as a representation of examples of good practice as indicated in the results of this study and comprises six main areas where attention can be directed in order to increase the inclusivity of counselling practice, namely: the use of a proactive approach to inclusion, greater attention given to relationship building, the operationalisation of equal opportunities policies, inclusive initial assessments, flexible and creative approaches to counselling and attention to training and

awareness raising in learning disability issues. These six areas are not intended to be exhaustive; the model is open to further development and is therefore not complete, nor are the areas necessarily comprehensive in nature, the model is in process.

The first component of the model is a proactive approach to counselling young people with learning disabilities involving networking with potential referral agencies, increasing levels of awareness that this client group can be offered counselling, advertising and promoting counselling services to the wider public and agencies dealing with learning disabled young people and producing accessible publicity materials and in doing so may reach the client group and their carers. Secondly, by focusing on relationship building with clients and their carers and providing a warm, friendly approach to the extent that greater resources, especially time are allocated counsellors may increase the level of inclusivity. The third element of the model is the operationalisation of equal opportunities policies. Although such policies are often part of the portfolio of organisational policies they need to be actually put into practice in ways that serve the needs of the minority groups they are aimed at. This includes requiring a proactive approach on the part of counsellors, managers and administrators. Fourthly, by carrying out inclusive initial assessments young people with learning disabilities counsellors have the opportunity to show their commitment to providing counselling for this client group along with assessing the appropriateness of counselling for the individual. The fifth component of the model involves the use of flexible and creative approaches to counselling,

whether in the provision of the service, for example appointment times and length of sessions or in the actual therapeutic work as with the use of art or other creative materials.

7.6 Summary

In this chapter I have discussed and evaluated the results from the survey and interview data used in this study in relation to the literature and used this information to build a model of inclusive counselling practice for young people with learning disabilities. I have examined inclusion in counselling and the potential for change, identifying inclusive counselling practice as a dynamic process that can be placed on a continuum rather than a static phenomenon. The case for counselling learning disabled young people in relation to legislation and policies and the appropriateness of counselling for this client group has been explored and the removal of barriers and increasing access to counselling in primary care, education and the voluntary sector.

The resulting model for inclusive counselling practice is developed from the results of this study linked with the literature and my experience from fieldwork. It comprises a proactive approach to counselling, a focus on relationship building, putting equal opportunities policies into practice, inclusive initial assessments, flexible and creative approaches to counselling, training and awareness-raising. In the concluding chapter I will look at the relation between my present work and my original research questions; anything that I would do differently now; implications for policy and practice in

counselling; further research that might follow from this study and the limitations of the study.

Chapter 8: Conclusions and Recommendations

8.1 Introduction

This chapter examines conclusions that are drawn from the research questions and findings of this study. The research questions are: Can counsellors make their practices more inclusive of young people with learning disabilities? How appropriate is counselling for this group of young people? What are the barriers to inclusion? Which strategies and techniques may be useful in overcoming these barriers? The conclusions in relation to the research questions are that they have been useful in driving the research process and enabled the main issues to be explored. Further understandings about the research problem relate to the finding that counsellors involved in specialist learning disability roles with this group of clients are more likely to be inclusive, whilst mainstream counsellors largely exclude. Therefore, the problem of inclusion in counselling may be resolved by referring to specialist services. However, this does not further the movement towards social inclusion. Implications for theory, practice and policy are explored and the ways in which this research has added to the knowledge bases in these areas. The pre-determined boundaries of the study and limitations arising from the research process are examined.

8.2 Conclusions about research questions

The main question driving the research process was 'Can counsellors make their practices more inclusive of young people with learning disabilities?' I translated this question into the hypothesis that counsellors are able to make their practices more inclusive and that they are motivated towards including this group of young people and the null hypothesis that counsellors are not able or motivated to increase the level of inclusion. I have examined the situation regarding counselling provision for this client group through data extracted from a survey of counsellors listed in the BACP Directory (2001) and a series of qualitative interviews with counsellors. The results challenge the null hypothesis by providing data indicating that there is a scale of inclusion in counselling represented by variables depicting a range of 'never' to 'often' represented in figure 6, page 213. It seemed reasonable to conclude that if a small number (3%) of counsellors are able to provide mainstream provision for these young people may be possible for others to change their practices in order to make them more inclusive. In other words, there is the potential for a higher level of inclusivity in spite of the results suggesting that counselling generally excludes young people with learning disabilities. It may be possible to build upon this potential to be inclusive, thereby challenging the null hypothesis and finding in support of the research question. Regarding counsellors' motivation towards inclusion, it appears from the results that given further knowledge, training and support, counsellors are generally

willing to try and be more inclusive, although there are several barriers to this process. Demographic data regarding qualifications, practice context and organisational context provided insights into the territory of inclusion in counselling and contributed to the development of profiles of inclusive counsellors, their practices and processes and a model for inclusive counselling practice. The notion of a hierarchy of inclusion on four major levels is suggestive of inclusion as a process (see figure 24, page 237) and provides a positive model for progress rather than a static and unchangeable model. Characteristics relating to the four levels of inclusivity include variables such as theoretical approach, counsellors' main occupational role, practice context and main source of referrals. The process of inclusion in counselling can be compared with the parallel process of inclusion in the education system and the shift from special schools towards inclusion in mainstream education with support for teachers and children supported by legislation, policies and strategies (Carrington and Robinson, 2004). This research makes a contribution to the theory on inclusion by adding the dimension of counselling to the existing literature on social inclusion (Milbourne, 2002) and inclusive education (Thomas and Glenny, 2002) regarding practices and processes.

The first supporting research question pertains to the rationale behind inclusion: Why should counsellors include young people with learning disabilities in counselling? The literature review and research into the social, historical and political basis for inclusion supports the notion that counselling should be more inclusive of this group of young people, identifying four main

reasons for inclusion: human rights; the prevalence of mental health problems in young people with learning disabilities; education, learning and social progress; and compliance with equal opportunities and anti-discriminatory legislation, thereby providing defence against litigation and accusations of discrimination. The legislation providing the rationale for inclusion in terms of human rights is presented in figure 30, page 247. The main theoretical framework for this research is human rights and although the findings do not extend existing research in terms of human rights, they do add to the existing body of knowledge by providing information regarding the rights of a particular group of people to appropriate mental health care. This research extends existing knowledge and understanding of mental health care practices by adopting a counselling rather than a psychology perspective and examining inclusion of this client group in mainstream services rather than services that may be specialised in nature.

The second key research question 'How appropriate is counselling for young people with learning disabilities?' takes account of the assessment processes involved in contemporary counselling practices and the need to use finite resources appropriately. Four qualifying categories were identified relating to the nature of learning disabilities: communication, the ability to process information, the ability to engage with the counselling process and the level of learning disability. Each of these factors inter-relates; the level of learning disability directly affects the individual's ability to communicate and to process information with each of these providing potential barriers to counselling.

Existing research in counselling provides information regarding the appropriateness and effectiveness of counselling for mental health problems such as depression and anxiety (DoH, 2001), the BACP have commissioned several studies to investigate these issues across a range of contexts including counselling in the workplace (McLeod, 2002) and counselling in primary care (Mellor-Clarke, 2001). A further study explores the appropriateness and effectiveness of counselling from the perspective of children and young people (Harris and Pattison, 2004). However, young people with learning disabilities are almost invisible in the results of these studies; therefore my research places this client group more firmly on the research agenda and provides a basis for further research in this area.

The third key question asks what the barriers are to inclusion in counselling and the findings identify eight main barriers, locating them in systems (health, social care, education, voluntary sector, criminal justice, employment services); counsellors; parents and carers; and the individual with learning disabilities (see figure 16). From these results I conclude that the main barriers to including young people with learning disabilities in counselling are not located in the individual and are more likely to be found in counsellors, systems, parents, carers, teachers and social care professionals. This research supports existing research findings in other contexts that situate social exclusion in systems and examine strategies for removing barriers as seen in the example of whole school approaches to inclusion (Carrington and Robinson, 2004). My

research extends theory by contextualising barriers to inclusion, identifying strategies to overcome these barriers in relation to counselling.

The strategies and techniques that counsellors either use or advocate using in order to include young people with learning disabilities in counselling practices and processes form the substance of the final key research question. The results suggest four main categories: creative techniques; therapeutic relationship; simplification of language and non-verbal communication (see figure 17, page228). When these results were related to the four levels of inclusivity pattern emerged showing that the most inclusive counsellors adopted these techniques and strategies to a higher degree (see figures 19, 20, 21, pages 231/232). This study agrees with existing research that young people with learning disabilities are essentially excluded from mainstream psychotherapeutic services (Prosser, 1999; Lindsay, 1999) in spite of their greater prevalence of mental health problems (Borthwick-Duffy, 1994; Department of Health and Home Office, 1992; Prosser, 1999)) and are more likely to be served by specialist psychological provision aimed at the resolution of behavioural problems. Existing research suggests that this is due to the externalised nature of symptoms that cause problems to parents, carers and teachers and is disruptive education processes for others in schools resulting in the provision of behaviour modification programmes rather than the provision of psychotherapeutic help for emotional problems and symptoms that are causing distress to the individual and may be internalised rather than externalised (Lindsay, 1999; Prosser, 1999). In other words, if symptoms of

psychological distress are not apparent in the form of behavioural problems and resulting in difficulties in management the individual is unlikely to be offered therapy. A good deal of the research into the mental health and emotional lives of this group of young people is researched through the discipline of psychology, for example, Lindsay (1999) and Prosser (1999). Therefore my research adds to the knowledge base by approaching the problem of inclusion in mainstream psychotherapeutic services from a counselling perspective; from the position that young people with learning disabilities may have a greater need for counselling due to the prevalence of mental health problems in this group; and by contextualising the counselling provision in primary care, education and voluntary sector counselling provision.

My conclusions in relation to the research questions are that they have worked in driving the research process and have led to the production of useful results that address the main issues of inclusion in counselling in so far as they have made possible the development of a model for inclusive counselling practice. However, in hindsight I would have focused the questions more sharply upon the motivations of counsellors towards inclusion and their perceptions of the social forces working against them, along with making more concrete links between counsellor motivation and strategies for inclusion.

8.3 Conclusions about the research problem

My own motivations towards researching this topic and the background to the research problem were discussed in section 1.2. Based on this section, implications for the research in furthering understanding about the research problem are explored. This incorporates qualitative findings about the research problem developed during the research process and those insights discovered during interviews. The research problem was based on the apparent lack of counselling services for young people with learning disabilities on courses at a college of further education. Some of these students were expressing emotional distress and required psychotherapeutic help and support. In my role as a teacher for students with special educational needs in the further education context I found that I was providing this counselling support myself, particularly as I was a qualified counsellor. My role as lead tutor for inclusive education and my personal belief in the value of inclusion for marginalized groups encouraged me to seek mainstream counselling provision for students rather than allow myself to be viewed as the specialist SENs counsellor. However, access to mainstream college counselling provision simply did not work in practice because the students seemed to prefer a known and trusted person to share their concerns with one who could communicate effectively with the individual, already being aware of the student's communication style and able to make adjustments accordingly. The findings from this research suggest that communication may form one of the major barriers to the inclusion of this group of young people in counselling practices and processes

due to the nature of learning disabilities and concomitant communication difficulties and strategies to increase inclusion incorporate the use of simplified language and non-verbal communication. Literature on the use of language in counselling was explored in section 2.4 and research carried out in the discipline of second language acquisition was applied critically to the discipline of counselling, for example, the concept of interactional modifications referred to as 'skeletonising' by Long (1983) and 'scaffolding' by Beveridge *et al.,* (1997) and Bruner (1986). This research makes a contribution to the body of knowledge regarding the research problem in that a greater understanding has been gained from the results on inclusive practices and strategies to include these young people. By comparing counsellors at different levels of inclusivity useful variables were isolated and explored. The subsequent development of a model for inclusive counselling practice was based upon the findings and this model highlights the research problem in that it would not be necessary to have a model for inclusive practice if counsellors were already inclusive. The model for inclusive practice adds to the body of knowledge on inclusion by extending the range of contexts such as models for inclusive education (DfES, 2001a) and inclusive society (Giddens, 1998). It appears that the initially encouraging findings showing inclusion in counselling as a process and indicating ways of increasing inclusivity are counter-balanced somewhat by the results identifying the most inclusive counsellors as those who already have another specialist learning disability role with the client. The research problem involved the lack of mainstream provision for this group of young people; psychotherapeutic help was, however, provided in the specialist

sector. One of the questions generated by this new knowledge linking inclusivity to counsellors with other roles in the field of learning disability is: 'Do counsellors need to be specialists in order to be inclusive?

8.4 Implications for theory, policy and practice

This research contributes to the knowledge base in counselling by providing information relating to a marginalized group. Research is continually adding to counselling theory, particularly in relation to special groups in society, for example, the results of a study carried out by Grove (2003) provides information on same-sex couples. New insights have been gained in terms of highlighting how much counselling actually may take place in the private sector and how counsellors operate mainly in the private rather then public arena. Even when working for statutory or voluntary organisations counsellors' practices and processes are essentially private (Smail, 2002). Through the findings of this research some of these practices and processes have been made public, adding to the existing knowledge base of counselling. This research makes a contribution to theory on young people with learning disabilities by providing evidence about the type of training that counsellors may need to enable them to work more effectively with this client group; through the findings on counsellors, their characteristics and their practices; by identifying excluding practices and the techniques and strategies that can be adopted in order to overcome these; and finally, by providing a model for inclusive counselling practice that can be used by counsellors, managers of services and policy makers to move counselling forward in terms of this client group. This

research contributes to the evidence-base for clinical practice in terms of effective strategies for working with young people who have learning disabilities, providing exploratory research that can be built upon and developed further by research.

This research has practical implications for counselling in the private, voluntary and statutory sectors. The findings highlight the training needs expressed by counsellors and identified by the researcher in interviews. Inclusive techniques and strategies can be adopted by counsellors not only as a way of including individuals with learning disabilities but also adapted to include other clients from marginalized groups who may have similar difficulties in accessing counselling help. For example, the use of simple, adapted language may be useful when counselling individuals from ethnic minority groups and who may use English as a second or other language; people with mental health problems affecting communication may benefit from the use of creative techniques and more attention to relationship building. The model for inclusive practice pulls together the various strands based on the findings of this research: proactive approach to inclusion; focus on building relationships; operationalisation of equal opportunities policies; inclusive initial assessments; flexible and creative approaches to counselling; and training and awareness. Each element of this model can be used to examine existing practices in order to identify strengths and areas in need of development. The model can then be used as a template for planning and developing inclusive practices and processes; strategies could be put in place based upon the inclusive model, which could then be adapted to use as a

template for evaluation. Global, national, professional and organisational policies already exist to support inclusion, however, the details of how these policies can be applied to specific client groups or individuals are not always readily available, therefore, the model for inclusive counselling practice may provide a framework that enables service managers and counsellors to actually address issues relating to inclusion, equal opportunities and anti-discrimination practices.

8.5 Proposals for training and continuing professional development

This study has highlighted several areas of training and continuing professional development for counsellors in mainstream practice. Firstly, practitioners require a good working knowledge of the Human Rights Act (1999) and the implications within their practice and context. Such training could be provided through the medium of workshops where case studies could be used to provided examples and opportunities to reflect on individual practice. My model for inclusive counselling practice would provide an audit tool to enable practitioners to assess the level of inclusivity within their practice and set targets for improvement. A greater awareness of issues such as race, gender, disability, power, social exclusion, social and economic deprivation on the part of the counsellor are likely to enrich the counselling process and as such form an integral component of the model for inclusive counselling practice. Continuing professional development workshops addressing these areas in relation to inclusivity and diversity are available. However, provision is limited

and access to training is more likely to be found in the South of England. I propose a series of continuing professional development workshops to be developed in conjunction with the British Association for Counselling and Psychotherapy and delivered nationwide. This would fit in with other types of training offered under the BACP umbrella and provide a coherent and standardised CPD package for counsellors that could form part of their credits towards renewing yearly accreditation. Sinason (2002) claims that training is a real issue for therapists who want to want with people who have learning disabilities and this may be addressed through the integration of learning disability awareness sessions into counselling training. However, I am aware of the tensions experienced by counselling trainers in providing all the necessary components required of counselling programmes. Moreover, learning disabilities forms only one area that makes up the field of 'diversity'. Nevertheless, legislation clearly requires that counsellors are inclusive of this group of people, therefore, I would propose that one training session on learning disability awareness within a two year professional counselling training programme would be a reasonable compromise. This would provide counsellors with the basics on which to build their practice and some idea of what their future training needs might be.

8.6 Limitations

The planned limitations to the research are outlined in chapter five, section 5.3, which relates to the research design and methods. Briefly, the intentional boundaries of the research involve the research population, limiting research to

counsellors listed in the BACP Directory for the year 2001, this was due to the disparate nature of counsellors and the wide variety of employment contexts, counsellors across the full range would be very difficult to reach and there would be no way of knowing that the counselling population was complete as there would have been with some other professional groups, for example nurses, who have a statutory requirement to register with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). This research is limited to the UK context and the views of counsellors rather than clients, parents or carers. Another intentional limitation relates to the exploration of four main concepts, namely, counselling, psychotherapy, inclusion and young people with learning disabilities; it was necessary to have these boundaries to the research to prevent the study from becoming unmanageable within the resources available for the project. A decision was also made to confine the research largely to the demographic characteristics of counsellors, their contexts and the four measurement variables of 'often', sometimes', 'rarely' and 'never'. Firm limitations or boundaries have been necessary in order to produce a research design that is valid for its purpose. However, the measurement variables also present limitations that emerged from the research process.

The measurement tool was developed through pre-pilot and pilot work with the variables of 'never', 'rarely', 'sometimes' and 'often' identified as measures for assessing the inclusion of young clients with learning disabilities by individual counsellors in their practices. It proved too difficult and unreliable to

use numerical measurements because counsellors generally do not keep statistical records regarding the client characteristic of learning disabilities. In the absence of firm diagnostic information (one of the findings from this research is that counsellors do not always have such prior information about clients) counsellors were making judgements as to whether individual clients had learning disabilities. I recognise the potential lack of reliability of this research measurement tool in terms of the subjective nature of the measurement variables. However, although the variables may not be a valid measure of inclusivity in counselling, without carrying out research into the actual validity of the variables as a measurement tool to provide standardisation it cannot be assumed that it lacks validity. Therefore, I acknowledge the potential unreliability and validity of the measurement tool and accept this in terms of this research due to the investigative and exploratory nature of the study.

Having recognized the limitations of the research methods in terms of the measurement tool and the research population, a further limitation of the research methods involves the qualitative nature of some of the data and the statistically invalid nature of some of the quantitative data, which mean that the findings are not generalisable and must therefore be viewed with caution. On the other hand, the methods, results and the way in which they have been extrapolated from the data serve the purpose of the research well in that the research was intended to be investigative and exploratory and as such form a

basis for the generation and development of further research questions that can focus on different, perhaps more specific areas for future research.

8.7 Implications for further research

Directions for further research include other topics and specific areas of the field, methodologies, alternative perspectives, practice and process research and different populations, other regions and countries; and various psychotherapeutic approaches. This research may provide a starting point for researching other topics within the field of counselling or advance research in topics such as the inclusion of other marginalised groups, for example, asylum seekers, homeless young people, people with a range of conditions affecting communication and young people generally; the use of speech and language in counselling; and the use of self as therapeutic in the counselling relationship. This research is confined to the UK perspective and could be narrowed down to examine inclusion in specific regions, as defined by geography or organisations such as health trusts or broadened to research inclusion in other countries. Investigating the topic from the perspective of young clients with learning disabilities would be useful and could contribute to the body of knowledge in the field. Research on the effectiveness of specific approaches to counselling and how each approach could make practice more inclusive may form provide useful information. However, in terms of taking this research forward, building upon it and giving it further value in terms of practice, I intend to make the model for inclusive counselling practice available to the wider counselling community as a tool for assessing practice and carry out

research based on findings from such assessments in order to build up a picture of inclusivity in relation to specific organisations.

Future research may be directed at developing methodologies to enable researchers to add further to the knowledge base in differing ways, for example, qualitative methodologies to facilitate effectiveness studies and qualitative methodologies to allow process research to be carried out in this area. Process research would be useful to discover the views of counsellors and clients on the therapeutic process and other related processes such as the relationship and psychological movement in counselling.

BIBLIOGRAPHY AND REFERENCES

Aanstoos C. M. (1983) The think aloud method in descriptive research. *Journal of Phenomenology*, Vol: 14, Part 2, Pages: 243-366.

Abbott A. (1992) From causes to events: Notes on narrative positivism *Sociological Methods and Research*, Vol: 20, Part: 4, Pages: 428-455.

Abercrombie N., Hill S., Turner B. S., (1986) *The Dictionary of Sociology*, London, Penguin Books.

Abraham S. (2001) *Eating Disorders: The Facts*, 5th Edition, London, Oxford University Press.

Almeida LN., Azevedo RS., Amaku M., Massad E. (2001) Cytomegalovirus seroepidemiology in an urban community of Sao Paulo, Brazil. *Revista de Saude Publica.* Vol: 35, Part: 2, Pages: 124-9.

Ajami F. (1978) Human Rights and World Order Politics, Cambridge, Cambridge University Press.

American Association for the Study of the Feebleminded (1921) Statistical Manual for the use of Institutions for the Feebleminded. In P. Dumbleton (1998) Words and Numbers, *British Journal of Learning Disabilities* Vol: 26, Pages: 151-153.

Androutsopoulou A. (2001) The self-characterisation as a narrative tool: Applications in therapy with individuals and family. *Sage Family Studies Abstracts* Vol: 23, Part: 3, Pages: 275-407.

Aoki Y. (2001) Polychlorinated biphenyls, polychlorinated dibenzo-p-dioxins, and polychlorinated dibenzoflurans as endocrine disrupters-what have we learned from Yusho disease? *Environmental research.* Vol: 86, Part: 1, Pages: 2-11.

APA (2004) http://www.apa.org/monitor/oct04/learningdisabil.html. Accessed 12/10/2003

Apter G. (2003) The Human Being: J. L. Moreno's Vision in Psychodrama. *International Journal of Psychotherapy.* Vol: 8, Part: 1, Pages: 31-36.

Assagioli R. (2000) Psychosynthesis: *A Collection of Basic Writings*. USA, The Synthesis Center.

Aston G. (1986) Trouble-shooting in interaction with learners: The more the merrier? *Applied Linguistics*. Vol: 7, Part 2, Pages: 113-127.

Axeline V. (1981) *Play Therapy*. London, Ballentine Books.

Baginsky W. (2004) School Counselling in England, Wales and Northern Ireland, NSPCC Online Information Resource.
www.nspcc.org.uk/Info_Briefing/School/Counselling/1.asp. Accessed 17/2/05

BACP (2001) *British Association for Counselling and Psychotherapy Directory*. Rugby.

BACP (2002) Definition of Counselling,
www.bac.psychotherapy.org.help.html

BACP (2002) *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Rugby.

BACP (2003) *Research Conference Proceedings*, May, Rugby.

BACP (2004) *Good Practice Guidelines for Counselling in Schools*, Rugby: British Association for Counselling and Psychotherapy.

BACP (2004) Ethical Framework. www.bacp.co.uk/ethical/_framework

Baird J., Stevenson JC., Williams DC. (2000) The evolution of ADHD: a disorder of communication? *Quarterly Review of Biology*. Vol: 75, Part: 1, Pages: 17-35.

Bandura (1997) *Social Learning Theory*. N.Y. General Learning Press.
BAP (2002) British Association of Psychotherapists: Definition of psychotherapy. www.bap.co.uk

Barnes C., Mercer G., Shakespeare T. (1999) *Exploring Disability*, London, Polity Press.

Bassey M. (1981) Pedagogic research: on the relative merits of search for generalization and study of single events, Oxford Review of Education. In J. Bell (1998) *Doing Your Research Project: A Guide for First-Time Researchers in Education and Social Sciences*. (2nd Edition) Open University Press, Buckingham.

Baszormeyi-Nagy I., Krasner B.T., Krasner B.R. (1986) *Between Give and Take: A Clinical Guide to Contextual Therapy*. London, Brunner-Routledge.

Baudrillard J. (1995) The virtual illusion: Or the automatic writing of the world. *Theory, Culture and Society.* Vol: 12, Pages: 97-107.

Bayne R., Nicolson P., Horton I. (1993) (Eds) *Counselling and Communication Skills for Medical and Health Practitioners.* London. Blackwell.

Bell J. (1998) *Doing Your Research Project: A Guide for First-Time Researchers in Education and Social Sciences.* (2nd Edition) Buckingham, Open University Press.

Bennick J., Gussak D.E., Skowran M. (2003) The role of the art therapist in a juvenile justice setting. *The Arts in Psychotherapy.* Vol: 30, Part: 3, Pages: 163-173.

Beardsmore A., Dorman T., Cooper SA., Webb T. (1998) *Journal of Intellectual Disability Research.* Vol: 42, Part: 6, Pages: 463-71.

Berends M. J. Tan-Sindhunata G. Leegte B. van Essen A. J. (2001) *Phenotypic variability of cat-eye syndrome.* Genetic Counseling. Vol: 12, Part: 1, Pages :23-34.

Berg J. M. (1966) The aetiological aspects of mental subnormality: pathological factors (pp6). In A.D.B. Clarke (1966) *Recent Advances in the Study of Subnormality.*

Berger A. (1980) *Encyclopaedic Dictionary of Roman Law.* London. Blackwell.

Bernstein B. (1960) Language and Social Class. In A.D.B. Clarke (1966) *Recent Advances in the Study of Subnormality.* National Association for Mental Health (March, 1966).

Bernstein (1961) *Social Class and Linguistic Development: A Theory of Social Learning.* London, Floud and Anderson.

Bernstein (1970) A Socio-Linguistic Approach to Social Learning. In P. Worsley. *Introducing Sociology.* London, Oxford University Press.

Besley A.C. (2002) Foucault and the turn to narrative therapy. *British Journal of Guidance and Counselling.* Vol: 30, Part: 2, Pages: 125-143.

Beveridge M., Conti-Ramsden G. (1997) *Children With Language Disabilities,* London, Open University Press.

Blair R.W. (1982) *Innovative Approaches to Language Teaching.* USA, Rowley.

Bolinger D. (1980) *Language: The Loaded Weapon.* London. Longman.

Bond, T. (2004a) A question of trust: an introduction to the Ethical Guidelines for Researching Counselling and Psychotherapy. In *Counselling and Psychotherapy Research (CPR)* 4(2): 4-9

Bond, T. (2004b) *Ethical Guidelines for Researching Counselling and Psychotherapy.* Rugby: British Association for Counselling and Psychotherapy, 12 pages. http://www.bacp.co.uk/e_g.html

Bond, T. (2003) 'Preface' in M.Jacobs and M. Walker (2003) *Training Resources: Introduction to Ethical Framework for Good Practice in Counselling and Psychotherapy*. Rugby: BACP.

Bond, T. 2002 E*thical Framework for Good Practice in Counselling and Psychotherapy,* Rugby: British Association for Counselling and Psychotherapy, 16 pages. http://www.bacp.co.uk/ethical_framework/

Bond T. (2000) *Standards and Ethics for Counselling in Action*. London: Sage.

Bonell-Pascual E., Huline-Dickens S., Hollins S., Esterhuyzen A., Sedwick P., Abdelnoor A., Hubert J. (1999) Bereavement and grief in adults with learning disabilities. A follow up study. *British Journal of Psychiatry*. Vol: 175, Pages: 348-50.

Booth T., Ainscow M. (Ed.) (1998) *From Them to Us: an International Study of Inclusion in Education*, London, Routledge.

Booth T., Ainscow M., Dyson A. (1998) England, Inclusion and Exclusion in a Competitive System. In M.Ainscow (Ed) (1998) *From Them to Us: an International Study of Inclusion in Education.* London, Routledge.

Borgatti R., Piccinelli P., Passoni D., Dalpra L., Miozzo M., Micheli R., Gagliardi C., Balottin U. (2001) Relationship between clinical and genetic features in 'inverted duplicated chromosome 15' patients. *Paediatric Neurology*. Vol: 24, Part: 2, Pages: 111-6.

Borthwick-Duffy S. A. (1994) Epidemiology and the prevalence of psychopathology in people with mental retardation. *Journal of Consulting and Clinical Psychology*. Vol: 62, Pages: 17-27.

Boszormenyi-Nagy I., Krasner B.T. (1986) *Between Give and Take: A Clinical Guide to Contextual Therapy,* London, Bruner/Mazel.
Bowlby J. (1969/1975) *Attachment: Vol. 1 of Attachment and Loss. New York.* Basic Books.

Breakey J. (1997) The role of diet and behaviour in childhood, *Journal of Paediatric Child Health.* Vol: 33, Part: 3, Pages: 190-4.

Brindle D. (2000) *Learning Disability Woman Takes Commission Role.* Guardian Newspaper (Nov.) London.

British Deaf Association (2004) www.britishdeafassociation.org.uk

British Psychological Society (BPS) (2000) *Learning Disabilities: Definitions and Contexts,* Professional Affairs Board, The British Psychological Society.

British Association for Counselling and Psychotherapy (BACP) (2003) Ethical Framework, Rugby. www.bac.org.uk

British Institute for Learning Disabilities (BILD) (2003) Fact Sheet No. 1: Learning Disabilities. www.bild.org.uk

British Institute for Learning Disabilities (BILD) (2003) Fact Sheet No. 3: Advocacy. www.bild.org.uk

Brown R. (1977) Introduction. In C. Snow and C. Ferguson (Eds) *Talking to Children: Language Input and Acquisition.* Cambridge. Cambridge University Press.

Brown H.D. (1987) *Principles of Learning and Teaching.* (2nd Edition) Englewood Cliffs. N.J. Prentice Hall.

Brown H. (1995) *Valuing People with Learning Disabilities Strategy Document: Abuse and Protection Issues.* Kent. Salomen Centre for Social and Psychological Development.

Brown A. J., & Dowling P. C. (1998). *Doing Research/Reading Research: A Mode of Interrogation for Education.* London: Falmer Press.

Bruner J. (1986) *Actual Minds, Possible Worlds.* Cambridge. Harvard University Press.

Brunton, K. (1997) Stigma. *Journal of Advanced Nursing.* Vol: 26, Part: 5, Pages: 891-898.

Bryman A. & Cramer D. (1990) *Quantitative Data Analysis for Social Scientists.* London. Routledge.

Buchanan A. Wilkins R. (1991) Sexual abuse of the mentally handicapped: difficulties in establishing prevalence. *Psychiatric Bulletin.* Vol: 15, Pages: 601-5.

Bureau of the Concensus (2003) *Current Population Survey, Annual Social and Economic Supplement* (ASEC) Washington. Bureau of the Concensus for the Bureau of Labor Statistics.

Burnard (1997) *Counselling Skills for Health Professionals*. London. Nelson Thornes.

Burt C. (1937) The Subnormal Mind. In P. Dumbleton (1998) Words and Nunbers. *British Journal of Learning Disabilities*. Vol: 26, Pages: 151-153.

Cans C. Wilhelm L. Baille MF. Du Mazaubrun C. Grandjean H. Rumeau-Roqette C. (1999) Aetiological findings and associated factors in children with severe mental retardation. *Developmental Medicine and Child Neurology*, Vol: 41, Part: 4, Pages 233-9.

Carrington S., Robinson R. (1004) A case study of inclusive school development: a journey of learning. *International Journal of Inclusive Education*. Vol:8, Parrt: 2, Pages: 141-153.

Centre for Studies on Inclusive Education (CSIE) (2000) *International Perspectives on Inclusion*. Bristol.

Casement P. (1992) *On Learning from the Patient*. London: Routledge.

Centre for Counselling Studies (CESCO) (2003) *Handbook for Counselling Programmes,* Durham, University of Durham.

Centre for Studies on Inclusive Education. (CSIE) (2000) *International Perspectives on Inclusion*. Bristol.

Cervantes R. (1983) 'Say it Again Sam': the effect of repetition in dictation scores. Term paper, ESL 70, University of Hawaii at Manoa. In Chaudron C. (1988) *Second Language Classrooms: Research on Teaching and Learning*. Cambridge: Cambridge University Press.

Charles D. C. (1953) Ability and accomplishment of persons earlier judged mentally deficient, in Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality*, National Association for Mental Health (March 1966).

Chaudron C., Richards J. (1986) The effect of discourse markers on the comprehension of lectures. *Applied Linguistics*, Vol: 7, Pages 113-127.

Chaudron C. (1983) Foreigner talk in the classroom-an aid to learning? In Seliger H., Long M. (eds.) (1983) *Classroom-orientated Research in Second Language Acqusition*. Massachusetts: Rowley, Newbury Hose.

Chelley J., Mandel JL. (2001) Monogenic causes of x-linked mental retardation. *Nature Reviews Genetics*, Vol: 2, Part: 9, Pages: 669-

80.Chenowith, L. 1996. Violence and Women with Disabilities. *Violence Against Women*. Vol: 2, Part: 4.

Childline (2001)
http://www.childline.org.uk/Somefactsandfiguresaboutsuicide.asp

Children's Alliance for England (1977-2003) *Annual Children's Rights Reports*.

Chin H.Y., Bernard-Opitz V. (2000) Teaching conversational skills to children with autism: the effect on the development of a theory of mind. *Journal of Autism and Developmental Disability*, Vol: 30, Part: 6.

Chomsky N. (1958) A Review of B.F. Skinner's 'Verbal Behaviour', *Language*, Vol 35, Pages: 26-58.

Clarke A. D. B. and Clarke A. M. (1953) How constant is the IQ? In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Clarke A. D. B. and Clarke A. M. (1954) Three further studies. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Clarke A.D. B. and Hermelin B. F. (1955) Adult imbeciles: their abilities and trainability. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Clarke A. D. B. and Clarke A. M. (1958) Cognitive and social changes in the feeble-minded. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Clarke C. (2000) Perceptual adjustments to foreign accented English in research or spoken language, *Processing Progress Report,* Vol: 24, Pages: 321-335, Bloomington, Indiana: Speech Research Laboratories, Indiana University.

Clarke L. (2002) Under new management. *Counselling and Psychotherapy Journal,* Vol: 13, 6 July.

Clark M. Oxman A.D. (Eds) (2003) *Cochrane Reviewers' Handbook.* Pages: 4-20. Oxford. The Cochrane Collaboration.

Clarkson P. (2003) *On Psychotherapy 4*. London: Whurr.

Clarkson P. (Ed) (1998) *Counselling Psychology: Integrating Theory, Research and Supervised Practice*. London : Routledge.

Claude R.P. (Ed.) (1976) *Comparative Human Rights*. Baltimore: John Hopkins University Press.

Cohen A.D., Fass L. (2001) Oral language instruction: teacher and learner beliefs and the reality in EFL classes at a Colombian University. *Journal of Language and Culture*. Vol: 6, Pages 43-62.

Cohen N. (1999) *Depth and Connectedness*. An experiential workshop given at the University of Durham.

Cooley C. H. (1909) Human Nature and the Social Order. In Gergen K. J. (1968) *The Self in Social Interaction*. London : Wiley.

Copeland I. (1999) Normalisation: an analysis of aspects of special educational needs. *Educational Studies*, Vol: 25, Part: 1.

Copeland I. (1998) History is not the past: a reappraisal of the development of the provision for mentally handicapped children in England and Wales, 1870-1914, *History of Education Society Bulletin*, No.: 62, November.

Corbett J. (1979) Psychiatric morbidity and mental retardation: A framework for the future. In James F. E. and Smith R. P. (Eds.) *Psychiatric Illness and Mental Handicap*. London: Gaskell Press.

Corbett A. (1999) *Long-term Psychotherapy for Victims of Child Sexual Abuse with Learning Disabilities*, (RESPOND), RCN Conference, University of Kent consultancy research figures on abuse (1993).

Cordoni L. (1996) *A Learning Disability is Only One Part of a Child*. Learning Disabilities Newsbriefs. Learning Disabilities Association of America. Nov/Dec.

Corey G. (1995) *Theory and Practice of Counselling and Psychotherapy*. USA: Brookes Cole.

Council for Disabled Children (1994) *Policy Statement on Inclusion*. London. CDC.

Cowan LD., Leviton A., Dammann O.(2000) New research directions in neuroepidemiology. *Epidemiologic Reviews*. Vol: 22, Part: 1, Pages: 18-23.

Cowie H. and Salm A. (1998) Learning experiences of counsellors in training. In Clarkson P. *Counselling Psychology: Integrating Theory, Research and Supervised Practice*. London : Routledge.

Coyle A.(1998) Qualitative research in counselling psychology: using the counselling interview as a research instrument. In Clarkson P. *Counselling Psychology: Integrating Theory, Research and Supervised Practice*. London: Routledge.

CPS (2003) *Sexual Offences Act*, London: Crown Prosecution Service.

Crace J. (2000) *The New Citizens*. Guardian Educational Supplement, (February).

Cranston M. (1973) *What are Human Rights?* USA: Taplinger Pub. Co.

CRD (2001) *Undertaking systematic reviews of research on effectiveness: CRDs guidelines for those carrying out reviews or commencing research*, NHS York, CRD Report 4 (2nd Ed.).

Croll P., Moses D. (2000) *Special Needs in the Primary School: One in Five.* London: Cassell Academic Press.

Cronemberger M. F. de Castro Moreira J. B. Brunoni D. Mendonca T. S. Alvarenga E. H. Rizzo A. M. Diogo S. M. (2001) (?) Journal of Pediatric Opthlmology and Strabismus. 38(3):156-62, 2001 May-Jun.

Czaja R. and Blair J. (1996) *Designing Surveys: A Guide to Decisions and Procedures*. London: Sage, Pine Forge Press.

Dabora S. L. Jozwiak S. Franz D. n. Roberts P. S. Nieto A. Chung J. Choy Y. S. Reeve M. P. Thiele E. Egelhoff J. C. Kasprzyk-Obara J. Domanska-PakielaD. Kwiatkowski D. J. (2001) American Journal of Human Genetics. 68(1):64-80.

Dagger R. (1997) *Civic Virtues: Rights, Citizenship and Republican Liberalism*. Oxford University Press.

Darlington Borough Council (2003) *Counselling in Secondary Schools.* Darlington. Local Education Authority.

Davies C. (2002) *Changing Society.* London. Scope.

Davis K. (1947) Final note on a case of extreme isoloation. In Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality*. National Association for Mental Health.

Department of Health and Home Office (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: HMSO.

Dendy M. (1899) The importance of permanence in the care of the feeble-minded. In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities*. London: Routledge.

Department for Education (DfE) (1987) *The Education Reform Act.* London: HMSO.

Department for Education (DfE) (1986) *The Education Act.* London: HMSO.

Department for Education (DfE) (1981) *Education Act.* London: HMSO.

Department for Education (DfE) (1970) *The Education (Handicapped Children) Act.* London: HMSO.

Department for Education: Special Educational Needs (DfE: SENS) (1978) *Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (Warnock Report).* London: HMSO.

Department of Health and Office of Population Censuses and Surveys, (1995) DHSS. London: HMSO.

Dewey J. (1916) *Democracy and Education*. London: The MacMillan Company.

Department for Education (DfE) (1989) *Children Act.* London: HMSO.

Department for Education (DfE) (1994) *Code of Practice in the Identification and Assessment of Children with Special Educational Needs.* London: HMSO.

Department for Education (DfE) (1993) *The Education Act.* London: HMSO.

Department for Education (DfE) (1993) *National Exclusions Reporting System.* London: HMSO.

Department for Education and Employment (DfEE) (1999) *Disability Rights Commission Act.* London: HMSO.

Department for Education and Employment (DfEE) (1996) *Statistics in Schools.* London: HMSO.

Department for Education and Employment (DfEE) (1995) *The Education Act.* London: HMSO.

Department for Education and Employment (DfEE) (1995) *Disability Discrimination Act.* London: HMSO.

DfEE (1993) *National Exclusions Reporting System.* London: HMSO.

Department for Education and Skills (DfES) (1999) *RAE Review*. London: HMSO.

Department for Education and Skills (DfES) (2001a) *SENs Code of Practice*. London. HMSO.

Department for Education and Skills (DfES) (2001b) *Inclusive Schooling: Children with Special Educational Needs* DFES/0774/2001.

Department for Education and Skills (DfES) (2003) *The Future of Higher Education*. White Paper, London: HMSO.

Department for Education and Skills (DfES) (2003) *Skills Strategy White Paper*. London: HMSO.

Department for Education and Skills (DfES) (2004) *Childrens' Bill*. London. HMSO.

Department for Education and Skills (DfES) (2004) OFSTED Report. Tuckswood Community First School. Norfolk. www.creativecorner.co.uk

Department for Education and Skills (2004) Inclusion and Trends. www.dfes.gov.uk/trends/index.cfm Accessed 2/2/05.

Department for Education and Skills (2004) Inclusion and Trends. www.dfes.gov.uk/trends/upload/xls/3_4t.xls. Accessed 28/2/05

Department for Education and Skills (2005) Statistics on School Exclusions, www.dfes.gov.uk/trends/upload/xls/3_4t.xls Accessed 16/2/05.

Department for Work and Pensions (DfWP) (1999) *New Deal Initiative*. London. HMSO.

Department of Health and Social Services (DHSS) (1989) *The Children's Act*. London: HMSO.

Department of Health (DoH) (2003) www.doh.uk/learningdisabilities/facts.html

Department of Health (DoH) (2001) *NHS Research Guidelines*. University of York. Centre for Research and Dissemination (CRD).

Department of Health (DoH) (2001) *Treatment Choice in Psychological Therapies and Evidence Based Clinical Practice Guideline*. London: HMSO.

Diamond G.M. Liddle H.A., Hogue A., Dakof G.A. (1999) Alliance-building interventions in family therapy: a process study. *Psychotherapy,* Vol: 36, Pages: 355-67.

Diana, The Princess of Wales Memorial Fund, www.theworkgoeson.org (1996)
Di Cicco M., Padoan R., Felisati G., Dilani D., Moretti E., Guerneri S., Selicorni A. (2001) *International Journal of Pediatric Otorhinolaryngology,* Vol: 59, Part: 2, Pages:1747-50.

DiGuiseppe R., Linscott J., Jilton R. (1996) Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied and Preventative Psychology,* Vol: 5, Pages 85-100.

Docherty S., Sandelowski M. (1999) Focus on qualitative methods of interviewing children. *Research on Nursing and Health,* Vol: 22, Pages: 177-85.

Donnelly J. (2002) *Human Rights in Theory and Practice.* USA: Cornell University Press.

Dryden W. (1996) *Developing Cognitive Behavioural Counselling.* London: Sage.

Dryden W. (2000) *Rational Emotive Behavioural Counselling in Action.* London: Sage.

Dumbleton P. (1998) Words and Nunbers. *British Journal of Learning Disabilities,* Vol: 26, Pages:151-153.

Durkheim E. (1987/1970) *Suicide: A Study in Sociology.* London: Routledge.

Douglas J. W. B. and Bloomfield J. M. (1958) Children under five. In Clarke A. D. B. (Eds) *Recent Advances in the Study of Subnormality.* National Association for Mental Health (March 1966).

Dyson A., Farrell P., Hutcheson G., Polat F., Gallannaugh F. (2004) *Inclusion and Pupil Achievement.* HMSO: DFES.

Ebata A.T., Moos R.H. (1990) Coping and adjustment in distressed and healthy adolescents, *Journal of Applied Developmental Psychology,* Vol: 12, Pages: 33-54.

Egan G. (1994) *A Systematic Approach to Effective Helping.* N.Y.: Brookes Cole.

Egan G. (2001) *The Skilled Helper: A Problem Management and Opportunity Development Approach to Helping.* USA: Wadsworth.

Ellis W.S. (1996) Lexical learning by children with specific language impairment: effects of linguistic input presented at varying speaking rates. *Journal of Speech and Hearing Research,* Vol: 39, Pages: 177-190.

Elvik, S.L. Berkowitz, C.D. Nicholas, E. Lipman, J.L., Inkelis, S.H. (1990) Sexual abuse in the developmentally disabled: dilemmas in diagnosis. *Child Abuse and Neglect.* Vol: 14, Page: 497-502.

Emetis (2004) Common Entrance Exam, www./emetis.com/primer/exams/htm
Equal Opportunities Commission (2003) *Valuing diversity will make Britain stronger*. Press release, Barbara Roche, London: HMSO.

Erickson E.H. (1963/1994) *Identity and the Life Cycle*. New York: Norton.

Esmer C. Alvarez-Mendoza A. Lieberman E. Del Castillo V. Riaura-Sanz C. (2001) Liver fibrocystic disease and polydactyly: Proposal of a new syndrome. American Journal of Medical Genetics. Vol: 101, Part: 1 Pages :12—16.

Etherington, K. (2000) Narrative Approaches to Working with Adult Male Survivors of Sexual Abuse. London: Jessica Kingsley Publishing.

Everall R.D., Paulson B.L. (2002) The therapeutic alliance: adolescent perspectives. *Counselling and Psychotherapy Research Journal.* Vol: 20, Part 2, Pages: 78-87.

Fairweather D. V. I. And Illsley R. (1960) Obstetric and social origins of mentally handicapped children. In Clarke A. D. B. (Eds) *Recent Advances in the Study of Subnormality*, National Association for Mental Health (March 1966).

Ferenczi S. (1955) *Final Contributions to the Methods of Psychoanalysis: Selected Papers of Sandor Ferenczi.* (Ed. Baleant M.) N.Y.: Basic Books.

Fish S. (1989) *Doing What Comes Naturally: Change, Rhetoric and the Practice of Theory in Literary and Legal Studies (Post-Contemporary Interventions).* USA: Duke University Press.

Fichera M. Silengo M. Spalletta A. Giudice M. L. Romano C. Ragusa A. (2001) Prenatal diagnosis of ATR-X syndrome in a fetus with a new G>T splicing mutation in the XNP/ATR-X gene. *Prenatal Diagnosis*. Vol: 21, Part: 9, Pages:747-51.

Finkelhor D. (1986) *Sourcebook on Child Sexual Abuse*. Newbury Park, CA: Sage.

Fombonne E. (1999) The Epidemiology of Autism: a review. *Journal of Psychological Medicine.* Vol: 29, Pages: 769-786.

Forrester V. (1999) *The Economic Horror*. (English translation), Cambridge: Polity Press.

Forster-Gibson C. J. Davies J. MacKenzie J. J. Harrison K. (2001) Cryptic duplication of 21q in an individual with a clinical diagnosis of Down syndrome *Clinical Genetics*. Vol: 59, Part: 6, Pages: 438-43.

Foucault M. (1980) *Power and Knowledge: Selected Interviews and Other Writings (1972-1977)*. London: Pantheon.

Foucault M. (1977/1995) *Discipline and Punish: The Birth of the Prison*. New York: Sheridan.

Fowler R.B., Orenstein J.R. (1993) *An Introduction to Political Theory: Toward the Next Century*. New York: Harper Collins.

Freud S. (1899) Letter to Wilhelm Fleiss, 21/9/1899. In Masson J. (1985) *The Assault on Truth: Freud's Suppression of the Seduction Theory*. London: Penguin.

Freud S. (1900/1983) *The Interpretation of Dreams*. London: Avon Publishers.

Freud S. (1990) *Beyond the Pleasure Principle: The Standard Edition*, James Trachey (Ed.), London: W.W. Watson and Co.

Friery K. (2003) The price of counselling. *Counselling and Psychotherapy Journal*, Vol: 14, Part: 8, Pages: 7-9.

Furey, Joan A. Psychological intervention and combat casualty care. *NCP Clinical Newsletter* Vol: 1, Part: 3.

Future Foundation (2004) *The Age of Therapy*, Rugby: British Association for Counselling and Psychotherapy.

Galdzicki Z., Siarey R., Pearce R., Stoll J., Rapoport SI.(2001) On the cause of mental retardation in Down syndrome: extrapolation from full and segmental trisomy 16 mouse models. *Brain Research—Brain research Reviews*. Vol: 35, Part: 2, Pages: 115-45.

Ganji M. (1975) *The Realization of Social and Cultural Rights: Problems, Policies, Progress (Special Rapporteur of the Commission of Human Rights)*. New York: UN E/CN.4/1131/Rev.1: 326.

Gass S., Veronis E. (1991) Miscommunication in non-native speaker discourse. In Coupland N., Giles H., Weimann J. (Eds.) *Miscommunication and Problematic Talk*. London: Sage.

Geldard K., Geldard D. (1999) *Counselling Adolescents*. London: Sage.

Gelso C.G., Carter J.A. (1994) Components of the psychotherapy relationship: their interaction and unfolding during treatment. *Journal of Counselling Psychology,* Vol: 41, Pages 296-306.

Gemignani F. Marbini A. (2001) Charcot–Marie–Tooth disease (CMT): distinctive phenotypic and genotypic features in CMT type 2. *Journal of the Neurological Sciences.* Vol: 184, Part: 1, Pages:1-9.

Gergen K. (1991) *The Saturated Self: Dilemmas of Identity in Modern Life.* USA: Basic Books.

Gibbs S.E. (2000) *Ready to Roll for a Doctorate.* Letter in the Higher Education Supplement of the Guardian Newspaper, 22nd February.

Giddens A. (1999) *The Third Way and its Critics.* Cambridge: Polity Press.

Giddens A. (1999) *Reith Lectures.* BBC Radio 4.

Giddens A. (1998) *The Third Way: The Renewal of Social Democracy.* Cambridge: Polity Press.

Gil E. (1996) *Treating Abused Adolescents.* N.Y.: Guildford Press.

Gilliland J., McGuiness J. (1989) *Counselling and Special Educational Needs in Special Educational Needs Review.* Neville Jones (Ed.) London: Falmer Press.

Gilmore S. (1973) *The Counsellor in Training.* N.J.: Prentice Hall.

Gilovitch T. (1991) *How we know what isn't so: The fallibility of human reason in everyday life.* New York: Free Press.

Glinoer D. (1977) The regulation of thyroid function in pregnancy: pathways of endocrine adaptation from physiology to pathology. *Endocrine Reviews.* Vol: 18, Part: 3, Pages: 404-433.

Goffman E. 1963. *The Presentation of Self in Everyday Life.* Garden City, NY: Anchor Books.

Golden L. (2001) Creative Writing and Therapy. *The Family Journal,* Vol: 9, Part: 2, Pages: 201-206.

Goodey C. F. (1996) The Psychopolitics of Learning Disability in Seventeenth Century Thought In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities.* London: Routledge.

Goss S. and Rose S. (2002) Evidence-based practice: a guide for counsellors and psychotherapists. *Counselling and Psychotherapy Research Journal*, Vol: 2, Part: 2, Pages: 147-151.

Gravestock S. (2000) Eating disorders in adults with intellectual disability. *Journal of International Disability Research*, Vol: 44, Part: 6, Pages 625-637.

Griffiths R. (1991) Personality and second language learning: theory, research and practice. In Sadtano E. (Ed.). *Language Acquisition and the Second/Foreign Language Classroom*. Singapore: SAMEO Regional Language Centre.

Grove J. (2003) Can heterosexual counsellors help same-sex couples? An exploratory study. *Counselling and Psychotherapy Research Journal.* Vol: 3, Part:2, Pages: 129-138.

Gunzburg H. C. (1958, 1966) Psychotherapy with the feeble-minded. In Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality, National Association for Mental Health* (March 1966).

Gunzburg H. C. (1960) Rehabilitation of the mentally subnormal. In Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality, National Association for Mental Health* (March 1966).

Habeas Corpus Act (1679) *Liberty Library of Constitutional Classics*. http://www.constitution.org/liberlib.htm

Hammill D. (1993). A brief look at the learning disabilities movement in the United States. *Journal of Learning Disabilities*. Vol: 26, Pages: 78-90.

Halmos P. (1966) *The Faith of the Counsellors: A Study of the Theory and Practice of Social Case Work and Psychotherapy*. N.Y.: Shocken Books.
Hamlyn D. W. (1989) *The Pelican History of Western Philosophy.* London:Penguin Books.

Hanna F.J., Hanna C.A., Keys S.G. (1999) Fifty Strategies for Counselling defiant, aggressive adolescents: reaching, accepting and relating, *Journal of Counselling and Development*, Vol: 77, Pages: 395-404.

Harris B., Pattison S. (2004) *Counselling Children and Young People: A Review of the Research Evidence*. Rugby: BACP.

Harris M. (2002) *Fear of debt deterring would-be students (press release).* Partners in Care, University UK Survey, www.universitiesuk.ac.uk/mediareleases/show

Hart C. (1998) *Doing a Literature Review*, London:Sage Publications.

Hayes, N. (1997) (ed) *Doing Qualitative Analysis in Psychology,* London: Psychology Press.

Henkin L. (1978) (Ed.) *The Rights of Man Today*. USA: Westview Press.

Hong Kong Federation of Youth Groups (2001) *Indicators of Youth Values: 2001*, Youth Trends in Hong Kong.

Hood K. The challenge of evidence-based practice for learning disabilities. *British Journal of Nursing*. Vol: 10, Part: 8, Pages: 517-22.

Hornby, G., Hall, E., and Hall, C. (eds)(2003). *Counselling Pupils in Schools: Skills and Strategies for Teachers*. London: Routledge: Falmer

Hornby, G. (2000). *Improving Parental Involvement*. London: Cassell.

Hyme D. (2000) The emergence of socio-linguistics: a response to Samarin. *Journal of Sociolinguistics,* Vol: 4, Part: 2, Pages: 312-315.

Inskipp F. (1996) *Skills Training for Counsellors*. London: Sage.

Jacobs M. (2000) *Psychodynamic Counselling in Action*. London: Sage.

Jefferson T. (1776) *US Declaration of Independence: Right to Institute New Government*. http://www.loc.gov/exhibits/jefferson/jefdec.html

Jobin A. M. (2002) *Le Journal Créatif: à la rencontre de soi par l'art et l'écriture*. Montreal: Editions du Roseau.

Johnson P. (1981) Effects on reading comprehension of language complexity and cultural background of a text, *TESOL Quarterly,* Vol: 15, Pages: 169-81.

Jolowicz H. F. and Nicholas B. (1972) *Historical Introduction to the Study of Roman Law*. 3rd Ed. London: Cambridge University Press.

Joyce J.A. (1979) *The New Politics of Human Rights*, USA: Martin Pub. Co.

Joyce P., Sills C. (2001) *Skills in Gestalt Counselling and Psychotherapy*, London: Sage.

Jung C., Fordham M. (Ed.) (1974) *The Archetypes of the Collective Unconscious: Collected Works of C.G. Jung*, Vol.: 9, Part: 1.

Kalff D. (1980) *Sand-Play: A Psychotherapeutic Approach to the Psyche*, London: Sigo Press.

Kaplan A. (1964) The conduct of inquiry. In Miles M. B. & Huberman A. M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook (2nd Edition).* London: Sage Publications.

Kazdin A.E. (2000) *Psychotherapy for Children and Adolescents: Directions for Research and Practice.* N.Y.: Guildford Press.

Kennedy E.C. (1975) *Human rights and psychological research: A debate on psychology and ethics.* New York: Thomas Y. Crowell, Pages: 37-68.

Kirk S. A. (1958) Early education of the mentally retarded. In Clarke A. D. B. (1966) *Recent Advances in the Study of Subnormality.* National Association for Mental Health (March 1966).

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *Counseling Psychologist,* 12(3), 43-55.

Kivitie-Kallio S. Norio R. (*2001 Cohen Syndrome: Essential features, natural history, and heterogeneity.* American Journal of Medical Genetics. Vol: 102, Part: 2, Pages:125-35.

Knecht T. (1999) Pica- a qualitative appetite disorder. *Schweizerische Medizinische Wochenschrift. Journal Suisse de Medecine.* Vol: 129, Part: 36, Pages:1287-92.

Kovacs J. (2002) *Writing with Multiple Intelligences: Creative Opportunities for Teachers, Writers and Therapists.* Portland: Blue Heron Press.

Kristjandottir R, Uvebrant P., Wiklund LM. (2000) Clinical characteristics of children with cerebral white matter abnormalities. *European Journal of Paediatric Neurology.* Vol: 4, Part: 1, Pages:17-26.

Kulkarni M., Kalantre S., Upadhye S., Karande S., Ahuja S. (2001) Approach to learning disability. *Indian Journal of Paediatrics.* Vol: 68, Part: 6, Pages: 539-46.

Lambert M.J. (1992) Measuring Counseling Outcome: a rejoinder, *Journal of Counselling and Development,* Vol: 70, Pages: 538-539.

Landreth G. (2002) *Play Therapy: The Art of the Relationship.* Portland, Oregon: Brunner Routledge.

Laungani P., West W. (2004) *Cross-Cultural Therapy: Theory, Research and Applications,* Workshop given at BACP research Conference.

Lee D. (2003) Pacific Resources for Education and Learning. *Pacific Educator,* (Sept).

Leib SL., Tanber MG. (2001) In search of strategies for preventing brain damage as a sequala of bacterial meningitis. *Schweizerische Medizinische Wochenschrift. Journal Suisse de Mediecine.* Vol: 130, Part: 24, Pages: 928-35, 2000, June 17.

Levitas AS., Reid CS. (1998) Rubinstein-Taybi Syndrome and psychiatric disorders. *Journal of Intellectual Disability Research.* Vol: 42, Part: 4, Pages: 284-92.

Lincoln Y. S. & Guba E. G. (1985) Naturalistic Inquiry. In Miles M. B. & Huberman A. M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook (2nd Edition).* London: Sage Publications.

Lindsay W.R. (1999) Cognitive Therapy. *The Psychologist*, Vol: 12, Part: 5, Pages: 238-241.

Locke J. (1690/1975) An Essay Concerning Human Understanding. In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities.* , London: Routledge.

Lomas P. (1973) *True and False Experience: The Human Element in Psychotherapy.* N.Y.: Talinger.

Long M. (1983) Native speaker/non-native speaker conversation in the second language classroom. In Clarke M., Hanscombe J. (Ed.) (1983) *On TESOL '82.* Washington D.C.: TESOL.

Long M. (1990) What you don't know can't help you: an exploratory study of background knowledge and second language listening comprehension. *Studies in Second Language Acquisition.* Vol: 12, Pages: 65-80.

Long M. (1991) Assessment strategies for SLA theories. *Applied Linguistics.* Vol: 14, Pages: 225-49.

Lord C., Ris., Lambrecht L., Cook E.H., Bennet J., Leventhal L., Dilavore P.C., Rickeles A., Rutter M. (2000) The Autistic-Observation Scale-Generic: A Standard Measure of Autism. *Journal of Autism and Developmental Disorders,* Vol:30, Part: 3.

Louis W.R., Low A.M., Canny N.P., Marshall P.J. (1998) *The Oxford History of the British Empire: The 18th Century (Oxford History of the British Empire, Vol. 2).* Oxford University Press.

Lowe N. (1984) *Mastering Modern British History.* Basingstoke: Macmillan Educational Ltd.

Lowenfield M. (1967) *Play in Childhood*. N.Y.: Wiley.

Lindsay W. R. (1999) Cognitive Therapy. *The Psychologist*, Vol.: 12, Part: 5, Pages: 238-241.

Luria A. R. (1961) The role of speech in the regulation of normal and abnormal behaviour. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966)

Lynch B.K., McNamara T.F. (1998) Using G-Theory and Many-Facet Rasch Measurement in the Development of Performance Assessments of the ESL Speaking Skills of Immigrants. *Language Testing,* Vol: 15: (23), Part: 2, Pages:158-180.

Mackay H., West W., Moorey J., Guthrie E., Margison F. (2000) *Training in psychodynamic interpersonal therapy: primary care counsellors' experiences of changing their practice.* BACP Research Conference (May, 2000) Rugby: BACP.

Mahoney G.T., Seely P. (1976) The role of the social agent in language acquisition: implications for language intervention. In Ellis N.R. (Ed.) *International Review of Research in Mental Retardation*, Vol: 8, N.Y.: Academic Press.

Malindzsisa J. (2001) *Towards effective student counselling for distance learners*. Conference Proceedings, SSCSA (Society of School Counsellors in Southern Africa), October, University of Natal.

Malhotra Bentz V. and Shapiro J. J. (1998) *Mindful Inquiry in Social Research.* London: Sage Publications.

Marks-Mishne J. (1986) The treatment relationship: alliance, transference, countertransference and the real relationship, in Marks-Mishne J. (Ed.) *Clinical Work with Adolescents*. N.Y.: Free Press.

Martin D. (1997) On teenagers and tattoos. *Journal of American Association of Child and Adolescent Psychiatry,* Vol: 36, Pages: 860-861.

Martin D.J., Garske J.P., Davis M.K. (2000) Relation of the therapeutic alliance with outcome and other variables: a meta-analysic review. *Journal of Consulting and Clinical Psychology,* Vol: 68, Pages: 438-450.

May R. (1997) *Surveys and Social Research: Issues, Methods and Process (2nd Edition).* Buckingham: Open University Press.

McConville B. (2001) *Saving Young Lives*. UK: Childline.

McGuiness, J. (1998) *Counselling in Schools*. London: Cassell.

McLeod J. (2001a) Editorial. *Counselling and Psychotherapy Research Journal*, Vol: 1, Part: 1.

McLeod J. (2001b) *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

McLeod J. (2002) *Counselling in the Workplace: The Facts*. Rugby: BACP.

McNamee S. and Gergen K. J. (Eds) (1992) *Therapy as Social Construction*. London: Sage Publications.

Mead G. H. (1959) *Mind, Self and Society*. Chicago: Chicago University Press.

Mellor-Clark J. (1998) *CORE System Information Management Handbook*. University of Leeds: Core System Group.

Mellor-Clark J. (2000) *Counselling in Primary Care in the Context of the NHS Quality Agenda*. Rugby: BACP.

Meribov G. P., Schopler E., Hearsey K. A. (1994) *Behavioural Issues in Autism: Current Issues in Autism*. New York: Plenum Press.

Merquior J.G. (1991) *Foucault*. London: Fontana Press.

Milbourne L. (2002) Life at the margin: education of young people, social policy and social exclusion. *International Journal of Inclusive Education*. Vol: 6, Part: 4, Pages: 325-343.

Miles M. B. & Huberman A. M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook (2nd Edition)*. London: Sage Publications.

Mead G. H. (1959) *Mind, Self and Society*. Chicago: Chicago University Press.

Mill J. S. (1975) *Three Essays: On Liberty, Representative Government and The Subjection of Women*. Oxford: Richard Wollheim (Ed.), Oxford University Press.

Miller F. J. W., Court S. D. M., Walton W. S. and Knox E. G. (1960) Growing up in Newcastle-upon-Tyne. In Clarke A. D. B. (Eds) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966)

Milner J. (1980) *Counselling in Education*. London: Dent and Sons.

Milroy J. (2001) Language ideologies and the consequences of standardization, *Journal of Sociolinguistics*, Vol: 5, Part: 4, Pages: 230-255.

Mitchell R.P., Freidman S. (1994) Sandplay: Past, Present and Future. In Bawyer L.R. (Chapter 8) *Current Trends: Basic Tenets of the World Technique*, Pages: 10-12; *Basic Tenets of Sandplay*, Pages: 53-55, NYC: Routledge.

Mittler P. (1999) Equal Opportunities-For Whom? *British Journal of Special Education*, Vol: 26, Part: 1.

Moreno J.L., Buer F. (1999) *Moreno's Therapeutische Philosophie, Zuden Grundidideen von Psychodrama ad Soziometrie*, Leskead: Butrich, Verlag.

Monk G. (1996) How Narrative Therapy Works, 3-31. In Monk G., Windslade J., Crocket K., Epston B. (Eds) *Narrative Therapy in Practice: The Archaeology of Hope*. USA: Jossey Bass.

Morse N. and Field M. (1996) *Nursing Research: The Application of Qualitative Approaches (2nd Edition)* London: Chapman and Hall.

Montgomery-Devlin J. (2004) The Barnados'young peoples' therapeutic project: an evaluation. *Childcare in Practice.* Vol: 10, Issue: 1, pages: 7-19.

Morrall P. (2000) *Madness and Murder*. London: Taylor/Francis.

Morrall P. (2001) *Sociology and Nursing*. London: Routledge.

Morrall P. (1998) *Mental Health Nursing and Social Control*. London: Whurr.

Morrall P., Hazleton M. (2004) *Mental Health, Global Policies and Human Rights*. London: Taylor/Francis.

Murray C.J.L., Lopez A.D. (Eds) (1996) *The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge. USA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press. 1996.

Naidoo R., S. Sehoto (2002) *Towards making a difference: exploring the cultural assumptions of the traditional Amanguni*. Conference Proceedings SSCSA, October, University of Natal.

National Advisory Committee on Creative and Cultural Education (1999), *All Our Futures, Creativity, Culture and Education*. DfEE, HMSO.

National Audit Office (2002) *Widening Participation in Higher Education in England, Report by the Comtroller and Auditor*, General HC 458 Session 2001-2, National Audit Office, 18th January, 2002, London: The Stationary Office

National Childrens' Homes (2004) Child and Family Counselling (No: 28, 2001) www.nch.org.uk/lifematters/index4_2001.asp?.126

NCC (1989) (National Curriculum Council) *A Curriculum for All: Special Needs in the National Curriculum.* York: NCC

Nelson-Jones R. (1982) *Introduction to Counselling Skills: Texts and Activities*. London: Sage.

Nelson-Jones, R. (1992) *Lifeskills helping: A textbook of practical counselling and helping skills*. Sydney: Holt, Rinehart and Winston.

Nelson-Jones R. (1997) *Practical Counselling and Helping Skills: Texts and Exercises for the Lifeskills Model*. London: Sage.

Nelson-Jones R. (1999) *Introduction to Counselling Skills*. London: Sage.

Nelson-Jones R. (2003) *Practical Counselling and Helping Skills*. London: Sage.

Neugebauer R. (1996) Mental handicap in Meieval and Early Modern England: Criteria, measurement and care. In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities*. London: Routledge.

NHS Centre for Reviews and Dissemination (2001) *Undertaking systematic reviews of research on effectiveness: CRD's guidance for those carrying out reviews or commissioning research*. York: CRD, Report No. 4 (2nd ed.)

Nicholas B. (1962) *An Introduction to Roman Law*. Oxford: Oxford University Press.

Nezu C.M., Nezu A.M., Gill-Weiss M.J. (1992) *Psychopathology in Persons with Mental Retardation: Clinical Guidelines for Assessment and Treatment.* Cambridge. Cambridge University Press.

Nolte M. (2001) *The relevance of the skills and roles of the student counsellor in making a difference.* Conference Proceedings, October, SSCSA, University of Pretoria.

Norwich, B. & Kelly, N. (2004). *Moderate learning difficulties and the future of inclusion.* Falmer/Routledge.

Norwich, B. (2002). Education, inclusion and individual differences : recognising and resolving dilemmas. *British Journal of Educational Studies 50*(4), 482-502.

Numminen H., Service E., Ahonen T., Korhonen T., Tovanen T., Patja K., Ruuoppila I. (2000) Working memory structure and intellectual disability. *Journal of Intellectual Disability Research*, Vol: 44, Part 5, Pages: 5579-90.

O'Carroll, D. (1999) Supporting research. *Nursing Standard,* Vol: 14, Part: 2, Page: 31.

OFSTED (2004) *Pupils with Specific Learning Difficulties in Mainstream Schools, London:* OFSTED Publications Centre.

Organisation for Economic Cooperation and Development (OECD) (2001) Education at a Glance Indicators, Table E1.1. *Labour Force Participation Rates (1999 figures).* Table E5.1 Higher Earnings (1999 data), www.oecdeducation@aglance.org

Oppenheim A. N. (1973) *Questionnaire Design and Attitude Measurement.* London: Heinnemen.

Orlinski D.E., Grawe K., Parkes B.K. (1994) *Process and Outcome in Psychotherapy.* In Garfield, S., & Bergin, A. (1994). Handbook of Psychotherapy and Behavior Change. (4th ed.). New York: John Wiley.

Owen N. (Ed.) (2001) *Human Rights, Human Wrongs: The Oxford Amnesty Lectures*. Oxford: University Press.

Oxford Centre for Suicide Research (1998) *Annual Report on Suicide Statistics.* Oxford: University of Oxford.

Parker K.C., Forrest D. (1993) Attachment disorder: An emerging concern for school counselors. *Elementary School Guidance & Counseling*. Vol: 27, Part: 209-215.

Pattison S. (1998) *The Role of Counselling Within Inclusive Learning. MA Dissertation,* Unpublished. School of Education, University of Durham.

Pearsall J. (Ed) (2002) Concise Oxford Dictionary. Oxford: Oxford University Press.

Penrose L. S. (1938) A Clinical and Genetic Study of 1,280 cases of Mental Defect. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality.* UK: National Association for Mental Health (March 1966)

Penrose L. S. (1954) The Biology of Mental Defect. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality.* UK: National Association for Mental Health (March 1966)

Penrose L. S. (1962) Biological Aspects. Proceedings of the London Conference on the Scientific Study of Mental Deficiency, 1960. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Piaget J. (1970) *Main Trends in Psychology*. London: George Allen & Unwin.

Pointon C. (2002) Foreign Correspondent. *Counselling and Psychotherapy Journal*, Vol: 13, Part: 8, Pages: 22-25.

Popper K. (1934/1959) *The Logic of Scientific Discovery*. London: Hutchinson.

Presser S. and Blair J. (1994) Survey Pretesting: Do Different methods Produce Different Results? *Sociological Methodology,* Vol: 24, Pages: 73-104.

Prosser H. (1999) An invisible morbidity? *The Psychologist*, Vol: 12, Part: 5, Pages: 234-237.

Psychotherapy: Noch einmal. In Bergin A.E., Garfield S.L. (Eds.) *Handbook of Psychotherapy and Behaviour Change (4th Ed.)*. N.Y.: Wiley.

Pattison S. (2004) Cultural diversity: mapping the experiences of students on an international counsellor training programme, *Counselling Research Journal,* Vol: 3, Part: 2, Pages: 107-113.

Pattison S (1998) *Counselling and Learning Disabilities: An Exploration*, MA Counselling Dissertation, School of Education, University of Durham.

Pearsall J. (Ed.) (2002) *Concise Oxford Dictionary*. Oxford: Oxford University Press.

Piaget J. (2001) *The Psychology of Intelligence, (2nd Ed.)*. London: Routledge.

Piaget J. (1970) *The Science of Education and the Psychology of the Child*. N.J.: Grossman.

Pica T., Long M. (1986) The linguistic and conversational performance of experienced and inexperienced teachers. In Day R. (Ed.) *Talking to Learn: Conversation in Second Language Acquisition*. Mass.: Newbury House, Rowley.

Pointon J. (2002) Foreign Correspondent. *BACP Journal,* Vol: 13, Part: 8, Pages: 22-25.

Popper K. (1934/1959) *The Logic of Scientific Discovery*. London: Hutchinson.

Prosser H. (1999) An invisible mortality? *The Psychologist*, Vol: 12, Part: (5), Pages: 234-237

Qualification and Curriculum Authority (QCA) (1998) *Education for Citizenship and the Teaching of Democracy in Schools*. DfEE. London: HMSO.

Rajagopalan B. (2001) Non-bullous ichthyosiform erythroderma associated with retinitis pigmentosa *American Journal of Medical Genetics*. Vol: 99, Part: 3, Pages:181-4.

Rataisuo S., Taiminen T., Salokangas RK. (1999) Characteristics of people with learning disabilities admitted for psychiatric inpatient treatment. *Journal of Intellectual Disability Research*. Vol: 43, Part 2, Pages: 112-8.

Raz J. (1986) *The Morality of Freedom*. Oxford: Clarendon Press.

Rappoport L. and Kren G. (1996), in Rowan J. and Cooper M. (Ed) (1999) *The Plural Self: Multiplicity in Everyday Life*. London: Sage Publications.

Reber A. S., (1985) *The Dictionary of Psychology*. London: Penguin Books.
Reeve D. (2002) Oppression in the counselling room, *Counselling and Psychotherapy Research,* Vol: 2, Part: 1, Pages: 11-19.

Reiffe C., Terwogt M. T., Stockmen L., (2000) *Journal of Autism and Developmental Disorders*, Vol.: 30, Part: 3.

Reiss, Levitan and Szyszko (1992) Emotional disturbance in mental retardation: diagnostic overshadowing. *American Journal of Mental Deficiency*. Vol: 86 Pages :567-574.

Reyes B. (1994) Cultural symbols and images in the counselling process, *Pastoral Psychology,* Vol: 42, Pages: 277-84.

Rheingold H. L. (1956) The modification of social responsiveness in institutional babies. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Rheingold H. L. (1960) The measurement of maternal care. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Richardson L. (1994) Writing: a method of inquiry.In Clarkson C. (1998) (Ed) *Counselling Psychology: Integrating Theory, Research and Supervised Practice.* London: Routledge.

Robertson A. H. (1977) *Human Rights in Europe, 2nd Ed*. Manchester: Manchester University Press.

Rodis J.F., Egan G.F., Craffy A., Ciarleglio L., Greenstein R.M., Scorza W.E. (1990) Calculated risk of chromosomal abnormalities in twin gestations. *Obstetrics and Gynaecology*. Vol: 76, Pages: 1037-1041).

Rogers C. (1946) Significant aspects of client-centred therapy. *American Psychologist,* Vol: 1, Pages: 415-422.

Rogers C. (1951) *Client-Centered Therapy*. London: Constable Press.

Rogers C. (1972) *Becoming Partners: Marriage and its Alternatives.* N.Y.: Delacorte Press.

Rogers C. (1962) Comment on article by F.L. Vance. *Journal of Counseling Psychology*. Vol: 9, Pages: 16-17.

Rogers N. (1993) *The Creative Connection: Expressive Art as Healing*. USA: Expressive Press.

Ross C. (1997) *Something to Draw On: Activities and Interventions Using a Art Therapy Approach*. USA: Jessica Kingley.

Rotenburg K.J. (1995) *Disclosure Processes in Children and Adolescents*. Cambridge: Cambridge University Press.

Rousseau J.J. (1754) *A Dissertation on the Origin and Foundation of the Inequality of Mankind and is it Authorised by Natural Law?* (Translated by G.D.H. Cole), http://www.marxists.org/reference/subject/philosophy/works/fr/ineq/htm

Rowan J, and Cooper M. (Ed.) (1999) *The Plural Self: Multiplicity in Everyday Life*. London: Sage Publications.

Rowan J. (1997). The six schools of transpersonal psychotherapy. London: Sage.

Royal College of Psychiatrists (2004) *Psychotherapy and Learning Disabilitiy*, Council Report CR116, London: RCP.

Rubin J.A. (2001) *Approaches to Art Therapy: Theory and Practice, (2nd Ed.).* London: Brunner Routledge.

Rushton P. (1996) Idiocy, the Family and the Community in Early Modern North-East England. In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical Perspectives on People With Learning Disabilities*. London: Routledge.

Russell B. (1946/1993) *History of Western Philosophy*. London: Routledge.

Rutter, M., Tizard, J., Yule, W. (1976) Research report: Isle of Wight studies, 1964-1974. *Psychological Medicine*, Vol: 6, Pages: 13-332.

Ryce-Menuhin J. (1992) *Jungian Sand Play: The Wonderful Therapy*. N.Y.: Routledge.

Sanders M.G. (1996) *School-family-community partnerships and the academic achievement of African American urban adolescents*,. Centre for research on the Education of Students Placed at Risk (Eric Doc. Report Service ED402404J).

Santayana G. (1972) *Realms of Being*. New York: Cooper Square Publishers, Inc., (originally published 1942 by Charles Scribner's Sons).

Sebba J., Ainscow M. (1996) International Developments in Inclusive Schools: Mapping the Issues, *Cambridge Journal of Education,* Vol: 26, Part: 1, Pages: 5-18.

Seedhouse P. (1996). Classroom interaction: possibilities and impossibilities. *ELT Journal*. Vol: 50, Part: 1, Pages: 16-24.

Seifert K. L. and Hoffnung R. J. (2000) *Child and Adolescent Development: 5th Edition*. New York: Houghton Mifflin.

Seligman M. (1995) The Effectiveness of Psychotherapy: The Consumer Reports Study. *American Psychologist*, Vol: 50, Part: 12, Pages: 965-974.
Shakespeare T. (Ed.) (1998) *The Disability Reader*. London: Cassell.

Seifert K.L., Hoffnung R.J. (2000) *Child and Adolescent Development (5th Ed.)*. N.Y.: Houghton Mifflin.

Shalev RS., Gross-Tsur V. (2001) Developmental dyscalcula. *Paediatric Neurology*, Vol: 24, Part: 5, Pages: 337-42.

Shapiro M. B. (1951) An experimental approach to diagnostic testing. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Shapiro D. and Seligman D. (1982) Meta-analysis of comparative outcome studies: A replication and refinement. *Psychological Bulletin*, Vol: 92, Pages: 581-604.

Shirk S., Saiz C. (1992) Clinical, empirical, and developmental perspectives on the relationship in child psychotherapy, *Development and Psychopathology,* Vol: 4, Pages: 713-28.

Shucman H. (1960) Evaluating the educability of the severely mentally retarded child. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966)

Silverman D. (2000) *Doing Qualitative Research: A Practical Handbook.* London: Sage Publications.

Silverstone L. (1996) *Art Therapy the Person-Centred Way in Counselling: The BACP Reader* London: (Ed.) Palmer S., Milner P., Sage.

Sinason V. (1992) *Mental Handicap and the Human Condition*, London: Tavistock Press.

Sinason, V. (2002) Treating people with learning disabilities after physical or sexual abuse. *Advances in Psychiatric Treatment,* 8, pp 424-432.

Skeels H. M. and Harms I. (1948) Children with inferior social histories: their mental development in adoptive homes. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Skidmore D. (1999) Continuities and developments into the education of pupils with learning difficulties. *British Journal of Educational Studies*, Vol: 47, Part: 1, Pages: 3-16.

Skodak M. and Skeels H. M. (1949) A final follow-up study of 100 adopted children. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Smail D. (1995) *Love for Sale: 'Psychotherapy as Prostitution' Revisited.* Unpublished Talk, www.davidsmail.freeuk.com,introfa.html

Smail D. (2000) *Counselling in a Cruel World,* Unpublished Talk. www.davidsmail.freeuk.com,introfa.html

Smail D. (2001) *Taking care: An Alternative to Therapy/Why Therapy Doesn't Work (Double Volume)*. London: Robinson Press.

Smail D. (2002) *Helping With Distress*. Unpublished Talk, www.davidsmail.freeuk.com,introfa.html

Smith JC. (2001) Angelman Syndrome: evolution of the phenotype in adolescents and adults. *Developmental Medicine and Child Neurology*. Vol: 43, Part: 7, Pages: 476-80.

Snow C. (1972) Mothers' speech to children learning language. *Child Development,* Vol: 43, Pages: 549-65.

Snow C. (1977) The Development of Conversation Between Mothers and Babies, *Journal of Child Language*, Vol: 4, Pages: 1-22.

Snow C., Fergusson C. (1977) (Eds.) *Talking to Children: Language Input and Acquisition*. Cambridge: Cambridge University Press.

Snow C., Hoefnage-Hohle M. (1978) Age Differences in Second Language Acquisition. In Hatch E. (Ed.) *Second language Acquisition*. USA: Rowley.

Sobsey, D. (1994) Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance? Baltimore: Paul H. Brooks Publishing.

Social Justice Commission (1974/1993) *The Justice Gap*. London : IPPR.

Sockal A., Bricmont J. (2003) *Intellectual Impostures* (second edition), London: Profile Books.

Sockal A., Bricmont J. (1997) *Impostures Intellectuelles,* Paris: Profile Books.

Sommers-Flanagan J., Sommers-Flanagan R. (1995) Psychotherapeutic techniques with treatment-resistant adolescents. *Psychotherapy,* Vol: 32, Pages: 332-334.

Spector M. and Kituse J. (1977) Constructing Social Problems. In Dumbleton P. (1998) Words and Nunbers. *British Journal of Learning Disabilities.* Vol: 26, Pages: 151-153

Spence J., Walton W. S., Miller F. J. W. and Court S. D. M. (1954) A thousand families in Newcastle-upon-Tyne. In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. National Association for Mental Health (March 1966).

Speller V., Kelly M. (2003) Moving towards evidence-based practice: the work of the Health Development Agency. NHS. http://www.hda.nhs.uk/evidence/archive.html

Steinberg L., Lamborn S., Dornbusch S.M., Darling N. (1996) Impact of parenting practice on adolescent achievement: authoritative parenting, school involvement and encouragement to succeed. *Child Development,* Vol: 63, Part: 5, Pages: 1266-1281.

Steinberg L. (1996) *Beyond the Classroom: Why School Reform Has Failed and What Parents Need to Do*. N.Y.: Simon Schuster.

Stoll C. (2001) Problems in the diagnosis of fragile X syndrome in young children are still present. *American Journal of medical Genetics*. Vol: 100, Part: 2, Pages: 110-5.

Stooler A. and Colman R. D. (1965) Virus aetiology for Down's syndrome (mongolism). In Clarke A. D. B. (Ed) *Recent Advances in the Study of Subnormality*. UK: National Association for Mental Health (March 1966)

Stromme P., Hagberg G., (2000) Aetiology in severe and mild mental retardation: a population-based study of Norwegian children. *Developmental Medicine & Child Neurology* Vol: 42, Pages:76–86.

Syme L. (2000) Counselling/Psychotherapy: What's the Difference? *Counselling and Psychotherapy Journal,* Vol: 11, Part: 6, Pages: 332-334.

Taylor S. E. (1991) Health Psychology. In (1998) *Counselling Psychology: Integrating Theory, Research and Supervised Practice*. London: Routledge.

Taylor V.L., Adelman H., Kaser-Boyd N. (1986) The Origin Climate Questionnaire as a tool for studying psychotherapeutic process, *Journal of Child and Adolescent Psychotherapy,* Vol: 3, Pages: 10-16.

Thomas G., Tarr J. (1999) Ideology and Inclusion: A Reply to Croll and Moses, *British Journal of Educational Studies*, Vol: 47, Part: 1, Pages: 17-27.

Tizard M., Rutter M., GrahamP., Yule J., Whitmore K.(1976) Research Report: Isle of Wight studies. *Psychological Medicine* Vol: 6, Pages: 313-332.

Thomas G., Glenny G. (2002) Thinking about inclusion. Whose reason? What evidence? *International Journal of Inclusive Education.* Vol: 6, Part 4, Pages: 345-369.

Tomlinson J. (1996) *Report on Inclusive Education in Further Education.* DfEE, HMSO.

Tomlinson S. (1983) *A Sociology of Special Education*. London: Routledge and Kegan Paul.

Thompson D. (Ed) (1995) *The Concise Oxford Dictionary (Ninth Ed.).* Oxford: Clarendon Press.

Tonge N. (1993) *Challenging History: Industrialisation and Society 1700 – 1914*. Challenging History Series. London: Nelson.

Trent J. (1994) Inventing the Feeble Mind: A History of Mental Retardation in the United States. In Dumbleton P. (1998) Words and Nunbers, *British Journal of Learning Disabilities,* Vol: 26, Pages: 151-153

Trivasse M. (2002) Counselling Through an Interpreter. *Counselling and Psychotherapy Journal*, Vol: 14, Part: 4, Pages 21-23.

UK Council for Psychotherapy (UKCP) (2003) *Equal Opportunities Document*. London: www.psychotherapy.org.uk

United Nations (1997) *Economic and Social Council (Children with Disabilities) Resolution 20*. Geneve. UN.
United Nations (1997) *Universal Declaration of Human Rights*. Geneva: UK.

United Nations (1993) *Standard Rules on Opportunities for Persons with Disabilities*. General Assembly Resolution 48/96 (annex) 20th December. Geneva: UN.

United Nations (1989) *Convention on the Rights of the Child*. General Assembly Document A/Res/44/25, 12th December, Articles 2,23, (UNICEF). Geneva: UN.

United Nations (1975) *Declaration of the Rights of Disabled Persons*. General Assembly Resolution 3477(XXX) 9th December. Geneva: UN.

United Nations (1990, 1971, 1970, 1950) *European Convention on Human Rights and Fundamental Freedoms*. Council of Europe, Strasbourg: UN.

Van der Kolk MB., Bender MH., Goris RJ. (1999) Acute abdomen in mentally retarded patients: role of aerophagia. Report of nine cases. *European Journal of Surgery*. Vol: 165, Part: 5, Pages: 507-11.

Van Deurzan-Smith E. (1994) *Can Counselling Help?* Occasional Paper, 11th Hartop Lecture, University of Durham.

Van Deurzan E. (1998) *Paradox and Passion in Psychotherapy: An Existential Approach to Therapy and Counselling*. London: John Wiley.

Van Deurzan E. (2003) *Core Concepts in Existential Therapy*. London: Sage.

Vincent M. (1986) Simple text and reading text Part 1: some general issues in Brumfit C., In Carter R. (Eds.) *Literature and Language Teaching*. Cambridge: Cambridge University Press.

Van Maanen V. (1977) Linking ways of knowing with ways of being practical. *Curriculum Inquiry*, Vol: 6, Part: 3, Pages: 205-228.

Visser J. (1999) (National Association for SENS) *Placing Value on Inclusion*. UK: TES, 29th October.

Vitale E. Specchhia C. Devoto M. Angius A. Rong S. Rocchi M. Schwalb M. Demelas L. Paglietti D. Manca S. Mastropaolo C. Serra G. (2001) Novel X-linked mental retardation syndrome with short stature maps to Xq24. *American Journal of Medical Genetics*. Vol: 103, Part: 1, Pages: 1-8.

Vgotsky L. (1962) *Language and Thought.* Boston: MIT Press.

Vogt W. (1993) *Dictionary of Statistics and Methodology.* London: Sage.

Winnicott D. W. (1975) *Collected Papers.* London: Karnac Books.

Waiswol N. (1995) Projective techniques as psychotherapy. *American Journal of Psychotherapy,* Vol: 49, Pages: 244-59.

Waller D., Gilroy A. (eds.) (1992) *Art Therapy: A Handbook.* London: Open University Press.

West W. (1997) Counselling Psychotherapy and religion. In King-Spooner S., Newnes C. (Eds) *Spirituality and Psychotherapy.* Ross-on-Wye: PCCS Books.

West W., Clark V. (2004) *Learnings from a pilot project into counselling supervision.* BACP Research Conference (May, 2004) Rugby: BACP.

West W. (2004) *Spiritual Issues in Therapy: Relating Experience to Practice.* London: Palkgrave/Macmillan.

Willemson M. A. Ijlst L. Steijlen P. M. Totteveel J. J. de Jong J. G. van Domburg P. H. Mayatepek E. Gabreels F. J. Wanders R. J. (2001) Clinical, biochemical and molecular genetic characteristics of 19 patients with the Sjögren-Larsson syndrome. *Brain.* Vol: 124, Part: 7, Pages: 1426-37.

WHO (2001) *The World Health Report.* Geneva: WHO.

Wilska M., Kaski M. (1999) Aetiology of intellectual disability—the Finnish classification: the development of a method to incorporate WHO ICD_10 coding.. *Journal of Intellectual Disability research.* Vol: 43, Part: 3, Pages: 242-50.

Wilska ML. Kaski MK. (2001) Why and how to assess the aetiological diagnosis of children with intellectual disability/mental retardation and other neurodevelopmental disorders: description of the Finnish approach. *European Journal of Paediatric Neurology.* Vol: 5, Part: 1, Pages: 7-13.

Winnicott D. W. (1975) *Collected Papers.* London: Karnac Books.

Wintour P. (2000) *Rights Act Will Put British Way of Life on Trial.* UK: The Observer Newspaper, 13th February.

Wolfensberger W. (1972) The Principle of Normalisation in Human Services. In Wright D. and Digby A. (1997) *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities.* London: Routledge.

Woolfe R., Dryden W., Charles-Edwards D. (1989) The nature and range of counselling practice. In Dryden W., Charles-Edwards D., Woolfe R. (Eds) *Handbook of Counselling in Britain*. London: Routledge.

Wood F., Grigovenko G. (2001) Emerging issues in the genetics of dyslexia: a methodological preview, *Journal of Learning Disabilities,* Vol: 34, Part: 6, Pages: 503-511.

Wright D, Digby A. (1997) *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities*. London: Routledge.

Yale (2004) English Bill of Rights (1689) http://www.yale.edu/lawweb/avalon/england.htm

Yamada M. Matsuura S. Tsukahara M. Ebe K. Ohtsu M. Furuta H. Kobayashi I. Kawamura N. Okano M. Shouji R. Kobayashi K. (2001) Combined immunodeficiency, chromosomal instability, and postnatal growth deficiency in a Japanese girl. *American Journal of Medical Genetics*, Vol: 100, Part: 1, Pages: 9-12.

Zic A., Igric L. (2001) Self-assessment of relationships with peers in children with intellectual disability. *Journal of Intellectual Disability Research*, Vol: 45, Pages: 202-11.

Zill N., Shoenborn C.A. (1988) Developmental, Learning, and Emotional Problems: Health of Our Nation's Children. *Vital and Health Statistics from the National Centre for Health Statistics*. Vol: 190, Part: 16, Pages: 91-1250. United States: Child Trends Inc.

Zollers N.J., Ramanathan A.K., Yu M. (1999) The relationship between school culture and inclusion: how an inclusive school supports inclusive education. *International Journal of Qualitative Studies in Education,* Vol: 12, Part: 2, Pages: 157-174.

APPENDICES

Appendix 1: Interview Record Sheet

Interview date:

Counsellor No.

Qualifications:

Training:

Length of time counselling:

Professional body:

Supervision:

Referrals:

Referral of those with label of LD:

Premises:

Age-group:

Sex:

Counselled YPLD:

Understanding of the term Learning Disabilities:

How do you know a person has LD?

Understanding of term Young Person:

Appropriateness of counselling:

Difficulties in counselling YPLD:

Techniques:

Who should counsel?

Access to counselling for YPLD:

Understanding of counselling (client):

Perceptions of what makes an Inclusive Counselling Practice (in general):

Indicators of inclusive counselling practice:

Increasing access to counselling for YPLD:

APPENDIX 2: Letter accompanying survey questionnaire

Date.....

Dear.....

Research Project: An Assessment of Counselling/Psychotherapy Provision for Young People With Learning Disabilities (Aged 12-19 years inclusive)

The enclosed questionnaire is aimed at collecting data as part of a research project being carried out for my PhD in Counselling and Special Educational Needs in CESCO (the Centre for Studies in Counselling) at the University of Durham. It would be much appreciated if you would be able to take the time to complete the questionnaire and return it in the enclosed stamped addressed envelope by..... at the latest.

Information provided in the questionnaire will be kept confidential, being filed and referred to by a code number. However, if you wish to be included in a series of follow-up interviews, it will be necessary to include your name and address, which will be removed from the main questionnaire and retained separately.

The aim of the research is to assess the existing provision of counselling and psychotherapy for young people who have learning disabilities from there to develop a model of 'an inclusive counselling practice'. The project will go on to provide recommendations for improvements in counselling provision for this particular group of clients.

Yours sincerely,

Sue Pattison

Lecturer in Guidance and Counselling
and Special Educational Needs
University of.....

APPENDIX 3: Survey Questionnaire

(The formatting of this questionnaire differs from the master due to formatting requirements of the PhD Thesis)

Questionnaire: Study 1

This questionnaire forms part of a research project aimed at exploring and improving the provision of counselling/psychotherapy for young people who have learning disabilities.

For the purposes of this research project young people are defined as those aged 12- 19 years inclusive.

Learning disabilities is defined as delayed or incomplete development combined with some form of social malfunction, such as educational or occupational failure or an inability to look after oneself. The term 'learning disability' replaces the previously used term 'mental handicap'.

SECTION A : General Information – to be filled in by all participants.

Code Use only

1. Are you aware of having ever having counselled young people who have learning disabilities? (Aged 12-19 years inclusive)

Never ☐
Rarely ☐
Sometimes ☐
Often ☐

Young people with learning disabilities form my main client group ☐

2. Could you please indicate your main approach to counselling/psychotherapy?

Psychodynamic ☐
Person-centred ☐
Gestalt ☐

Cognitive-behavioural ☐
Psychosynthesis ☐

Other ☐
Please state type.....

Coding use only

3. Please indicate whether counselling/psychotherapy is your main occupational role.

Yes ☐ **Counselling/therapy** is **my main occupational role**

No ☐ **Counselling/therapy** is not **my main occupational role but forms part of it.**

My main occupational role is:.....

Other ☐ **Please specify.....**

.....

.....

4. Please indicate whether you come into contact with young people who have learning disabilities in your main occupational role.

Yes ☐ **I** do **come into contact with young people who have learning disabilities in my main occupational role.**

No ☐ **I** do not **come into contact with young people who have learning disabilities in my main occupational role.**

5. Could you please indicate your counselling/therapy practice context (you may wish to indicate more than one).

Private practice ☐
Voluntary sector ☐
Education ☐
Health ☐
NHS ☐
Social services ☐

Other ☐

6. **Please specify.....**

Coding use only

7. Do you work for an organisation eg MIND?
If so, could you please indicate which organisation:

.....

8. Could you please indicate your main source of referrals for your counselling/therapy clients (you may wish to indicate more than one).

Advertising ☐
Self-referral ☐

Word of mouth ____
General practitioners ____
Social workers ____

Other ☐

Please indicate main source of referral.....

9. If you wished to increase the inclusion of young people learning disabilities in your counselling/psychotherapy practice could you please list any ideas below:

.....

.....

.....

.....

Participants who have experience of counselling young people with learning disabilities are invited to continue and complete Section B - all other participants please go straight to Section C.

SECTION B : Specific to participants who have experience in providing counselling/psychotherapy to young people with learning disabilities, all other participants proceed to Section C.

Coding use only

y

10. If young people with learning disabilities are part of your counselling/therapy practice, could you please indicate how they get to know about your service:

Advertising ☐
Care managers ☐
Teachers ☐
Psychologist ☐
Occupational Therapist ☐

Other ☐
Please specify.....

11. Could you please indicate if you have experienced any difficulties when counselling young people with learning disabilities, e.g. attending for sessions, engaging in the counselling/therapeutic process. If so, why do you think that was?

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12. Could you please indicate whether you adopt any particular techniques, strategies or approaches when counselling young people who have learning disabilities.

No ☐ I do not **adopt particular techniques, strategies or approaches when counselling young people who have learning disabilities.**

Yes ☐ I do **adopt particular techniques, strategies or approaches when counselling young people who have learning disabilities.**

Please outline techniques, strategies and approaches below:

.....

.....

.....

.....

.....

.....

13. Please indicate if you have had any training in counselling or psychotherapy for young people who have learning disabilities.

No ☐ I have not **had training in counselling young people who have learning disabilities.**

Yes ☐ I have **had training in counselling young people who have learning disabilities.**

Please specify type of training.....

.....

.....

.....

Coding use only

14. If you have made any attempts to further increase access to counselling/psychotherapy for young people with learning disabilities, please indicate strategies below and whether they appear to have been successful.

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15. Could you please indicate any aspects of your counselling/therapy training that have been useful to you in counselling young people who have learning disabilities:

.....

.....

.....

.....

16. Please outline briefly below what you believe the characteristics of an *inclusive counselling/psychotherapy practice* to be:

.....

.....

.....

.....

.....

.....

Please proceed to SECTION C.

SECTION C : To be completed by all participants.

17. Please indicate whether you wish to take part in a research Interview regarding counselling and young people with learning disabilities:

No ☐ I do not **wish to take part in a research interview.**

Yes ☐ I do **wish to take part in a research interview.**

If yes, **please include your name address and contact point below:**

Name:

Address:

Postcode:

Telephone:

Email:

Thank you for your time and effort in completing this questionnaire – the information will be used to help improve the provision of counselling services for young people who have learning disabilities.