Adapting Compassion-Focused Therapy for People with Intellectual Disabilities and Other Cognitive Impairments

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Foreward

This foreword has been included to provide context regarding the circumstances which led to the changes to my original project, which was interrupted in March 2020 due to the COVID-19 pandemic. My original project had intended to explore a face-to-face group Compassion-Focused Therapy (CFT) intervention (Appendix 9, p.132) but due to the restrictions relating to the pandemic this was no longer possible to conduct. I was required to re-design the project and submit Substantial Amendments to the Research Ethics Committee. My current project, presented in Chapter 2: Major Research Project (p. 43), now explores a one-to-one CFT intervention delivered via video call.

As a result of the disruption, the time required to redesign the study and the challenging circumstances, the current study is not on the same scale, nor of the same rigour, as had been previously intended. Nevertheless, it remains, in my view, an extremely interesting exploratory study, which I have very much enjoyed being a part of.

Chapter 1: Systematic Review

A Systematic Review of Adapted Compassion-Focused Therapy for People with Cognitive Impairments

Prepared in accordance with the author requirements for Journal of Applied Research in Intellectual Disabilities (JARID; Appendix 1, p.76)

Abstract

Background

Compassion-Focused Therapy (CFT) may provide a useful intervention for individuals with cognitive impairments. However, psychological interventions for such people require careful adaptations.

Method

Multiple databases were searched for studies on CFT for people with intellectual disabilities, autism spectrum disorder, brain injuries or dementia. The quality of the studies' reporting of their interventions was evaluated. Frameworks were developed to review the adaptations employed and the CFT features included in the interventions.

Results

Seven studies on participants with intellectual disabilities, four on people with acquired brain injuries, and two on individuals with dementia were found. No studies explored CFT and autism spectrum disorder. The quality assessment indicated that studies could have benefited from increased detail in their accounts of their interventions, and highlighted a lack of methods for measuring and enhancing adherence to protocols. The reviews of therapy adaptations and CFT features showed that studies varied in the extent to which their interventions were adapted and the degree to which the main features of CFT were incorporated.

Conclusions

This review summarises the beginnings of an evidence base for CFT for people with cognitive impairments. It provides a centralised source of ideas for adapting CFT and points to avenues for future research.

Key Words: Compassion-Focused Therapy; cognitive impairment; intellectual disability; autism spectrum disorder; brain injury; dementia

Introduction

Compassion-Focused Therapy (CFT) is a transdiagnostic psychological therapy developed by Gilbert (2009). It was originally aimed at reducing feelings of shame and self-criticism but is now applied more broadly, e.g. to feelings of anxiety. Previous systematic reviews on CFT indicate its potential to be a beneficial intervention for a range of presentations (Leaviss and Uttley, 2015; Craig et al, 2020). As indicated by the latter review, randomised control trials of people with eating disorders, depression and psychosis indicate that CFT is more effective than no treatment, or treatment as usual. This systematic review aims to explore the research that has been conducted on CFT for people with a cognitive impairment, specifically people who have an intellectual disability, autism spectrum disorder, an acquired brain injury or dementia. It aims to summarise the ways in which such interventions have been adapted to the needs of these populations.

As outlined by Gilbert (2009), CFT draws from evolutionary and social psychology, attachment theory, neuroscience and Buddhism. The CFT model consists of three affect regulation systems: 1) the threat system, responsible for detecting and protecting against threat; 2) the drive system, responsible for motivation and obtaining resources; and 3) the soothing system, responsible for feelings of social safeness and contentment. It is hypothesised that in people with high levels of shame and self-criticism the threat and drive systems are dominant, whilst the soothing system is underdeveloped, making it harder for people to feel safe and content. The aim of CFT is to rebalance these systems by activating the soothing system. This is said to be achieved through fostering one's capacity to experience compassion, defined as "the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (Gilbert, 2014).

Overviews of the therapy are provided by Gilbert (2010) and Kolts (2016). Typically, CFT includes psychoeducation regarding the evolution of the brain and the three affect regulation systems. It also involves formulation to increase the client's understanding of how their early life experiences have shaped their threat, drive, and soothing strategies. The therapy employs various exercises to develop the individual's ability to experience the "felt sense" of compassion and to build a compassionate identity. These include exercises to help prepare the way for experiencing compassionate feelings such as warmth and connectedness. For example,

mindfulness exercises such as soothing rhythm breathing aim to settle the body and mind by focusing attention on the breath, whilst safe place imagery promotes a feeling of safety through imagining a peaceful setting in which one experiences a sense of belonging. Clients are supported to experience the giving and receiving of compassion through various practices, including imagery, recalling memories, and letter writing, and individuals are encouraged to shift into a compassionate perspective to help with specific problems.

The experiential focus of CFT, may make the therapy particularly accessible to individuals with cognitive impairments, compared with traditional talking therapies. Many people living with cognitive impairments experience mental health difficulties. For example, the prevalence of psychiatric symptoms or disorders amongst people with intellectual disabilities has been found to range from 13.9% to 74% (Buckles et al 2013), whilst the pooled prevalence of psychiatric disorders in people with autism spectrum disorder has been identified to be 54.8% (Lugo-Marin et al, 2019). In brain injury, the pooled prevalence of Axis 1 psychiatric disorders has been calculated as being 54% (Scholten et al, 2016), whilst in dementia, the prevalence of depression and anxiety have been estimated to be 25% and 14%, respectively (Kuring et al, 2018). Thus, the development of effective psychological therapies for these groups is essential.

The presence of cognitive impairments can make it challenging for individuals attending therapy to meaningfully engage with the intervention and make use of it in their lives. Areas of deficit for people with intellectual disabilities, autism spectrum disorder, acquired brain injury or dementia can include communication, understanding, memory, attention, and executive functioning, with each type of cognitive impairment consisting of different neuropsychological profiles, and individuals within each group having their own personal areas of difficulty (American Psychiatric Association, 2013; Camicioli, 2014; Lindsay et al, 2013; Tyerman and Kind, 2004). Thus, it is vital that psychological therapies, such as CFT, are appropriately adapted to the needs of people with cognitive impairments. Indeed, published research has explored therapy adaptations for non-CFT interventions for each of these conditions, indicating a need for such adaptations (e.g. Cheston and Ivanecka, 2017; Cooper et al, 2018; Gallagher et al, 2019; Lindsay et al, 2013; Regan and Varanelli, 2013; and Surley and Dagnan, 2019).

This review will therefore address the following questions: 1) what research has been conducted on CFT for people with cognitive impairments?; 2) what is the nature of the

adaptations that have been made?; and 3) to what extent do the studies' interventions incorporate the main features of CFT?

Methods

The writing of this systematic review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al, 2009).

Search Strategy

In order to maximise the scope of the review, the eligibility criteria were made relatively wide-ranging. *Populations*: Studies were included if participants had a diagnosis of intellectual disability, autism spectrum disorder, a brain injury or dementia, or if they were attending a specialist service, program, course or voluntary group for people with difficulties consistent with these diagnoses. Studies were excluded if participants were children (defined as <16 years). *Intervention*: The intervention was required to be described as CFT or as deriving from CFT. *Comparison*: The presence of controls was not stipulated for inclusion in the review. *Outcome*: No requirements were made regarding reported outcomes. *Study design*: No conditions regarding specific study design were imposed. However, papers were required to present original research. Reviews, conference publications, opinion pieces, editorials and book chapters were excluded. Studies that were not peer-reviewed were also excluded, as were those not in English. Finally, no limit was placed on publication date.

Databases and Search Terms

CINAHL (EBSCOhost), Cochrane CENTRAL, Embase (Ovid; 1947 to present, updated daily), MEDLINE(R) (Ovid; 1946 to July Week 3 2020) and APA PsycINFO (EBSCOhost) were searched on the 26th July 2020 by the author, no additional raters were utilised. The following search terms were applied to abstracts: compassion* OR self-compassion* AND cognitive impairment OR intellectual disability* OR learning disability* OR mental retard* OR autism OR ASD OR developmental disorder* OR developmental disability* OR head injur* OR brain injur* OR brain damage OR stroke OR dementia* OR Alzheimer*. Boolean operators "AND" and "OR" were

employed to combine the terms, and truncation (indicated by an asterisk) was used to ensure that all word endings were identified. No limits were applied. Articles were exported to Endnote, duplicates removed, and titles/abstracts screened to exclude irrelevant articles. The full texts of the remaining articles were then read and assessed for eligibility. In addition, previous systematic reviews (Leaviss and Uttley, 2015; and Craig et al, 2020) and the final set of studies were hand-searched for further eligible studies. A flowchart illustrating the selection process is provided in Figure 1.

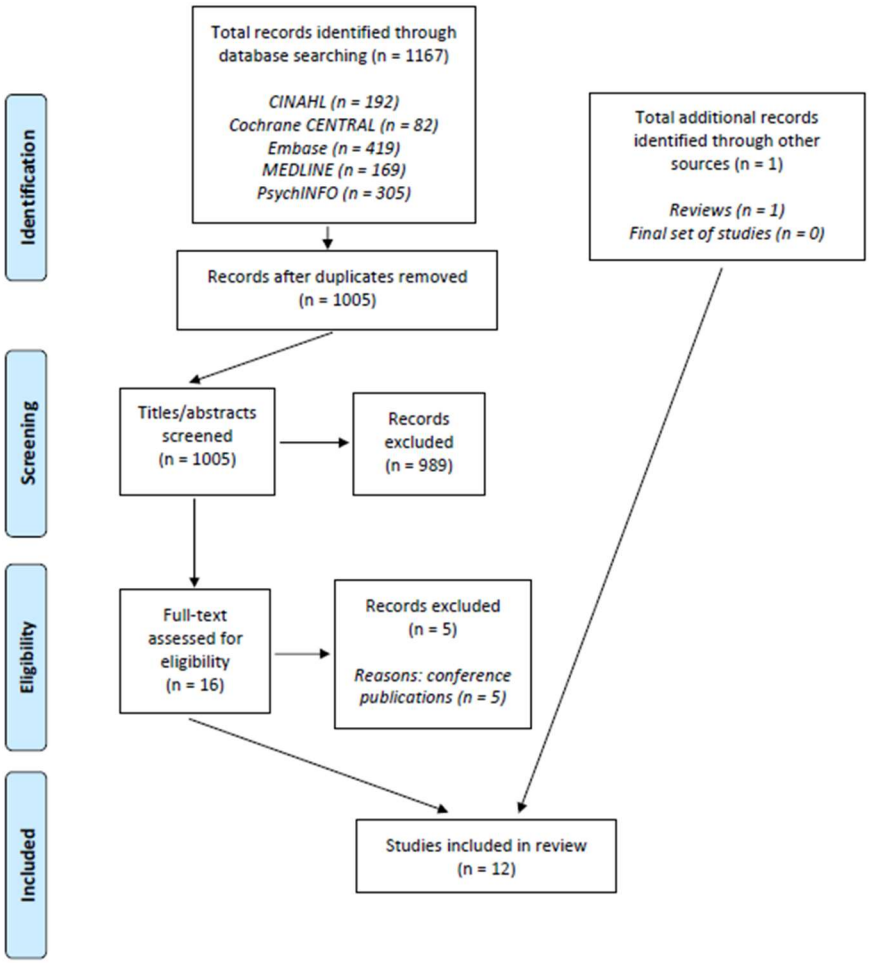

Figure 1

Flowchart of selection process

Data Extraction

Data regarding the studies' characteristics were extracted. These are summarised in Tables 1-3. The quality of the studies' reporting of their interventions was assessed, and data regarding this are also included in these tables. The therapy adaptations and the CFT features

incorporated into the studies' interventions were reviewed. Data regarding these are presented in Tables 4-6 and Tables 7-9, respectively.

Of note, supplementary material was available for Campbell et al (2019) and this was used when reviewing the study. Supplementary material was not available for the remaining studies.

Quality Evaluation of Reporting of Interventions

The quality of the studies' reporting of their interventions was assessed. This was achieved by following the approach taken by Gallagher, McLeod and McMillan (2019) who reviewed Cognitive-Behavioural Therapy adaptations for people with a brain injury. In their systematic review the "intervention" items of the CONSORT (Consolidated Standards of Reporting Trials) checklist extension for non-pharmacological treatments (Boutron et al, 2008) were adapted and used to form a quality rating scale. The items and scoring of this scale are as follows: 1) precise details of the experimental intervention were offered (0 = information was sparse; 1 = main components of intervention were described; 2 = intervention could be replicated from the description); 2) descriptions of the different components of the intervention were included (0 = no; 1 = yes); 3) descriptions of the procedure for tailoring the intervention to individual participants were present (0 = no; 1 = yes); 4) details of how the intervention was, or could be, standardised were specified (0 = no; 1 = yes); 5) details of how adherence to the protocol was assessed or enhanced were included (0 = no; 1 = yes). Higher quality scores therefore indicate a higher quality rating. Gallagher et al's (2019) operational definitions of the items were obtained from the authors. All studies were rated against this scale by the author of the current review and by a second, independent rater. The initial percentage agreement between the two raters was 88.3%. Discrepancies were resolved through discussion and agreement reached.

Evaluation of Therapy Adaptations

The following four steps were taken to carefully develop a framework to assess the presence of therapy adaptations in the reviewed studies. At each of these steps, key texts (i.e. American Psychiatric Association, 2013; Camicioli, 2014; Gallagher et al, 2019; Lindsay et al, 2013; Surley and Dagnan, 2019; and Tyerman and Kind, 2004) regarding features of intellectual disabilities, brain injury and dementia, and therapy adaptations for people with cognitive impairments,

were consulted. Each step was also conducted through discussion with the research team, who have expertise in the area.

1. Adaptations from the 12 reviewed studies were collated and reduced, where possible, by collapsing similar items together.
2. An initial set of categories were developed to group the adaptations under common areas of need typically associated with people with cognitive impairments. These initial categories were: 1) understanding; 2) attention; 3) cognitive load; 4) memory; and 5) engagement.
3. The collated adaptations were grouped under the five "areas of need". Thus, testing whether all adaptations could be adequately captured by them. This was found to be the case.
4. Two changes were made to this initial framework: 1) to reduce overlap, the cognitive load and attention categories were merged, leading to four final areas of need; 2) for clarity, the engagement adaptations were grouped into "promotion of in session engagement", and "promotion of home practice". This led to the final framework which can be viewed in Tables 4-6.

Each of the reviewed studies were then assessed against this framework for evidence of the presence of the adaptations using a content analysis approach (White and Marsh, 2006). This was completed by the author and a second, independent reviewer. The percentage agreement between the two reviewers was 66%. Discrepancies were resolved through discussion and agreement reached.

Evaluation of CFT Features

A framework to categorise the CFT features present in the studies was also carefully developed. Gilbert's (2010) and Kolts' (2016) overviews of CFT were used to inform the development of an initial framework of the key features of the therapy, in collaboration with the research team, who have experience delivering CFT interventions. The framework was tested against the reviewed studies and adjusted until all the CFT features present in the studies could be captured. The key texts and research team were consulted throughout this process. The main categories of the final framework were: 1) understanding the CFT model; 2) formulation; 3) preparing the body and mind; 4) establishing safety; 5) tuning into compassion; 6)

practising/experiencing compassion; 7) blocks/fears; and 8) home practice. The second category was sub-divided into personalised and group formulations. The sixth category was divided into four subcategories: 1) compassion from oneself to oneself; 2) compassion from another to oneself; 3) compassion from oneself to another; and 4) focus on a specific area of difficulty.

All studies were reviewed against the framework through a content analysis by the author and the second reviewer. This was to identify whether the studies had incorporated the various types of CFT features. The initial percentage agreement between the two reviewers was 75.3%. Discrepancies were resolved through discussion and agreement reached.

Results

Question 1: What research has been conducted on CFT for people with a cognitive impairment?

The search identified 12 studies exploring CFT for people with a cognitive impairment. There were six studies with participants with intellectual disabilities, four studies with participants with brain injuries, and two studies with participants with dementia. No studies specifically explored CFT for participants with autism spectrum disorder. However, two studies did report that some participants presented with a comorbid "autism spectrum condition" (Studies 5 and 6).

The median quality rating on the adapted CONSORT rating scale used to evaluate the quality of the reporting of the studies' interventions was 3.5, out of a maximum of 6, with the range of scores being 2-5. All studies reported details of the therapy components, with all but one reporting examples of how the intervention was tailored to individuals. Nevertheless, only one study (Study 10) was reported to have sufficient detail for replication. This study, along with only two others, reported details of how the intervention was, or could be, standardised. Study 10 was the study with the highest quality score and the only one which provided supplementary material. This included a script of the intervention which, along with the details in the main report, contributed to the study's high quality rating. Study 5 had the lowest quality rating.

Although it reported a general list of therapy components, these were said to be administered to participants depending on what was felt to be accessible and acceptable to each participant. It was therefore not possible to identify which components were administered to each individual. Of note, no studies were rated as including details of how adherence to the protocol was assessed or enhanced. Gallagher et al's (2019), operational definition of this focused on whether recordings or observations were reported to have been made. However, four of the studies reported using supervision, which could also be viewed as a way of enhancing adherence to the protocol.

Tables 1-3 provide a summary of the studies' characteristics. As this review is concerned with the adaptations and content of CFT interventions, details regarding outcomes have not been included.

Table 1

Characteristics of studies with participants with an intellectual disability

Study No.	Authors & Country	Aims	Design & Analysis	Participants			Intervention				Quality Rating Score (/6)
				Setting & Presenting difficulties	Gender, Age & Ethnicity	Sample Size	Modality	Number of sessions	Session frequency	Session duration	
1	Cooper and Frearson (2017); UK	To test whether formulation and intervention using a CFT approach could be adapted for individual therapy with a person who has an intellectual disability to treat low mood and improve self-compassion	Case study; mixed methods	Community-based intellectual disability team; moderate intellectual disability, low mood and comfort eating	Male; mid 40s; White British	1	Individual	13 (7 sessions of engagement, assessment and initial formulation, and 6 sessions of CFT)	Weekly	Not reported	3
2	Clapton et al (2018); UK	To explore and evaluate feasibility and acceptability of CFT groups for adults with intellectual disabilities	Case series; mixed methods	Community-based intellectual disability team; mild intellectual disability (IQ between 51 and 69, and associated impairment in day-to-day adaptive skills) and anxiety, depression or mixed anxiety and depression	4 females, 2 males; mean age 38.5 years (SD 15.6); ethnicity not reported	6	Group	6	Not reported	90 mins	3
3	Hardiman et al (2018); UK	To carry out a mixed methods investigation of the effects of a CFT intervention	Case series; mixed methods	Community-based intellectual disability team; mild to moderate intellectual disability (based on clinical judgement and British Psychological Society (2015) guidelines)) and clinical anxiety (GAS-ID score ≥ 13)	2 females, 1 male; age range 31-48 years; White British	3	Individual	12-15	Weekly	Not reported	3

4	Brougham et al (2020); UK	To explore whether individuals with an intellectual disability were able to generate and use a compassionate image	Non-randomised controlled feasibility/pilot study (control condition = participants without intellectual disabilities); mixed methods	Specialist college course; intellectual disability	Those with intellectual disabilities: 10 males, 6 females; age range 17-24 years; ethnicity not reported. Those without intellectual disabilities: 9 males, 6 females; age range 17-35 years; ethnicity not reported	31 (16 with intellectual disabilities and 15 without an intellectual disabilities)	Individual	2 for those with intellectual disabilities, 1 for those without intellectual disabilities	Weekly for those with intellectual disabilities. N/A for those without intellectual disabilities	30 minutes and 60 minutes for those with intellectual disabilities. 90 mins for those without intellectual disabilities	3
5	Cowles et al (2020); UK	To provide an overview of CFT and its application to trauma, and to outline some case studies using CFT with people with intellectual disabilities	Case series; qualitative	Setting not reported; mild to moderate intellectual disability and history of trauma, and one or more of the following: autism spectrum condition diagnosis, obsessive-compulsive disorder, depression, severe generalised anxiety disorder diagnosis and schizophrenia	2 males, 1 female, age range 50s-70s; 2 White British, 1 Black Caribbean	3	Individual	Not reported	Not reported	Not reported	2
6	Goad and Parker (2020); UK	To evaluate a compassion-focused therapy group intervention for people with an intellectual disability experiencing low mood, high self-criticism, and feelings of shame	Case series; quantitative	Community-based intellectual disability team; diagnosis of mild intellectual disability and high levels of self-criticism, shame and associated distress, and one or more of the following: autism spectrum condition diagnosis, attention deficit disorder, and psychosis diagnosis	3 males 3 females; age range 19- 39 years; 2 White British, 4 mixed ethnicity	3	Group	10 sessions	Not reported	Not reported	3

Note. A number of studies did not report how they defined mild and moderate intellectual disability, for reference, the tenth version of the International Classification of Diseases (ICD-10; World Health Organization, 2016) defines mild intellectual disability as an IQ score of approximately 50-69 and a moderate one as approximately 35-49. The eleventh version of the classification system (ICD-11; World Health Organization, 2019) defines mild intellectual disability as adaptive behaviour and intellectual functioning being two to three standard deviations below the mean, and a moderate intellectual disability as adaptive behaviour and intellectual functioning being three to four standard deviations below the mean. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) *defines levels of severity in relation to three domains (conceptual domain, social domain and practical domain) and provides a rich description across each of the domains for each level of severity.*

Table 2

Characteristics of studies with participants with a brain injury

Study No.	Authors & Country	Aims	Design and Analysis	Participants			Intervention				Quality Rating Score (/6)
				Setting & Presenting Difficulties	Gender, Age & Ethnicity	Sample Size	Modality	Number of Sessions	Session Frequency	Session Duration	
7	Ashworth et al (2011); UK	To present a single clinical case that illustrates the application of CFT in the context of a holistic neuropsychological rehabilitation program, and report on the outcomes of the intervention	Case study; mixed methods	Neuropsychological rehabilitation program; traumatic brain injury with low self-esteem and mental health difficulties	Female; 23 years; ethnicity not reported	1	Individual	24 (6 sessions of CBT formulation and 18 sessions of CFT). Delivered in the context of a holistic neuro-psychological rehabilitation program	Weekly	50 mins – 1 hour	3
8	O'Neill and McMillan (2012); UK	To investigate whether compassionate imagery can increase empathy in those with low empathy after severe head injury	Randomised controlled feasibility/pilot study (control condition = relaxation imagery); quantitative	Rehabilitation services and voluntary groups; severe head injury (post traumatic amnesia > 1 day)	Compassionate imagery group: 2 males, 10 females; mean age 45.33 (SD 15.6); all White British. Relaxation group: 1 male, 11 females; mean age 39.08 (SD 11.08); all White British	24	Individual	1	N/A	30 mins	3
9	Ashworth et al (2015); UK	To assess the feasibility, safety and potential value of CFT for patients with an acquired brain injury and emotional difficulties receiving neuropsychological rehabilitation	Observational feasibility/pilot study; mixed methods	Neuropsychological rehabilitation program; acquired brain injury and mental health difficulties including anxiety and depression	7 males, 5 females; age range 21-55 years, mean age for males 46.1 years (SD 9.64), mean age for females 33.5 years (SD 8.36); all White British	12	Group and individual	Group: 4. Individual: maximum of 18. Delivered in the context of a holistic neuro-psychological rehabilitation program	Group: all 4 sessions in 1 week. Individual: weekly	Group: full day. Individual: not reported	3

10	Campbell et al (2019); UK	To determine whether participants with severe head injury allocated to a brief compassion-focused imagery intervention show greater change in compassion than those exposed to relaxation imagery	Randomised controlled feasibility/pilot study (control condition = relaxation imagery); qualitative	Community brain injury service, inpatient neuro-rehabilitation units, voluntary groups; severe head injury (post traumatic amnesia > 1 day)	20 male, 4 female; mean age 47 years (SD 8.9), age range 30-59; ethnicity not reported	24	Individual	1	N/A	1 hour	5

Table 3

Characteristics of studies with participants with dementia

Study No.	Authors & Country	Aims	Design and Analysis	Participants			Intervention				Quality Rating Score (/6)
				Setting & Presenting Difficulties	Gender, Age & Ethnicity	Sample Size	Modality	Number of Sessions	Session Frequency	Session Duration	
11	Collins et al (2018); UK	To evaluate the effectiveness of a CFT group on reducing anxiety, depression, and respiratory rate in people with dementia and their spouses, and improving quality of life of people with dementia	Observational study; quantitative	Memory service; ICD-10 dementia diagnosis	20 male, 12 female; mean age 74.12 years (SD 5.98), age range 57-85; all Caucasian	64 (32 with dementia and 32 spouses)	Group	6	Weekly	2 hours	3
12	Craig et al (2018); UK	To develop a CFT intervention for people with dementia with depression and/or anxiety, and to assess its feasibility, acceptability, and utility	Case series; mixed methods	Memory service; DSM-IV dementia diagnosis, specifically mild to moderate dementia (10-25 on MoCA or ≤ 88 on ACE-III) and depression (> 10 on the CSDD) and/or anxiety (≥ 11 on the RAID)	6 female, 1 male; age range 53-88; 5 White British, 1 White European, 1 Black African	7	Individual	10	Not reported	1 hour	4

Note. ACE-II = Addenbrooke's Cognitive Examination, Third Edition (Hsieh et al, 2013); CSDD = Cornell Scale for Depression in Dementia (Alexopoulos et al, 1988); MoCA = Montreal Cognitive Assessment (Nasreddine et al, 2005); RAID = Rating Anxiety in Dementia scale (Shankar et al, 1999).

Question 2: What is the nature of the adaptations that have been made?

Tables 4-6 provide a summary of the adaptations that have been used in each study and their corresponding areas of need.

All six studies with participants with intellectual disabilities, three out of four of the brain injury studies, and both dementia studies included adaptations to promote understanding. Three out of six of the intellectual disability studies, three out of four of the brain injury studies and one of the two dementia studies incorporated adaptations for the management of attention and cognitive load. All six of the intellectual disability studies, three out of the four brain injury studies and both dementia studies used adaptations to support memory. Only one of the six intellectual disability studies and one of the four brain injury studies used adaptations to promote engagement in sessions, whilst neither of the dementia studies did so. Five of the six intellectual disability studies, two of the four brain injury studies and both dementia studies incorporated support for home practice. One of the intellectual disability studies (Study 4) and one of the dementia studies (Study 11) did not set home practice but did include adaptations which could promote this. On the other hand, one of the intellectual disability studies (Study 3) did set home practice but did not incorporate support for this.

A fuller description of some of the adaptations outlined in Tables 4-6 is provided below, in order to provide insight into the nature of the changes made.

Understanding

In terms of the "visual supports" category in Tables 4-6, Study 1 included a colourful diagram of the CFT model's emotion regulation systems and Study 4 used photographs to support participants' understanding of storyboard vignettes. Study 5 involved drawing emotions and the use of pictures of emotions to communicate with staff. In Study 6, the emotion regulation systems were represented via coloured rope circles of different sizes to correspond to how participants viewed the relative contributions of their threat, drive and soothing systems. The study also reported using bubbles for the breathing exercise. This presumably involved blowing bubbles to provide a visual indication of slow breathing. Study 9 involved the use of "images on mobile phones", Study 11 reported using "visual imagery" to "facilitate discussion about current

emotional states", while Study 12 reports using "visual handouts". No further details were provided regarding these adaptations.

Regarding the "simplification of the CFT model" category in in Tables 4-6, both Studies 1 and 5 removed the drive system when referring to the emotion regulation systems, to include only the threat and safety systems. Study 1 named these as such, whilst Study 2 named these "sad/worried/scared" and "calm/kind/happy/strong".

In relation to the "examples of compassion" category in in Tables 4-6, Study 4 provided examples of compassionate statements and non-compassionate statements (e.g. "I care about you" vs "You should not have said that. Why did you say that?"). Study 6 refers to "exploring the difference in compassionate and critical thoughts, feelings and behaviours" and appears to have done so through a card sorting exercise. Study 10 included a video featuring an actor playing a client who had supposedly received the intervention. The character shares his own examples of compassion. These include his feelings of compassion towards his dog, his sister's feelings of compassion towards her friend, and a sense of mutual compassion between himself and his friends.

Attention and Cognitive Load

The category entitled "in session alert set to prompt self-monitoring" in Tables 4-6 refers to an adaptation used in Study 7. The therapist had initially been prompting the participant to check in with her feelings during the sessions. Alerts were then set to allow her to self-monitor, and she later became able to self-monitor without the alert.

Memory

The "interactive methods of consolidation" category in Tables 4-6 consisted of the adaptations in Studies 5 and 6 that were previously mentioned in the "Understanding" section of this review, namely the drawing of emotions in Study 5, and the card sorting exercise, use of bubbles, and use of ropes in Study 6. In the latter, participants were able to adjust the sizes of the rope circles themselves. In addition to these, Study 10 included a quiz, and guided reflection with the researcher following a compassionate practice.

Engagement: Promotion of In-Session Engagement

The "relatable content" category in in Tables 4-6 refers to adaptations used in Studies 4 and 10. Study 4 included relatable content through the vignettes described in the "Understanding" section of this review. These depicted interpersonal scenarios that the participants, who were college students, would have been likely to relate to, e.g. making a mistake in class, academic failure, and college course rejection. In Study 10, the characters in the video also reported in the "Understanding" section of this review, made reference to local sports and popular food. These were topics that the participants would have been likely to relate to.

The category entitled "scaffolding through the use of forced-choice and open questions" in Tables 4-6 relates to Study 4. Participants were provided with scaffolding when developing their own compassionate image. This is a CFT exercise in which individuals develop a mental image of a compassionate entity and imagine receiving compassion from them, as a means to strengthen their ability to experience compassionate feelings (Gilbert, 2009). In Study 4 participants were asked forced-choice questions (e.g. "is it a person, animal or fictional character?") to support them to make decisions regarding the nature of their compassionate image. They were then asked open questions to allow for a fuller description of the image.

Engagement: Promotion of Home Practice

In terms of the "handout(s) provided" category in Tables 4-6, Study 2 described supplying workbooks, and Studies 5, 7 and 12 reported providing instructions or summary sheets. Study 12 stated that participants were offered "flashcards" featuring their chosen method of coping or practice.

Regarding the "support provided around when to implement practice(s)" category in Tables 4-6, Studies 2 and 9 included a focus on maintenance and planning of home practice. Although these can feature in non-adapted psychological therapy, these were included in this category to capture this form of support. The vignettes in Study 4 described in the "Understanding" and "Engagement: Promotion of In-Session Engagement" sections of this review provided examples of the types of interpersonal scenarios in which the compassionate image exercise can be used, thus supporting participants to apply the technique.

The “home practice prompt(s)/reminder(s)” category in in Tables 4-6 included visual prompts to build a “physical toolbox” of strategies in Study 1, and text message alerts in Studies 7 and 9. As previously mentioned in the “Understanding” section of this review, Study 9 involved the use of images on a mobile phone. This is likely to have been used to promote home practice.

In relation to the “carer involvement offered/required” category in Tables 4-6, in studies 2, 6 and 12 participants were offered the choice of being accompanied to sessions by a carer, while Study 11 required participants to attend with their spouses. Study 12 specifically stated that the carer’s role was to facilitate home practice. Study 5 provided written instructions for carers and encouraged them to support the participant through praise and by keeping a log of positive events and reading this out to the participant. Staff meetings were held around compassion, as well as sessions with family members to share CFT formulations and ideas for home practice.

Table 4

Adaptations used in studies with participants with an intellectual disability

Area of Need	Adaptation		Study Number					
			1	2	3	4	5	6
Understanding	Simplified language			X	X	X	X	
	Visual supports		X	X	X	X	X	X
	Simplification of CFT model		X				X	
	Examples of compassion provided					X		X
	Checking of understanding		X					
Attention and Cognitive Load	Reduced session duration					X		
	Reduced practice duration							
	Inclusion of break(s)							X
	Repeatedly returning to written agenda							
	In session alert set to prompt self-monitoring							
	Slow pacing of session content		X			X		
Memory	Verbal summaries		X	X				X
	Written summaries			X			X	
	Repetition of practice(s)			X	X	X		X
	Interactive method(s) of consolidation						X	X
Engagement	Promotion of in session engagement	Relatable content				X		
		Scaffolding through use of forced choice and open questions				X		
	Promotion of home practice	Handout(s) provided		X			X	
		Audio resource(s) provided						
		Support provided around when to implement practice(s)		X		X		
		Home practice prompt(s)/reminder(s)	X					
		Carer involvement offered/required		X			X	X

Table 5

Adaptations used in studies with participants with a brain injury

Area of Need	Adaptation		Study Number			
			7†	8	9†	10
Understanding	Simplified language					
	Visual supports		X		X	
	Simplification of CFT model					
	Examples of compassion provided					X
	Checking of understanding					X
Attention and Cognitive Load	Reduced session duration		X		X	
	Reduced practice duration					X
	Inclusion of break(s)		X			X
	Repeatedly returning to written agenda		X			
	In session alert set to prompt self-monitoring		X			
	Slow pacing of session content		X			X
Memory	Verbal summaries		X			X
	Written summaries		X			X
	Repetition of practice(s)		X		X	X
	Interactive method(s) of consolidation					X
Engagement	Promotion of in session engagement	Relatable content				X
		Scaffolding through use of forced choice and open questions				
	Promotion of home practice	Handout(s) provided	X			
		Audio resource(s) provided				
		Support provided around when to implement practice(s)			X	
		Home practice prompt(s)/reminder(s)	X		X	
		Carer involvement offered/required				

† Study 9 makes reference to the adaptations in Study 7. However, it is unclear how many of these were included in Study 9, and vice versa. The adaptations included in the table for these studies have therefore been limited to those which are explicitly reported in the respective papers. It is acknowledged that this may be an under-representation of the adaptations made.

Table 6

Adaptations used in studies with participants with dementia

Area of Need	Adaptation		Study Number	
			11	12
Understanding	Simplified language			
	Visual supports		X	X
	Simplification of CFT model			
	Examples of compassion provided			
	Checking of understanding			X
Attention and Cognitive Load	Reduced session duration			
	Reduced practice duration			X
	Inclusion of break(s)			
	Repeatedly returning to written agenda			
	In session alert set to prompt self-monitoring			
	Slow pacing of session content			X
Memory	Verbal summaries		X	X
	Written summaries			X
	Repetition of practice(s)		X	
	Interactive method(s) of consolidation			
Engagement	Promotion of in session engagement	Relatable content		
		Scaffolding through use of forced choice and open questions		
	Promotion of home practice	Handout(s) provided		X
		Audio resource(s) provided		X
		Support provided around when to implement practice(s)		
		Home practice prompt(s)/reminder(s)		
		Carer involvement offered/required	X	X

Question 3: To what extent do the studies' interventions incorporate the main features of CFT?

Tables 7-9 provide a summary of the CFT features incorporated in the studies' interventions. Of note, further to the CFT features of Study 2 outlined in Table 7, the study reported including "further brief compassion practices to incorporate into daily life". It was not possible to infer what these related to and they were therefore not categorised.

Understanding the CFT Model

"Understanding the CFT model" comprised of psychoeducation of the CFT model. It included psychoeducation on the evolution of the brain and the notion that our cognitive and emotional processes are, as described by Gilbert (2010), "not of our design and therefore not our fault". The latter concept is associated with the idea that we do, nevertheless, have a responsibility to improve our situation by training our minds. Another aspect included in the "understanding the CFT model" category is psychoeducation regarding the emotion regulation systems. The focus on the concept of compassion alone, without further psychoeducation around the model, was insufficient for inclusion in this category. Four of the six intellectual disability studies, two of the four brain injury studies and both dementia studies incorporated psychoeducation regarding the CFT model.

Formulation

The "formulation" category encompassed subcategories for the inclusion of individualised formulations and group ones. Three of the six intellectual disability studies, two of the four brain injury studies and one of the dementia studies included personalised formulations. In the remaining dementia study (Study 11), dementia was conceptualised as a threat, and group discussions were held regarding the emotional impact of the diagnosis. This was, therefore, categorised as a group formulation. Similarly, in addition to the personalised formulation in Study 9, a group formulation was also provided regarding the functions of self-criticism and shame after an acquired brain injury.

Preparing the Body and Mind

"Preparing the body and mind" included exercises which settle the body and focus the mind, thus preparing the way for experiencing compassionate feelings. This category comprised of soothing rhythm breathing, a key CFT exercise involving the deliberate slowing down of the breath (Kolts, 2016). It also consisted of progressive muscle relaxation, listening to relaxing music and mindfulness practices, such as the body scan and mindfulness of an object. All of the reviewed studies, bar one of the intellectual disability studies (Study 4), incorporated at least one practice from this category.

Establishing Safety

The "establishing safety" category consisted of practices which were felt to be primarily aimed at promoting individuals' sense of safety. It included safe place imagery which involves imagining a peaceful setting in which one experiences a sense of belonging (Kolts, 2016). The category also encompassed the use of safety statements and grounding objects. Four of the six intellectual disability studies, one of the four brain injury studies and both dementia studies included at least one of these.

Tuning into Compassion

"Tuning into compassion" consisted of exercises which were felt to enable individuals to begin to develop an embodied sense of the experience of compassionate feelings but did not involve the flow of compassion from one being to another, nor the focusing of compassion on a specific area of difficulty. These were instead captured by the "Practising/Experiencing Compassion" category. "Tuning into compassion" included compassionate self imagery. This is an exercise in which individuals imagine having compassionate qualities, such as wisdom, kindness and confidence (Kolts, 2016). Compassionate colour imagery was also included in this category. This consists of imagining that a chosen colour, felt to be compassionate, is surrounding the individual and flowing through their body. Pastel as opposed to dark colours are said to be more frequently chosen for this exercise (Gilbert, 2010). Other practices included in this category included remembering feeling close to somebody, gratitude exercises, celebrating the successes of participants and the use of compassionate objects. Four out of six of the intellectual

disability studies, three out of four of the brain injury studies and both dementia studies included at least one of these 'tuning into compassion' exercises.

Practising/Experiencing Compassion

Interventions in all 12 studies incorporated forms of "practising/experiencing compassion". Subcategories were made to provide a more detailed account of these. These included three subcategories representing the three "flows", or directions, of giving/receiving compassion, i.e. from oneself to oneself, from another to oneself, and from oneself to another (Gilbert, 2010). A further subcategory representing the focusing of compassion to address a specific area of difficulty was also formed. Details of the practices and exercises encompassed by these subcategories are provided below.

Compassion from Oneself to Oneself. This subcategory consisted of developing compassion for oneself, reducing self-criticism and engaging the compassionate part of oneself to do so. It included a "hand on heart" practice (Clapton et al, 2018; Craig et al, 2018). Although descriptions of this were not provided, it was believed to relate to Neff's (2021) supportive touch exercise involving soothing the self through placing one's hand on one's heart. This category also encompassed compassionate letter writing. This is a CFT exercise which consists of writing a letter to oneself from a compassionate perspective (Gilbert, 2010). The mindfulness concept of loving kindness for the self was also included. In addition, the category consisted of positive self-statements and compassionate reframing thought records with related behavioural experiments. Exercises involving directing compassion towards oneself whilst looking in the mirror were also included. One study used an "inner kind friendly voice" exercise (Clapton et al, 2018). Details were not provided but the exercise was felt to be likely to have involved directing compassion towards oneself. Furthermore, this category encompassed the scheduling of additional positive/soothing activities, including spending time with others. Four out of six intellectual disability studies, all four brain injury studies and one of the two dementia studies featured at least one item from this category.

Compassion from Another to Oneself. This subcategory included recalling a past experience of someone being kind to oneself and an "inner best friend exercise" involving imagining how a best friend would talk to oneself (Cowles et al, 2020). This category also encompassed imagining an ideal compassionate image (Gilbert, 2010). This consists of

imagining an entirely compassionate entity and experiencing receiving compassion from them. In addition, the "compassion from another to oneself" category involved the use of the therapeutic relationship, and relationships with staff/carers and other group members to promote the experience of compassion from others. All six intellectual disability studies, two of the four brain injury studies and one of the two dementia studies included at least one item from this category.

Compassion from Oneself to Another. This subcategory consisted of developing compassion towards others and engaging the compassionate part of oneself to do so. It included encouraging compassion toward other group members and recalling a memory of being compassionate to someone else. One of the six intellectual disability studies, three of the four brain injury studies and one of the dementia studies included at least one item from this category.

Focus on Specific Area of Difficulty. The subcategory included bringing compassion to specific areas of difficulty including shame, self-criticism and trauma, or any other participant examples. It encompassed compassionate chair work and the multiple selves exercise. Chair work involves the use of chairs to represent the different parts of the client. In CFT this includes a compassionate chair to represent the compassionate version of the self. Other parts of the person that can be represented by chairs include the self-critical, anxious or angry selves. The client is invited to sit in the compassionate chair and cultivate the motivation and feeling to compassionately help the other parts of themselves (Gilbert, 2010). The multiple selves exercise is a structured exercise to help individuals relate compassionately to the various threat-based parts of themselves. It typically involves the use of chairs but can also be done on paper (Kolts, 2016). Four of the six intellectual disability studies, two of the four brain injury studies and one of the two dementia studies included at least one exercise which fitted into this category.

Blocks/Fears

This category involved addressing blocks and fears in relation to either imagery or compassion. Two of the six intellectual disability studies, two of the four brain injury studies and both dementia studies addressed at least one such type of block or fear.

Home Practice

In relation to the "home practice" category, five of the six intellectual disability studies, two of the four brain injury studies and one of the two dementia studies involved the setting of home practice.

Table 7

CFT features of interventions of studies with participants with an intellectual disability

CFT Features of Interventions		Study Number					
		1	2	3	4	5‡	6
Understanding the CFT model		X	X			X‡	X
Formulation	Personalised formulation	X	X			X‡	
	General group formulation						
Preparing body and mind		X	X	X		X‡	X
Establishing safety		X		X		X‡	X
Tuning into compassion		X	X			X‡	X
Practising/experiencing compassion	Compassion from oneself to oneself	X	X			X‡	X
	Compassion from another to oneself	X	X	X	X	X‡	X
	Compassion from oneself to another						X
	Focus on specific area of difficulty	X	X			X‡	X
Blocks / fears			X				X
Home practice		X	X	X		X‡	X

‡ Study 5 reported that the techniques were administered depending on what was accessible and acceptable to each individual.

Table 8

CFT features of interventions of studies with participants with a brain injury

CFT Features of Interventions		Study Number			
		7	8	9	10
Understanding the CFT model		X		X	
Formulation	Personalised formulation	X		X	
	General group formulation			X	
Preparing body and mind		X	X	X	X
Establishing safety				X	
Tuning into compassion			X	X	X
Practising/experiencing compassion	Compassion from oneself to oneself	X	X	X	X
	Compassion from another to oneself	X		X	
	Compassion from oneself to another		X	X	X
	Focus on specific area of difficulty	X		X	
Blocks / fears				X	X
Home practice		X		X	

Table 9

CFT features of interventions of studies with participants with dementia

CFT Features of Interventions		Study Number	
		11	12
Understanding the CFT model		X	X
Formulation	Personalised formulation		X
	General group formulation	X	
Preparing body and mind		X	X
Establishing safety		X	X
Tuning into compassion		X	X
Practising/experiencing compassion	Compassion from oneself to oneself		X
	Compassion from another to oneself	X	
	Compassion from oneself to another	X	
	Focus on specific area of difficulty		X
Blocks / fears		X	X
Home practice			X

Discussion

A small number of studies exploring CFT for people with cognitive impairments have been conducted, with most research having been carried out with participants with intellectual disabilities, followed by those with brain injuries and then dementia. No studies were focused specifically on participants with autism spectrum disorder. Research for all participant groups remains at an early stage, with studies generally being exploratory in nature and having small sample sizes. Some studies recruited participants with cognitive impairments and mental health difficulties, whilst others recruited individuals with cognitive impairments only. Studies varied in the lengths of their interventions. Most of them explored full adapted interventions consisting of several CFT features over numerous sessions, whilst a few were brief and focused on the adaptations of specific CFT features. Most interventions were delivered on a one-to-one basis, some were group interventions, and one consisted of both modalities.

The review outlines the ways in which CFT was adapted to take account of participants' cognitive deficits. There is a considerable range in the extent to which adaptations have been applied, with one study using no adaptations across any of the categories representing the different areas of need identified in the review (i.e. understanding, attention and cognitive load, memory and engagement), and others incorporating adaptations across them all. Although there is not necessarily a direct relationship between the number of adaptations included in an

intervention and the effectiveness of the therapy, one can assume that incorporating adaptations that address a fuller range of participants' needs would be beneficial.

The review also provides a summary of the CFT features included in the studies' interventions. As may be expected given the focus of CFT, all of the studies included at least one form of practising or experiencing compassion. This ranged from one such practice/experience, to several. Studies varied in the extent to which they incorporated the remaining categories of CFT features identified in the review (i.e. understanding the CFT model, formulation, preparing the body and mind, establishing safety, blocks/fears and home practice). These serve to provide context and support for practising/experiencing compassion, as well as opportunities for consolidation. Thus, their inclusion could increase the benefit of interventions.

Limitations

This review excluded studies that were not in the English language and that were not peer-reviewed. This may have led to relevant studies in other languages, or that have not been published in peer-reviewed journals, being overlooked. The search was limited to studies that were described as CFT, or as deriving from CFT, and therefore did not include interventions which may consist of similar components (e.g. loving-kindness practices in mindfulness-based interventions). In addition, as a second rater was not utilised when screening the studies for eligibility, there is greater risk that relevant studies may have been missed. Furthermore, the focus of this review is a rapidly evolving field and additional relevant studies may have been published during the course of writing this review.

Due to time constraints, the study authors could not be contacted. The reviewing of the adaptations and CFT features incorporated by the studies was therefore based on interpretations of the available information. This meant that the process was limited by the extent of the information provided by the published papers.

Although inevitable, it is worth noting that it was not always possible to categorise the studies' adaptations and CFT features neatly into discrete categories. There is overlap between the categories of the adaptations framework (e.g. where handouts were given to participants, this was included in "handouts provided", as well as in "visual supports" and/or "written summaries provided"). Thus, some adaptations have a broader impact across the identified categories than

others. Likewise, there is overlap between the categories of the CFT features framework (e.g. where compassion was used to work on self-criticism, this was included in both the "compassion from oneself to oneself" category and the "focus on specific area of difficulty" category). Furthermore, the CFT features framework does not indicate how many practices/exercises within a category a study has included, nor does it convey the amount of time spent on a given component. In addition, there is overlap between the adaptations framework and the CFT features framework (e.g. where carer involvement included providing participants with an opportunity to experience compassion from another, this was categorised as "carer involvement offered/required" in the adaptations framework as well as "compassion from another to oneself" in the CFT features framework).

Furthermore, it was beyond the scope of this review to focus on the findings of the studies. Given the early stage of research on CFT for people with cognitive impairments, it was felt important to provide an overview of the adaptations and CFT features included in the studies that have been conducted to date in order to facilitate the appropriate development of CFT interventions for future research with such population groups. However, it is acknowledged that not considering the adaptations and the CFT features within the context of the studies' findings limits the degree to which conclusions can be drawn regarding the usefulness of these components.

Finally, whilst the quality evaluation followed the same approach as that of Gallagher et al (2019), in their review of Cognitive-Behavioural Therapy for people with brain injuries, the quality assessment scale does not have established psychometric properties. However, the scale does allow the studies' reporting of their interventions to be examined against the "gold standard" CONSORT checklist. As previously reported, in order to ensure reliability of the quality coding, operational definitions of the items were obtained from Gallagher et al (2019) and care was taken to ensure that all studies were rated by a second, independent rater with discrepancies discussed until agreement was reached.

Recommendations for Future Research

Future studies should ensure interventions consist of adaptations across the full range of areas of need identified in this review. Furthermore, consideration of the specific needs of the different types of cognitive impairment would also be a pertinent avenue for future research.

For example, as brain injuries and dementia are acquired in adult life, individuals are more likely to have pre-existing knowledge about emotions that cannot be assumed for those with developmental conditions, such as intellectual disabilities and autism spectrum disorder. Thus, adaptations focusing on psychoeducation may be especially relevant for the latter groups. Of note, only two of the seven studies on intellectual disabilities were reported to have provided participants with examples of compassion. This would seem to be a crucial element to include in a CFT intervention for people with intellectual disabilities in order to ensure understanding of the central concept of the therapy.

Previous literature on adapting psychology therapies, other than CFT, for individuals with cognitive impairments have outlined additional adaptations that were not reported in the reviewed studies. Future research could explore the application of these adaptations to CFT. For example, Surley and Dagnan (2019) state that for individuals with intellectual disabilities it can be helpful to have a greater number of sessions, to consider the person's developmental level, and to be aware of any transference and counter-transference. Regarding brain injury, Gallagher et al (2019) suggest the use of SMART goals, modelling home task completion and encouraging the completion of tasks across a range of situations. They also mention encouraging individuals to keep a therapy notebook or folder containing key information and having sessions more frequently than once a week. The latter is echoed by Cheston and Ivanecka (2017) who suggest bi-weekly sessions for people with dementia. They also state that incorporating religious elements and tai chi into therapy can be helpful, as well as the inclusion of a long-term support group. Similarly, Regan and Varanelli (2013) suggest regular telephone follow-up/booster sessions following the end of the intervention.

In order to design optimally adapted CFT interventions for people with cognitive impairments it would be helpful to study, in detail, specific forms of practising or experiencing compassion, and explore the usefulness of adaptations for each. As previously stated, incorporating the other categories of CFT features identified in the review (i.e. understanding the CFT model, formulation, preparing the body and mind, establishing safety, blocks/fears and home practice) will likely increase the benefit of these interventions by providing context and support for practising/experiencing compassion, as well as opportunities for consolidation.

Once specific forms of practising/experiencing compassion have been sufficiently explored, adapted, and combined with the remaining categories of CFT features, investigating the

effectiveness of extended CFT interventions would be important. This could involve inclusion of multiple forms of practising/experiencing compassion across the subcategories identified in this review (compassion from oneself to oneself, compassion from another to oneself, compassion from oneself to another, and focus on specific area of difficulty). Practising/experiencing compassion across the three flows of compassion may be beneficial in strengthening one's experiences of, and capacity for, compassion, whilst focusing compassion on specific difficulties may improve results by targeting presenting difficulties or maintaining factors. Alternatively including numerous forms of practising/experiencing compassion may not be necessary. Indeed, including too many may be overwhelming for participants, whilst focusing on a small number may promote individuals' ability to use them. Comparing outcomes regarding these different approaches would therefore be valuable.

Future research should, of course, work towards studying larger sample sizes and participants with clinically significant mental health difficulties. It would also be of interest to compare one-to-one interventions with group therapies, as well as with those adopting both modalities. Studies should be guided by the CONSORT checklist extension for non-pharmacological treatments (Boutron et al, 2008) to improve the reporting of interventions and allow replication. As highlighted by the quality evaluation, publication of supplementary material including scripts or detailed intervention outlines can promote this. Studies should also utilise methods to measure and enhance adherence to protocols, such as through recordings, observations, and supervision. Moreover, in future, conducting a systematic review with a focus extending beyond the studies' interventions would be important. A broader quality evaluation would provide a valuable overview of existing research and further indicate areas for improvement. Once sufficient high-quality studies have been conducted, a meta-analysis would serve to advance the evidence base of CFT for people with cognitive impairments by synthesising effect sizes.

Conclusions

Research on adapting CFT for individuals with cognitive impairments is in its infancy, however, the reviewed studies do contribute to the development of an evidence base for the therapy in relation to people with intellectual disabilities, brain injury and dementia. The review indicates

the extent to which the studies' interventions are adapted to meet the needs of participants with cognitive impairments and the degree to which they include the main features of CFT. The findings suggest a need to focus future research on adequately exploring and adapting specific forms of practising/experiencing compassion. The adaptations and additional CFT features summarised in this review can provide ideas for doing so.

References

Alexopoulos, G. S., Abrams, R. C., Young, R. C., & Shamoian, C. A. (1988). Cornell scale for depression in dementia. *Biological psychiatry*, *23*(3), 271-284. https://doi.org/10.1016/0006-3223(88)90038-8

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. Arlington, VA: American Psychiatric Publishing.

Ashworth, F., Clarke, A., Jones, L., Jennings, C., & Longworth, C. (2015). An exploration of compassion focused therapy following acquired brain injury. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(2), 143-162. https://doi.org/10.1111/papt.12037

Ashworth, F., Gracey, F., & Gilbert, P. (2011). Compassion focused therapy after traumatic brain injury: Theoretical foundations and a case illustration. *Brain Impairment*, *12*(2), 128. https://doi.org/10.1375/brim.12.2.128

Boutron, I., Moher, D., Altman, D. G., Schulz, K. F., & Ravaud, P. (2008). Extending the CONSORT statement to randomized trials of nonpharmacologic treatment: explanation and elaboration. *Annals of internal medicine*, *148*(4), 295-309. https://doi.org/10.7326/0003-4819-148-4-200802190-00008

British Psychological Society (2015). *Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood*. Leicester, UK: British Psychological Society

Brougham, L., Pert, C., & Jahoda, A. (2020). Exploring the ability of individuals with an intellectual disability to generate and use a compassionate image. *Journal of Applied Research in Intellectual Disabilities*, *33*(6), 1296-1306. https://doi.org/10.1111/jar.12749

Buckles, J., Luckasson, R., & Keefe, E. (2013). A systematic review of the prevalence of psychiatric disorders in adults with intellectual disability, 2003–2010. *Journal of Mental*

Health Research in Intellectual Disabilities, *6*(3), 181-207. https://doi.org/10.1080/19315864.2011.651682

Camicioli, R. (2014). Diagnosis and differential diagnosis of dementia. In J. F. Quinn (Ed.), *Dementia: Neurology in practice* (pp.1-14). West Sussex, UK: John Wiley & Sons, Ltd.

Campbell, I. N., Gallagher, M., McLeod, H. J., O'Neill, B., & McMillan, T. M. (2019). Brief compassion focused imagery for treatment of severe head injury. *Neuropsychological rehabilitation*, *29*(6), 917-927. https://doi.org/10.1080/09602011.2017.1342663

Cheston, R., & Ivanecka, A. (2017). Individual and group psychotherapy with people diagnosed with dementia: a systematic review of the literature. *International journal of geriatric psychiatry*, *32*(1), 3-31. https://doi.org/10.1002/gps.4529

Clapton, N. E., Williams, J., Griffith, G. M., & Jones, R. S. (2018). 'Finding the person you really are… on the inside': Compassion focused therapy for adults with intellectual disabilities. *Journal of Intellectual Disabilities*, *22*(2), 135-153. https://doi.org/10.1177%2F1744629516688581

Collins, R. N., Gilligan, L. J., & Poz, R. (2018). The evaluation of a compassion-focused therapy group for couples experiencing a dementia diagnosis. *Clinical gerontologist*, *41*(5), 474-486. https://doi.org/10.1080/07317115.2017.1397830

Cooper, K., Loades, M. E., & Russell, A. (2018). Adapting psychological therapies for autism. *Research in autism spectrum disorders*, *45*, 43-50. https://doi.org/10.1016/j.rasd.2017.11.002

Cooper, R., & Frearson, J. (2017). Adapting compassion focused therapy for an adult with a learning disability—A case study. *British Journal of Learning Disabilities*, *45*(2), 142-150. https://doi.org/10.1111/bld.12187

Cowles, M., Randle-Phillips, C., & Medley, A. (2020). Compassion-focused therapy for trauma in people with intellectual disabilities: A conceptual review. *Journal of Intellectual Disabilities*, *24*(2), 212-232. https://doi.org/10.1177%2F1744629518773843

Craig, C., Hiskey, S., Royan, L., Poz, R., & Spector, A. (2018). Compassion focused therapy for people with dementia: A feasibility study. *International Journal of Geriatric Psychiatry*, *33*(12), 1727-1735. https://psycnet.apa.org/doi/10.1002/gps.4977

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: a systematic review of its effectiveness and acceptability in clinical populations. *Expert review of neurotherapeutics*, *20*(4), 385-400. https://doi.org/10.1080/14737175.2020.1746184

Gallagher, M., McLeod, H. J., & McMillan, T. M. (2019). A systematic review of recommended modifications of CBT for people with cognitive impairments following brain

injury. *Neuropsychological rehabilitation*, *29*(1), 1-21. https://doi.org/10.1080/09602011.2016.1258367

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment,* 15**,** 199-208. Advances in Psychiatric Treatment, 15(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features.* East Sussex: Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Goad, E. J., & Parker, K. (2020). Compassion-focused therapy groups for people with intellectual disabilities: An extended pilot study. *Journal of Intellectual Disabilities*, 1-19. https://doi.org/10.1177/1744629520925953

Hardiman, M., Willmoth, C., & Walsh, J. J. (2018). CFT & people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities*, *12*(1), 44-56. https://doi.org/10.1108/AMHID-07-2017-0030

Hsieh, S., Schubert, S., Hoon, C., Mioshi, E., & Hodges, J. R. (2013). Validation of the Addenbrooke's Cognitive Examination III in frontotemporal dementia and Alzheimer's disease. Dementia and geriatric cognitive disorders, 36(3-4), 242-250. https://doi.org/10.1159/000351671

Kolts, R. L. (2016). *CFT made simple: A clinician's guide to practicing compassion-focused therapy*. Oakland, CA: New Harbinger Publications.

Kuring, J. K., Mathias, J. L., & Ward, L. (2018). Prevalence of depression, anxiety and PTSD in people with dementia: a systematic review and meta-analysis. *Neuropsychology review*, *28*(4), 393-416. https://doi.org/10.1007/s11065-018-9396-2

Leaviss, J. & Uttley, L. 2015. Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychological Medicine,* 45**,** 927-945. https://doi.org/10.1017/S0033291714002141

Lindsay, W. R., Jahoda, A. J., Willner, P., & Taylor, J. L. (2013). Adapting Psychological Therapies for People with Intellectual Disabilities I. In J. L. Taylor, W. R. Lindsay, R. P. Hastings and C. Hatton (Eds.), *Psychological therapies for adults with intellectual disabilities* (pp. 69-83). West Sussex, UK: John Wiley & Sons, Ltd.

Lugo-Marín, J., Magán-Maganto, M., Rivero-Santana, A., Cuellar-Pompa, L., Alviani, M., Jenaro-Rio, C., … & Canal-Bedia, R. (2019). Prevalence of psychiatric disorders in adults with autism spectrum disorder: A systematic review and meta-analysis. *Research in Autism Spectrum Disorders*, *59*, 22-33. https://doi.org/10.1016/j.rasd.2018.12.004

Mindham, J., & Espie, C. A. (2003). Glasgow Anxiety Scale for people with an Intellectual Disability (GAS-ID): development and psychometric properties of a new measure for use with people with mild intellectual disability. *Journal of Intellectual Disability Research*, *47*(1), 22-30. https://doi.org/10.1046/j.1365-2788.2003.00457.x

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PloS medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., ... & Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. Journal of the American Geriatrics Society, 53(4), 695-699. https://doi.org/10.1111/j.1532-5415.2005.53221.x

Neff, K. (2021, March 8). Exercise 4: Supportive Touch. Retrieved from https://self-compassion.org/exercise-4-supportive-touch/

O'Neill, M., & McMillan, T. M. (2012). Can deficits in empathy after head injury be improved by compassionate imagery?. *Neuropsychological rehabilitation*, *22*(6), 836-851. https://doi.org/10.1080/09602011.2012.691886

Regan, B., & Varanelli, L. (2013). Adjustment, depression, and anxiety in mild cognitive impairment and early dementia: a systematic review of psychological intervention studies. *International Psychogeriatrics*, *25*(12), 1963-84. https://doi.org/10.1017/S104161021300152X

Scholten, A. C., Haagsma, J. A., Cnossen, M. C., Olff, M., Van Beeck, E. F., & Polinder, S. (2016). Prevalence of and risk factors for anxiety and depressive disorders after traumatic brain injury: a systematic review. *Journal of neurotrauma*, *33*(22), 1969-1994. https://psycnet.apa.org/doi/10.1089/neu.2015.4252

Shankar, K. K., Walker, M., Frost, D., & Orrell, M. W. (1999). The development of a valid and reliable scale for rating anxiety in dementia (RAID). *Aging & Mental Health*, *3*(1), 39-49. https://doi.org/10.1080/13607869956424

Surley, L., & Dagnan, D. (2019). A review of the frequency and nature of adaptations to cognitive behavioural therapy for adults with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities*, *32*(2), 219-237. https://doi.org/10.1111/jar.12534

Tyerman, A., & King, N. S. (2004). Interventions for psychological problems after brain injury. In L.H. Goldstein and J. E. McNeil (Eds.), *Clinical neuropsychology: A practical guide to assessment and management for clinicians* (pp. 385-404). West Sussex, UK: John Wiley and Sons Ltd.

White, M. D., & Marsh, E. E. (2006). Content analysis: A flexible methodology. *Library trends*, *55*(1), 22-45.

World Health Organization. (2016). *International statistical classification of diseases and related health problems* (10th ed.). https://icd.who.int/browse10/2016/en

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Chapter 2: Major Research Project

A Brief Compassionate Imagery Intervention for People with an Intellectual Disability: A Case Series in a Clinical Setting

Prepared in accordance with the author requirements for Journal of Applied Research in Intellectual Disabilities (JARID; Appendix 1, p.76)

Plain Language Summary

Exploring a brief adapted compassionate imagery intervention for people with intellectual disabilities

Background

People with intellectual disabilities experience widespread stigma, mistreatment and abuse. These are likely to lead individuals to experience shame and self-criticism, which can contribute to the development of mental health difficulties. Indeed, many people with intellectual disabilities experience mental health difficulties. Compassion-Focused Therapy (CFT; Gilbert, 2009) is a psychological therapy designed to reduce shame and self-criticism by developing a person's ability to experience compassionate feelings such as safety, warmth and connectedness. It has also been used with other difficulties (e.g. depression, eating disorders and psychosis). The compassionate image exercise is one CFT technique. It involves developing a mental image of a compassionate entity, such as a person or animal, imagining receiving compassion from them, and exploring the feelings associated with this (The Compassionate Mind Foundation, 2021). Brougham et al (2020) adapted this exercise for use with people with intellectual disabilities.

Aims

The current study involved the careful development of a brief adapted CFT intervention incorporating the adapted compassionate image exercise. It aimed to investigate whether participants who have mental health difficulties, as well as intellectual disabilities, were able develop a compassionate image and use it in times of difficulty. It also aimed to explore participants' views and experiences of the sessions. This included the additional adaptations that were specially designed for the study, and the remote delivery of the intervention.

Methods

Four participants experiencing mental health difficulties were recruited from a specialist psychology service for people with intellectual disabilities. They were supported to develop and

to use a compassionate image over two sessions delivered via video call. Data were collected from notes taken across the sessions and from participant interviews which were held following the intervention.

Findings

Participants were able to develop compassionate images and use them in times of difficulty. Furthermore, they reported experiencing benefits of using their compassionate images and of attending the sessions. Participants' views and experiences regarding the intervention's adaptations indicated that they played an important role in helping them to understand and make use of their learning.

Conclusions

This study indicates the potential clinical benefit of an adapted CFT intervention for people with intellectual disabilities. It also highlights that interventions for people with intellectual disabilities can be successfully delivered via video. As research in these areas is currently limited, this study serves to provide some initial evidence from which future research can develop. Thus, paving the way for a broader range of therapeutic options for this underserved group.

References

Brougham, L., Pert, C., & Jahoda, A. (2020). Exploring the ability of individuals with an intellectual disability to generate and use a compassionate image. *Journal of Applied Research in Intellectual Disabilities*, *33*(6), 1296-1306. https://doi.org/10.1111/jar.12749

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

The Compassionate Mind Foundation (2021, March 16). Exercises. Retrieved from https://www.compassionatemind.co.uk/resources/exercises

Abstract

Background

Research exploring the adaptation of Compassion-Focused Therapy (CFT) for individuals with intellectual disabilities is in its infancy.

Method

This case series was a development/early feasibility study in which a brief adapted CFT intervention was carefully designed. The intervention incorporated an adapted compassionate imagery exercise and the study aimed to explore whether participants could generate and use a compassionate image. The study also aimed to explore participants' views and experiences of the intervention, which was delivered via video call. Four people with intellectual disabilities experiencing mental health difficulties were recruited from a specialist psychology service.

Results

Participants were able to generate a compassionate image. They reported using them between sessions, described benefits of doing so, and expressed intention to use their compassionate image in the future. Participants also reported engaging well with other aspects of the intervention.

Conclusions

This exploratory study indicates the potential clinical benefit of an adapted CFT intervention for people with intellectual disabilities and adds to the limited evidence base regarding the remote delivery of interventions for this group.

Key Words: Compassion-Focused Therapy; compassionate imagery; intellectual disability; remote therapy

Introduction

Intellectual disabilities are characterised by deficits in both intellectual and adaptive (i.e. day-to-day) functioning that begin in childhood (American Psychiatric Association, 2013; World Health Organisation, 2019). The prevalence of intellectual disabilities has been identified as being between 0.95% and 1.55% (McKenzie et al., 2016). Studies have suggested that many people with intellectual disabilities experience mental health difficulties. For example, more than a third of people with intellectual disabilities were found to be experiencing mental health difficulties in a large scale, population-based study in Scotland (Cooper et al, 2007). In comparison, just under a quarter of individuals from the English general population were identified as having a psychiatric condition (McManus et al, 2009).

The stigma and abuse experienced by individuals with intellectual disabilities may be a contributory factor to the high prevalence of mental health difficulties in this population (Scior and Werner, 2016). For example, compared with people with physical disabilities, more negative stereotypes, greater social distance, greater withdrawal behaviours, and lower support of rights have been reported in relation to people with intellectual disabilities (Werner, 2015). A care provider in England and Wales ran a survey of more than 320 people in 2016 and found that 73% of respondents with an intellectual disability and/or autism had experienced hate crime, with 53% of respondents having done so in the past year (Dimensions, 2021). Jones et al (2012) reported that children with mental or intellectual disabilities have 4.28 times the odds of experiencing maltreatment (defined as either physical violence, sexual violence, emotional abuse or neglect) than individuals without a disability. Whilst Hughes et al (2012) calculated that adults with intellectual disabilities have 1.6 times the odds of experiencing violence than people without a disability. In a review of 16 studies, the majority of participants with intellectual disabilities reported feeling “different”, being aware of others holding negative views of people with intellectual disabilities, and experiencing feelings of shame, anger and powerlessness in relation to this (Logeswaran et al, 2019). Shame may play an important role in the development and maintenance of mental health difficulties in some people with intellectual disabilities (Clapton et al, 2018b). Self-criticism may also be a contributory factor (Esdale et al, 2015).

Compassion-Focused Therapy (CFT) could, therefore, be a fitting intervention for people with intellectual disabilities as it was originally developed by Gilbert (2009) to reduce shame and self-criticism. It is a transdiagnostic psychological therapy which draws from evolutionary and social psychology, attachment theory, neuroscience and Buddhism. The therapy proposes that there are three affect regulation systems: 1) the threat system, responsible for detecting and protecting against threat; 2) the drive system, responsible for motivation and obtaining resources; and 3) the soothing system, responsible for feelings of social safeness and contentment. It is hypothesised that in people with high levels of shame and self-criticism the threat and drive systems are dominant, whilst the soothing system is underdeveloped. The aim of CFT is therefore to rebalance these systems by activating the soothing system. This is said to be achieved through fostering one's capacity to experience compassion, defined as "the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (Gilbert, 2014).

As outlined by Gilbert (2010) and Kolts (2016) CFT employs various exercises to develop the individual's ability to experience the "felt sense" of compassion and to build a compassionate identity. These include exercises to help prepare the way for experiencing compassionate feelings, such as a mindfulness breathing exercise called soothing rhythm breathing. Clients are supported to experience the giving and receiving of compassion through a range of practices. This can include various imagery exercises, recalling memories and letter writing. In addition, individuals are encouraged to shift into a compassionate perspective to help with specific problems.

As indicated by two existing systematic reviews (Leaviss and Uttley, 2015; and Craig et al, 2020), there is growing evidence that CFT can be an effective intervention for a range of difficulties, as well as the original targets of shame and self-criticism. For example, randomised control trials of people with eating disorders, depression and psychosis indicate that CFT is more effective than no treatment, or treatment as usual (Craig et al, 2020). Furthermore, there are some early indications that adapted CFT interventions may be accessible to individuals with cognitive impairments, as outlined in the author's systematic review. The experiential focus of CFT may make the therapy particularly accessible for people with cognitive impairments compared with traditional talking therapies.

Nevertheless, interventions for people with intellectual disabilities require adaptations to support individuals to understand the content of therapy and to make use of it in their lives. Typical adaptations for people with mild to moderate intellectual disabilities include language simplification, the use of visuals and memory prompts (Jahoda et al, 2017). Published studies use a variety of methods to explore adaptations. Some look at the clinical outcomes of a whole adapted therapy to determine its effectiveness, while others focus on specific adapted techniques and explore in detail participants' ability to engage with them. For example, Brougham et al (2020) developed an adaptation of the compassionate image exercise (The Compassionate Mind Foundation, 2021). The current study adopted the latter approach and aimed to build on Brougham's (2020) research on this adapted exercise.

The compassionate image exercise is a CFT practice which involves developing a mental image of a compassionate entity, such as a person or animal, imagining receiving compassion from them, and exploring the feelings associated with this. This is said to strengthen one's ability to experience compassion, and thus activate the soothing system (The Compassionate Mind Foundation, 2021; Gilbert, 2009). Generating a compassionate image can be challenging for individuals who have had little experience of compassionate relationships in their lives (Gilbert et al, 2011). As reported above, many individuals with intellectual disabilities have endured adverse interpersonal experiences, and some may therefore have had a lack of personal experiences of compassion. This, alongside the additional challenges associated with having a cognitive impairment, would suggest that careful adaptation of the compassionate image exercise would be important for this group of people.

Brougham et al (2020) adapted the compassionate image task through simplified language, slowed pacing and by providing scaffolding to support decision-making. The participants, who were from a non-clinical sample of individuals with intellectual disabilities, were able to meaningfully engage with the exercise. The current study built on this research by recruiting participants with clinically significant mental health difficulties and by incorporating additional supports into the intervention.

The intervention was originally intended to consist of face-to-face group sessions. However, due to service changes relating to the coronavirus pandemic, this was changed to one-to-one sessions delivered via video call. There is currently a lack of research exploring the remote delivery of psychological interventions for individuals with intellectual disabilities (Rawlings et

al, 2021), and exploring participants' experiences of such an intervention is therefore highly pertinent.

Thus, the aims of this development/early feasibility case series were to carefully design a brief adapted CFT intervention incorporating Brougham et al's (2020) adapted compassionate image exercise, and to investigate whether participants from a clinical sample of people with intellectual disabilities could generate a compassionate image through this imagery exercise and make use of their image between sessions. The study also aimed to explore participants' views and experiences of the intervention, including regarding its remote delivery via video call.

Methods

Ethical Approval

The study conformed to the European Union General Data Protection Regulation (GDPR) and approval was received from NHS South East Scotland Research Ethics Committee (reference number: 20/SS/0041).

Design

This development/early feasibility case series adopted a mixed methods approach, with a descriptive account of the generation and use of the compassionate image, and a qualitative analysis of participant views and experiences of the sessions.

Participants

Four participants were recruited from a specialist National Health Service (NHS) psychology service in Scotland for people with intellectual disabilities aged 16 or above. The service covers the whole of the NHS Lanarkshire health board. Individuals were included in the study if they: a) were assessed by the service as experiencing mental health difficulties; b) had sufficient communication skills to engage with the tasks; and c) had capacity to provide informed consent. The study excluded those who: a) were actively suicidal; b) could not access the internet or the

software required for attending the sessions; c) had sensory impairments which were likely to inhibit their ability to engage with the study materials; or d) were known to have previously engaged in the compassionate image exercise.

Recruitment Procedure

Participants were recruited from the specialist psychology service. Staff were asked to consider anyone on their caseload who was in active receipt of therapy and who met the eligibility criteria. However, recruitment proved challenging, and to maximise the sample size, it was extended to include people on the service's waiting list and individuals attending community nursing staff for anxiety management.

Clinicians were approached multiple times over a five-month period. The author presented the study to staff via a PowerPoint presentation, and staff were provided with written recruitment guidance, and the "easy read" study information sheet (Appendix 2, p.84) and consent form (Appendix 3, p.95). The author engaged in frequent email exchanges and telephone calls with staff members to promote recruitment. Communication was facilitated by the author having had a placement within the service. A member of the research team is a permanent member of staff and regularly raised the issue of recruitment at team meetings.

Items from the Adaptive Behaviour Scale – Residential and Community (ABS-RC:2; Nihira et al, 1993) were used to help ensure that individuals had the necessary level of communication skills required to participate in the study. This consisted of assessing whether the person was able to: 1) talk to others about sports, family, or group activities; 2) use complex sentences containing "because" or "but"; and 3) answer simple questions such as "what is your name?" or "what are you doing?". Staff provided potential participants with the "easy read" study information sheet and consent form. Individuals were given time to think about whether they wished to participate and had the opportunity to discuss the study with a clinician who was independent from the project.

Intervention

The first phase of the study involved the development of the intervention so as to embed Brougham's et al's (2020) adapted compassionate image exercise into a clinically meaningful

context. The intervention was informed by CFT literature (e.g. Gilbert, 2010; Kolts, 2016), as well as the evidence base regarding therapy adaptations for individuals with intellectual disabilities (e.g. Surley and Dagnan, 2019). Additionally, the research team, who have extensive experience in adapting psychological therapies, including compassion-focused interventions, were consulted. An outline of the content of the sessions is provided in Appendix 4, p.98. A workbook (Appendix 5, p.103) was specially designed to support the participants' understanding and engagement in sessions, and to facilitate practice between sessions. Care was taken to use images and language that were accessible and engaging.

Participants attended two one-to-one intervention sessions delivered across two weeks. Sessions were delivered via video call using Attend Anywhere, a web-based platform currently being used across National Health Service Scotland (Attend Anywhere, 2021). Sessions were approximately between 45 minutes and two hours in duration, including short breaks when required. Participants attended without a carer.

In Session 1, participants were asked to identify current stressful situations. This was to provide them with examples of situations in which they could later apply their compassionate image. They were then offered psychoeducation regarding compassion to prepare them for developing their own compassionate image. This included examples of acts of compassion and of the emotional and physical effects associated with giving and receiving compassion. A breathing practice was included to facilitate the embodied experience of compassion, as this is a key feature of CFT (Gilbert, 2010). This was adapted for the intervention. Participants were then supported to develop their own compassionate image, described as a "Kind Helper". This was based on Brougham et al's (2020) adapted version of the compassionate image exercise (The Compassionate Mind Foundation, 2021). Adaptations included the simplification of language and a slowing of the pace, with one question being asked at a time. Forced-choice questions were used to provide scaffolding regarding decision-making. These were followed by open-ended questions to obtain fuller descriptions. A discussion regarding participants' experiences of developing their compassionate image was then held to identify any barriers or facilitators to image generation. Finally, participants were set a home task of using their compassionate image between sessions in times of difficulty.

Session 2 included a review of Session 1 to reinforce the information previously covered. It also consisted of a review of the week and of the home task. This was to identify whether

participants had experienced any of the stressful situations identified in Session 1 and whether they used their compassionate image to help them cope. This also allowed for the identification of any barriers or facilitators to image application. To encourage the use of their compassionate image between sessions, participants were supported to develop a key ring with a visual cue, to serve as a memory prompt. The participants were supported to decide on the nature of their key ring image(s). The home task was set once again, and the completed key ring was sent to the participants.

Measures and Interview

Background Information Sheet: to obtain the participants' socio-demographic details

A background information sheet (Appendix 6, p.115) was employed at an initial video call to obtain background socio-demographic data from the participants. This included the person's gender, living situation, and a description of their presenting mental health difficulties. Postcodes were used to generate the Scottish Index of Multiple Deprivation (SIMD; Scottish Government, 2021) quintile for each participant. The SIMD index utilises seven factors to determine the level of deprivation of postcodes: income, employment, education, health, access to services, crime and housing. Scores range from 1 (most deprived) to 5 (least deprived).

Data Recording Booklet: to record the participants' completion of in session and between session tasks

Session notes regarding the intervention were kept in a data recording booklet (Appendix 7, p.118). Data from Session 1 included information about the generation and use of compassionate images, alongside observations about the barriers and facilitators to image generation. Data from Session 2 included information regarding the application of the compassionate imagery and the barriers and facilitators to image application. A final one-to-one video call was held the week following Session 2. As before, a review of the week and the home task was held to identify whether participants had experienced any of the identified stressful situations, whether they had used their compassionate image, and to identify any further barriers and facilitators to image application. This information was also recorded in the data recording booklet. Furthermore, additional notes were kept of relevant observations and reflections across all video calls.

Semi-Structured Interview: to explore the participants' views and experiences of the intervention

A semi-structured interview was administered a week after Session 2, at the final video call. The topic guide (Appendix 8, p.130) drew on Sekhon et al's (2017) discussion of the construct of acceptability and was designed to obtain participant views and experiences regarding the various components of the intervention. The interview was audio recorded and transcribed.

WASI-II: to assess cognitive ability

The subtests of the WASI-II (Wechsler, 2011) which could be delivered remotely (i.e. Vocabulary and Similarities) were employed as measures of intellectual ability. This allowed the Verbal Comprehension Index (VCI) to be calculated. This is a measure of acquired knowledge, verbal reasoning, and attention to verbal information. The average internal consistency coefficient for the VCI, and its average test-retest stability coefficient are both excellent at .95. Interrater reliability is also excellent, at .95 for Vocabulary and .94 for Similarities. In terms of concurrent validity, correlations between the VCI of the WASI-II and the VCIs of the WASI, WAIS-IV and WISC-IV VCIs are high at .87, .88, .84, respectively.

The WASI-II subtests involve correct and incorrect answers and therefore contrast with the spirit of the interviews in which participants' views were sought. Therefore, the tests were administered at the end of the study to ensure participants felt able to freely express their views.

Data Analysis

Information from the data recording booklets obtained from Session 1 was used to provide descriptive accounts of whether participants were able to generate a compassionate image. This was defined as the compassionate image being caring, understanding, and comforting towards the participant, and was crosschecked by the research team. Information from the data recording booklets obtained from Session 2 and the final video call were used to provide a descriptive account of whether participants had used their compassionate image in the week

following Session 1 and the week following Session 2, and whether they had encountered any stressful situations during those weeks.

Data regarding participants' views and experiences of the sessions, obtained through the semi-structured interviews and data recording booklets, were subject to framework analysis. This approach provides a systematic structure to identify and analyse themes (Hackett and Strickland, 2018). A framework was developed consisting of categories and subcategories of participant views and experiences. The framework was based on the topic guide and agreed with the research team. Participant interviews were transcribed verbatim. These were read by the research team and discussed. Data summaries were produced for each interview. Information from the data recording booklets relating to the analysis framework were also included in the data summaries. This was possible, given the flexible nature of the framework approach (Gale et al, 2013). Additional categories, identified through analysis of the data summaries, were added to the final version of the framework. Codes were then applied to the data summaries and classed within the framework through discussion with the research team. At this stage an extensive list of categories and subcategories of participants' views was collated. In the final phase of the analysis, this detailed list of items was reduced through discussion with the research team. Categories were collapsed to form the final categories of participants' views.

Results

Recruitment Data

Clinicians reported considering a total of 13 individuals for the study. However, in the end, five of these people were not approached by staff to discuss the study. This was because three did not meet the eligibility criteria (two were actively suicidal, and one did not have capacity to provide informed consent) and two of them were viewed by staff to no longer be appropriate for the study (for one person online communication was felt to no longer be suitable and for the other it was felt that the study would interfere with their therapy). Eight individuals were approached by clinicians to discuss the study. However, three people later declined, and one person did not meet the eligibility criteria due to not having access to the internet.

Recruitment was initially focused on the psychology service's active caseload. It was then extended to include individuals on the service's waiting list and those attending community nursing staff for anxiety management, but no participants were recruited through these routes. The average number of people on the psychology service's caseload was 153 during the recruitment period, and the average number on the waiting list during this time was 14.5. However, the service provides assessment and intervention for people with a wide range of needs, and, as such, the active caseload and waiting list typically includes many individuals who would not meet the study's eligibility criteria (e.g. sufficient communication skills; capacity to provide consent).

The recruitment figures also need to be understood in the context of the COVID-19 pandemic. In the first instance, due to the pandemic, the original study which had received ethical approval had to be redesigned and Substantial Amendments submitted to the ethics committee. This meant that the time available for recruitment was reduced.

Another barrier to recruitment was the impact of the pandemic on staff. Many community nursing staff were redeployed due to the pandemic and were therefore unable to assist with recruitment. Moreover, the remaining nursing staff were being asked to prioritise urgent cases, making it more difficult to identify suitable participants for the study. This was also a highly stressful period for many staff and care had to be taken to avoid burdening them further with requests regarding study recruitment.

Finally, discussion with staff indicated that many individuals with intellectual disabilities were unable to use the technology required for engaging in video calls with clinicians, or did not have the necessary equipment. While a greater number of individuals may have since been supported to engage in video calls, recruitment for the study took place when individuals with intellectual disabilities were adjusting to the implications of the government restrictions and remote clinical sessions. Clinicians were also adapting to these new ways of working and of supporting their clients.

Participant Characteristics

The participants' clinical and socio-demographic information is provided in Table 1. Three individuals were of a similar age with the fourth being considerably older. Participants reported a range of living situations and mental health difficulties. One individual's Verbal Comprehension Index (VCI) score from the WASI-II was above 70 which is within the normal range of functioning. However, participants would have been carefully screened by the specialist service for people with intellectual disabilities from which they were recruited. Therefore, the VCI subtests may have captured the individual's particular strengths and provided a misleading picture.

Table 1

Participants' clinical and sociodemographic characteristics

Clinical/sociodemographic category		**Participant information**
Gender	Male	2
	Female	2
Age	Mean (SD)	33 (14.4)
	Range	24-58
Scottish Index of Multiple Deprivation (SIMD) quintile (1=most deprived; 5=least deprived)	Mean (SD)	2.25 (0.8)
	Range	1-3
Living situation	Alone	1
	With partner	1
	With family	2
Presenting mental health difficulties	Anxiety	3
	Depression	3
	Trauma	1
Verbal Comprehension Index (VCI) score from WASI-II	Mean (SD)	72.75 (15.3)
	Range	61-99

Data regarding participant ethnicity was not collected. The ethnicity breakdown of the population of the geographical area covered by the specialist service (NHS Lanarkshire health board) is 98% White (i.e. 92.4% White Scottish, 3.1% White Other British, 1.1% Irish, 0.7% Polish, 0.7% Other), 1.5% Asian, Asian Scottish or Asian British, and 0.5% Other Ethnic Groups (National Records of Scotland, 2021).

Data regarding the psychological interventions received by participants through the service was collated anonymously by staff. Two participants were in the middle stage of therapy, another was at the end of therapy, and the remaining participant was at the end of a specific phase of therapy. For two participants the interventions received were informed by Cognitive-

Behavioural Therapy. One participant received adapted Dialectical Behaviour Therapy and another Safety and Stabilisation work for trauma. All participants had an appointment the same week as the study sessions, on at least one occasion.

Generation and Use of Compassionate Image

Table 2 summarises the compassionate image characteristics generated by each participant. All participants provided rich descriptions of the physical appearance of their compassionate images and they were able to self-generate soothing statements. These included compassionate statements, as well as statements appearing to provide cognitive reframing and positive affirmations. In addition to these, P4 generated a statement that did not appear to be compassionate ("don't get angry, get even"). However, when this was discussed he was able to recognise this and promptly provided an alternative soothing statement ("forgive and forget"). The participants were able to provide additional information regarding their compassionate image when asked an open question regarding this.

Table 2

Compassionate image characteristics for each participant

Compassionate image characteristics	**Participant**			
	P1	**P2**	**P3**	**P4**
Brief description	Woman	Female character from animated film	Cartoon animal	Male character from animated film
Examples of self-generated soothing statements	▪ I am here for you ▪ Don't worry, everything will be okay	▪ I'm here to comfort you and support you ▪ We'll go for a nice long walk and talk about things	▪ You're doing better than you think you are ▪ You're a good guy	▪ Life is hard ▪ Things can only get better
Additional information provided	▪ Trustworthy ▪ Non-judgmental	▪ Born in the woods ▪ Takes participant on a sleigh ride with wolves trained to de-stress participant ▪ Has magic powers	▪ Funny ▪ Intelligent ▪ Thoughtful ▪ Exercises with participant to provide motivation	▪ Always in a positive mood and smiling ▪ Plays practical jokes

Table 3 summarises the participants' use of their compassionate image in the week following Session 1 and the week following Session 2. The participants reported using their compassionate image each week, except when they did not encounter any stressful situations.

Table 3

Reported use of compassionate image in Weeks 1 and 2 for each participant

Application	Participant			
	P1	P2	P3	P4
Week 1	Used	Not required	Used	Used
Week 2	Used	Used	Used	Not required

Participants' Views and Experiences of the Intervention

Table 4 presents the nine categories and corresponding participant views and experiences identified through the framework analysis, whilst Table 5 provides example quotations for each category. Individual participants expressed multiple views per category. Summaries are provided below:

Category 1: Salient Components

When asked what they remembered about the sessions, all participants identified the compassionate image exercise and the breathing practice. Other salient components included learning about compassion, identifying current stressful situations, and the images used in both the workbook and the key ring.

Category 2: Generation of Compassionate Image

Participants liked that the process of generating a compassionate image through the adapted exercise was a positive and engaging experience. For P2, this process extended beyond Session 1 as she later decided to give her compassionate image a middle name to symbolise the character's compassionate nature. Participants described what led them to choose their image, this ranged from a thoughtful process to an automatic one. Reported difficulties included struggling to remember specific details of the character the image was based on, and finding it hard to choose a meaningful image.

Category 3: Use of Compassionate Image

Several benefits of using the compassionate image were reported, including improved emotional wellbeing and reduced physical pain. Triggers for using the image included being faced with a difficult situation, as well as having the key ring and the workbook. Reported facilitators were practice, and having predefined the appearance of the compassionate image. Participants described two different approaches to engaging with their compassionate image: one was talking out loud to the image, and the other was using it in conjunction with the breathing practice and other relaxation strategies. In terms of likes, participants appreciated that the compassionate image was one of several useful skills and were delighted with how real their image appeared to them. On the other hand, participants were disappointed that their compassionate image was not real. Other barriers to engaging with the compassionate image included low mood and rumination.

Category 4: Breathing Practice

All participants reported finding the breathing exercise beneficial. Participants liked the practice due to viewing it as an important and accessible skill. Reported facilitators for the breathing exercise included practice and the visual instructions in the workbook. However, the instructions to close one's eyes were disliked by one participant who preferred to keep her eyes open. Other notable points were that participants reported recommending the breathing exercise to others and practising it between sessions, although this was not a set task.

Category 5: Use of Workbook

The participants reported liking the workbook and its accessible content, although one participant described having some difficulties with it and related this to his dyslexia. All the participants valued the images included, and the psychoeducation regarding compassion was felt to be helpful.

Category 6: Development and Use of Key Ring

Participants liked their key rings and enjoyed the process of choosing the images. They all chose two pictures: one to represent their compassionate image and one to symbolise compassion.

Although participants reported some difficulty in choosing an image, being provided with a selection of pictures was found to be helpful. P1, whose compassionate image was not a cartoon, preferred a cartoon of a woman over photographs of real women.

Category 7: Usefulness of Sessions

When asked, all participants reported that they would recommend the sessions to others. Sessions were felt to have had several benefits, including being relaxing and helping them to reflect on the support received from others. The identification of current stressful situations was experienced as cathartic, and the focus on self-compassion was said to have led to engaging in self-care activities.

Category 8: Future Use of Learning/Material

All participants reported intending to use their compassionate image, key ring, and the breathing practice in future, with all but one planning to continue using their workbooks. One participant expressed wishing to paint a picture of his compassionate image and hang it on his wall. He also hoped to apply the learning gained through the sessions to think positively. Participants were inspired to be compassionate to others and engage in acts of self-care.

Category 9: Video Call Delivery

Although some difficulties were encountered, the video calls were described as easy, with prior experience of video calls said to have been helpful. Some participants said they would have preferred the sessions to have been in person, however, being able to see the therapist on screen was viewed as a positive experience. A further advantage was attending the sessions from home.

Table 4

Participants' views and experiences derived from framework analysis

Categories/subcategories		**Participant views and experiences**	**Number of participants**
Salient components		Breathing practice	4
		Compassionate image exercise	4
		Identification of current stressful situations	2
		Not feeling rushed	1
		Images (workbook and/or key ring images)	2
		Learning about compassion	3
		Sessions being good and/or relaxing	1
Generation of compassionate image	Likes	Process was okay, easy and/or enjoyable	3
		Thought of having compassionate image felt exciting and/or motivating	2
		Opportunity to be creative	1
	Facilitators	Based compassionate image on someone would want in life	1
		Based compassionate image on character from animated film	2
		Picked idea that automatically came to mind	1
	Barriers/dislikes	Difficult to remember specific details of animated film character	2
		Difficult to choose a meaningful image due to feeling rushed	1
		Negative view of using imagination due to association with having been bullied for this	1
	Other	Later gave compassionate image a middle name to symbolise compassionate nature	1
Use of compassionate image	Benefits	Improved mood and/or motivation	3
		Relaxing and/or comforting	4
		Alternative to self-harming	1
		Reduced physical pain	1
	Triggers for use	Used in times of difficulty	4
		Used following workout as part of cooldown routine	1
		Used when loved ones unable to provide support	1
		Key ring	1
		Workbook	1
	Facilitators	Having predefined appearance of compassionate image	1
		Easier with practice	1
	Approach	Talked out loud to compassionate image and imagined response	1
		Used in conjunction with breathing practice and other relaxation strategies	2
	Likes	Felt real	2
		View compassionate image as one tool amongst others	1
	Barriers/dislikes	Compassionate image is not real	2
		Difficulty engaging with compassionate image due to low mood and rumination	1
		Embarrassed when using compassionate image with breathing practice in public	1

Breathing practice	Facilitators	Visual instructions in workbook	2
		Easier with practice	2
		Adopted compassionate approach towards practice	1
	Likes	Important skill	1
		Skill that is always accessible	1
		Different and/or easier than previously learnt breathing/relaxation practices	2
	Benefits	Calming and/or relaxing	4
		Motivating	1
	Barriers/dislikes	Instructions to close eyes	1
		Startled by phone call during between session practice	1
	Other	Practised between sessions	3
		Recommended to others	1
Use of workbook	Facilitators/likes	Liked workbook in general	3
		Accessibility of text	1
		Images	4
		Psychoeducation regarding examples of compassion	3
		Psychoeducation regarding physical effects of compassion	1
	Barriers/dislikes	Limited accessibility of text	1
		Having to write in workbook	1
Development and use of key ring	Likes	Process was enjoyable, fun and/or interesting	2
		Liked images and/or key ring	3
		Inspired to make key ring for family member in future	1
		Easier to carry than workbook	1
	Facilitators	Being provided with a selection of images	2
		Inclusion of cartoons in the selection of images provided	1
		Chose one picture to represent compassionate image and one to represent compassion	4
		Chose picture as it made participant smile	1
		Chose picture as it relates to participant's past	1
	Barriers/dislikes	Difficult to choose image(s)	3
Usefulness of sessions		Would recommend to others	4
		Discussion on self-compassion led to engaging in self-care activities	1
		Cathartic to discuss current difficulties	1
		Sessions were relaxing	1
		Helped to recognise support from others and pre-existing coping strategies	1
Future use of learning/material		Intention to use compassionate image	4
		Intention to use breathing practice	4
		Intention to use key ring	4
		Intention to use workbook	3
		Intention to dispose of workbook	1
		Intention to be compassionate to others	2
		Intention to engage in acts of self-care	1
		Intention to apply learning to think positively	1
		Intention to paint a picture of compassionate image and hang on wall	1
Video call delivery	Facilitators/likes	Easy	1
		Seeing therapist on screen	3
		Attending from home	3
		Prior experience of video calls	2
		Use of telephone when required	1
		Good quality	1
	Barriers/dislikes	Not meeting in person	2
		Background noise	1
		IT issue	1
		Time required to log on	1

Table 5

Examples of participants' views and experiences

Category	Quotations from interviews and data recording booklets	Participant
1. Salient components	…being kind can actually relax your body...Just being kind to them…you can actually see the relief in their, like in their body as well, as well as yourself, because you're actually being kind to someone.	P1
2. Generation of compassionate image	…makes me want to take the world on in one! Makes me feel I can do things I didn't like to do, like swimming lessons.	P4
3. Use of compassionate image	It was everything magic, it was magical, I sometimes feel magical moments, as if she was actually in the room, at one point!	P2
4. Breathing practice	…when you are feeling stressed, when you're feeling anxious it's…you know, you've always got that there in your back pocket.	P3
5. Use of workbook	It made sense when you looked at the pictures, what they were trying to tell you to do.	P4
6. Generation and use of key ring	Like the actual, the actual people you didn't actually know who they were, but a cartoon could make it look like the person you wanted it to be.	P1
7. Usefulness of sessions	…doing something to make yourself happy…like maybe dying your hair or watching a film or something, that makes you happy because you're actually being kind to yourself because probably before I wouldn't do that, I would probably just go "do you know what, it doesn't matter".	P1
8. Future use of learning/material	It was something that I hadn't realised before that maybe to…maybe to help people and to be kinder to help people so I'll keep that in mind when my friends are giving me [bother].	P4
9. Video call delivery	When it didn't work…I had to use my phone and I couldn't see you, and it was annoying. Got me stressed, but then I thought "what am I getting stressed about?" It's just I can still talk to you!	P2

Discussion

The current development/early feasibility study adds to Brougham et al's (2020) research in several important ways. In studying a clinical sample, it demonstrates that individuals with intellectual disabilities, who also struggled with clinically significant mental health difficulties, were able to generate a compassionate image. In addition, it explored participants' abilities to make use of their images and showed that they reported being able to apply them in times of difficulty. Furthermore, participants described experiencing benefits of using their compassionate images and of attending the sessions. These findings point to the clinical relevance of the intervention.

Participants' views on the intervention's adaptations indicate that they were instrumental in promoting engagement. These included the adapted compassionate image exercise developed

by Brougham et al (2020) which appeared to have facilitated the formation of well-developed compassionate images. Of note, however, participants' understanding of compassion and their ability to apply their compassionate image in times of difficulty appear to have been facilitated by the additional supports incorporated into the intervention. The value of these additions is in keeping with the evidence base regarding therapy adaptations for people with intellectual disabilities.

Indeed, in a review of Cognitive-Behavioural Therapy adaptations for people with intellectual disabilities, Surley and Dagnan (2019) highlight the need to augment activities, such as through the use of booklets and images. The workbook images appear to have played an important role in promoting engagement. Those illustrating acts of compassion led to discussion of personal examples. Furthermore, although the adapted breathing exercise was intended to be merely a supportive feature to facilitate the experience of compassionate feelings, it was clearly greatly valued by participants in its own right, and the visual instructions appear to have promoted this. The key rings were also appreciated by participants. This may have been facilitated by the participants' involvement in the development of their key rings. Although not reported, the fact that good quality photo holders were used may have also positively influenced views of the finished products.

Additionally, Surley and Dagnan (2019) highlight the importance of adopting a directive style. The workbook took this approach and used visual cues to provide a clear session structure. Simplifying the language and the use of examples are also reported to be important. These were taken into consideration in the development of the workbook and the session content. The identification of current stressors provided participants with examples of situations in which they could apply their compassionate image. It appeared to have helped individuals to generalise their learning and use their compassionate image in times of difficulty. The examples of acts of compassion and the emotional and physical effects of giving and receiving compassion appeared to have helped the participants develop a meaningful understanding of compassion, thus facilitating the use of the compassionate image. Finally, repetition is said to be a key adaptation. This was incorporated into the intervention and appeared to promote the participants' recall of the session content.

This study supports Brown et al's (2011) view that through careful adaptations, individuals with intellectual disabilities can understand and make use of specific psychological interventions.

This is important, given the paucity of research regarding psychological interventions for people with intellectual disabilities that Brown et al (2011) highlight. Furthermore, the study adds to the small but growing evidence base regarding adapted CFT interventions for people with intellectual disabilities, outlined in the author's systematic review.

The study findings are consistent with those exploring adapted CFT for individuals with other cognitive impairments. As outlined in the author's systematic review, to date these have included brain injury and dementia. For example, a single case study by Ashworth et al (2011) explored the use of a similar compassionate image practice with a person with a brain injury, within a one-to-one CFT intervention of 24 sessions. As in the current study, therapy adaptations included the provision of written summaries, images, prompts, and repetition. The participant reported finding the compassionate image helpful and highlighted the benefit of repetition in particular. Outcomes included a reduction in symptoms of anxiety and depression. Collins et al (2018) investigated an adapted group CFT intervention, lasting 6 sessions, for people with dementia, which also included a similar compassionate image exercise. The adaptations their intervention had in common with the current study were repetition and the use of visual information. They found a reduction in the participants' symptoms of depression and an improved quality of life. Findings from these studies cannot be attributed solely to the compassionate image exercise as they consisted of fuller CFT interventions, however, they do provide some indication that it can be successfully adapted to people with other cognitive impairments.

The approach taken in this study complements that of other studies which explore fuller adapted CFT interventions for individuals with intellectual disabilities (e.g. Clapton et al, 2018a). By focusing on specific CFT features and accompanying supports, the study was able to provide a detailed account of participants' experiences. This allowed for a close examination of the usefulness of the adaptations in relation to the specific CFT features studied, as well as identifying additional issues worthy of consideration.

One matter worthy of reflection relates to the views that participants expressed regarding their compassionate image *feeling*, but not *being,* real. A sense of excitement at the prospect of having a friend, and disappointment that this friend was not real, was apparent. Sadly, this is perhaps a reflection of the widespread chronic loneliness frequently experienced by individuals with intellectual disabilities (Gilmore and Cuskelly, 2014). Indeed, the high level of participant

engagement observed across sessions could have been influenced by further isolation incurred as a result of the government COVID-19 restrictions. Participants may have valued the development of their compassionate image and/or the contact with their therapist for this reason.

Another area of interest is the nature of the self-generated soothing statements. Some of these were positive affirmations (e.g. “you’re a good guy”). This may have been a response to feelings of shame, which would fit with findings that shame may be a key mechanism underlying the mental health difficulties of some people with intellectual disabilities (Clapton et al, 2018b).

Interestingly, a sense of fun was palpable across most sessions and evident in the playful nature of some of the participants’ compassionate images. Fredrickson’s (1998) broaden-and-build model of positive emotions posits that joy and playfulness can broaden one’s range of resources. Intuitively, playfulness appears somewhat incompatible with shame, however to the author’s knowledge no research has been conducted exploring this relationship. There is currently limited research on the therapeutic value of playfulness in adults, although there are some preliminary indications that it can be stimulated through short play-based interventions and lead to improved wellbeing (Proyer et al, 2021). Nevertheless, at this stage it is not possible to ascertain the extent to which the participants’ own sense of playfulness was manifest and the degree to which this was engendered by the compassionate image exercise.

Furthermore, the key rings provided are in keeping with Lucre and Clapton’s (2020) concept of a “Compassionate Kitbag”, said to consist of items that provide concrete representations of compassion. These items can be transitional objects. Indeed, the key rings may not simply have served as reminders to use the compassionate image but may also have symbolised the therapist’s compassion towards the individual. It is said that kitbags should contain a range of sensory items, and the key rings provided accessible visual representations of the concept of compassion and the participants’ compassionate images. As stated by Lucre and Clapton (2020), the emphasis that CFT places on imagery and experiential processes may mean it is particularly suited to individuals with intellectual disabilities, compared with traditional talking therapies. Certainly, participants appeared to respond well to the imagery and experiential aspects of the intervention.

Finally, despite the great trepidation initially felt by many clinicians working with individuals with intellectual disabilities at the beginning of the COVID-19 pandemic, this study demonstrated that participants were able to meaningfully engage with an intervention delivered via video call. From a therapist's perspective, the sessions were highly enjoyable, and this was felt to be a reflection of the participants' high level of engagement, despite the remote nature of the sessions. Nevertheless, it is acknowledged that for many individuals with intellectual disabilities this technology would be inaccessible (Rawlings et al, 2021).

As mentioned above, increased isolation resulting from the pandemic could have played a part in the high level of engagement. Participants also reported struggling with other aspects of the pandemic, including feeling confused about the restrictions, angry at witnessing others breaking the rules, and vulnerable in terms of their own health. Heightened distress relating to the pandemic could therefore have increased motivation to engage with the intervention and to learn a strategy that could have the potential to alleviate their distress. Indeed, all four participants named at least one pandemic-related stressor at the beginning of Session 1 when asked to identify current difficult situations. Having the opportunity to note these down in the workbook and to discuss them in terms of situations in which to apply their compassionate image may have strengthened participants' understanding as to the potential utility of the compassionate image when facing these stressors.

Limitations and Future Research

Interviews were conducted by the author, who also delivered the intervention. This is likely to have led to demand characteristics and is therefore a notable limitation of this study. Attempts were made to reduce this bias by making it clear to participants that they were the experts and that their views, regardless of their nature, were valued. This was explained at the beginning of the study, during discussions throughout the sessions, and prior to the semi-structured interview. In a similar vein, a further limitation relates to the author having also analysed the data. An attempt to minimise bias was implemented by ensuring that all members of the research team read the transcripts. The research team were then consulted throughout the data analysis process. Nevertheless, a risk of bias remains. This aspect of the study's design did, however, allow the data to be analysed with an in-depth grasp of context, gained through having a shared experience of the sessions with the participants, which may have allowed a more nuanced understanding of the participants' reports.

All participants were in active receipt of psychological therapy which could have had a significant impact on their engagement with the CFT intervention. Of note, participants had psychology appointments on the same weeks as the study sessions. Receiving other therapy is likely to have socialised participants to taking part in therapeutic sessions, facilitating their engagement with the therapist and the CFT content of the intervention. It may also have served as a prompt for the use of the compassionate image. Alternatively, taking part in another therapy could have had a disruptive effect on participants receiving the CFT intervention, due to an overload of information or conflicting information causing confusion.

Another considerable limitation is the small sample size and exploratory nature of the study, meaning interpretations of the study's findings must be made with great caution. Participants were relatively high functioning. This may have been a result of selection bias due to staff recruiting individuals they believed would most benefit from the study. Future research should explore whether individuals with more marked impairments are able to meaningfully engage with the adapted compassionate imagery intervention. In addition, three out of four of the participants were in their twenties. The findings therefore have limited generalisability to other age groups, especially in relation to older generations, who have been reported to experience greater digital exclusion (Office for National Statistics, 2021).

Furthermore, data on ethnicity was not collected. This means it is not possible to evaluate whether the sample is representative of the Lanarkshire population, nor the extent to which findings can be generalised to other populations. Of note, there are also differences in digital exclusion across ethnic groups, although these are reducing over time (Office for National Statistics, 2021). Future studies should make sure to collect data on participant ethnicity to allow readers to generalise findings to similar populations and to promote research with people from different backgrounds and with different cultural beliefs. Collecting data on spiritual and religious beliefs may also be of value as individuals may be practised in holding mental representations of spiritual or religious figures they view as ideal compassionate entities from which they receive compassion in times of difficulty.

As this was a development/early feasibility study, further work on feasibility would be important. It is hoped that this would lead to studies investigating the effectiveness and efficacy of this adapted compassionate imagery intervention. The intervention was brief, thus exploring

outcomes of an extended version would be of value. Doing so with participants who are not engaging in another psychological intervention at the same time would be crucial. Incorporating the session content into a fuller CFT intervention consisting of other carefully adapted CFT practices would also be of interest. In addition, it may be interesting to explore a group version of the compassionate imagery intervention, as was intended prior to the COVID-19 pandemic. This is because group CFT interventions have been found to be more effective than one-to-one interventions (Craig et al, 2020) and can provide the opportunity for experiencing compassion in relation to other group members (Bates, 2005). Conducting research on the remote delivery of such an intervention would also be relevant. Research has been conducted on group video call interventions (Lopez et al, 2020) but to the author's knowledge none has been conducted to date with people with intellectual disabilities.

Finally, exploring a compassionate image intervention, such as the one developed in this study, in relation to people's experiences of isolation and loneliness would be of value. Given the excitement participants expressed regarding their images *feeling* real, and the disappointment they reported about them not *being* real, it would be valuable to investigate whether loneliness serves as a facilitator or inhibitor in the development and use of a compassionate image, and whether engaging in such an intervention would be associated with any changes in feelings of loneliness. As the study was conducted during the COVID-19 pandemic when participants may have been experiencing increased isolation, it would be interesting to explore the intervention once the pandemic is over.

Conclusions

Although interpretation of this development/early feasibility study must remain cautious, the findings indicate the potential clinical benefit of adapted CFT interventions for people with intellectual disabilities and highlight a need for further research in this area. The study also adds to the limited evidence base regarding the remote delivery of interventions for people with intellectual disabilities.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. Arlington, VA: American Psychiatric Publishing.

Ashworth, F., Gracey, F., & Gilbert, P. (2011). Compassion focused therapy after traumatic brain injury: Theoretical foundations and a case illustration. *Brain Impairment*, *12*(2), 128. https://doi.org/10.1375/brim.12.2.128

Attend Anywhere (2021, March 16). Attend Anywhere. Retrieved from https://www.attendanywhere.com/

Bates, T. (2005). The expression of compassion in group cognitive therapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy*, 369-386. London: Routledge

Brougham, L., Pert, C., & Jahoda, A. (2020). Exploring the ability of individuals with an intellectual disability to generate and use a compassionate image. *Journal of Applied Research in Intellectual Disabilities*, *33*(6), 1296-1306. https://doi.org/10.1111/jar.12749

Brown, M., Duff, H., Karatzias, T., & Horsburgh, D. (2011). A review of the literature relating to psychological interventions and people with intellectual disabilities: Issues for research, policy, education and clinical practice. *Journal of Intellectual Disabilities*, *15*(1), 31-45. https://doi.org/10.1177%2F1744629511401166

Clapton, N. E., Williams, J., Griffith, G. M., & Jones, R. S. (2018a). 'Finding the person you really are… on the inside': Compassion focused therapy for adults with intellectual disabilities. *Journal of Intellectual Disabilities*, *22*(2), 135-153. https://doi.org/10.1177%2F1744629516688581

Clapton, N. E., Williams, J., & Jones, R. S. (2018b). The role of shame in the development and maintenance of psychological distress in adults with intellectual disabilities: a narrative review and synthesis. *Journal of Applied Research in Intellectual Disabilities*, *31*(3), 343-359. https://doi.org/10.1111/jar.12424

Collins, R. N., Gilligan, L. J., & Poz, R. (2018). The evaluation of a compassion-focused therapy group for couples experiencing a dementia diagnosis. *Clinical gerontologist*, *41*(5), 474-486. https://doi.org/10.1080/07317115.2017.1397830

Cooper, S. A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *The British journal of psychiatry*, *190*(1), 27-35. https://doi.org/10.1192/bjp.bp.106.022483

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: a systematic review of its effectiveness and acceptability in clinical populations. *Expert review of neurotherapeutics*, *20*(4), 385-400. https://doi.org/10.1080/14737175.2020.1746184

Dimensions (2021, May 6). How often are disability hate crimes committed? Retrieved from https://dimensions-uk.org/get-involved/campaigns/say-no-autism-learning-disability-hate-crime-imwithsam/know-more/often-disability-hate-crimes-committed/#:~:text=And%20our%202016%20survey%20found,crimes%20are%20grossly%20under%20reported.

Esdale, L., Jahoda, A., & Pert, C. (2015). Coping with criticism and praise. *American journal on intellectual and developmental disabilities*, *120*(3), 258-268. https://doi.org/10.1352/1944-7558-120.3.258

Fredrickson, B. L. (1998). What good are positive emotions?. *Review of general psychology*, *2*(3), 300-319.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, *13*(1), 1-8. https://doi.org/10.1186/1471-2288-13-117

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. East Sussex: Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. British Journal of Clinical Psychology, 53(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, research and practice*, *84*(3), 239-255. https://doi.org/10.1348/147608310X526511

Gilmore, L., & Cuskelly, M. (2014). Vulnerability to loneliness in people with intellectual disability: An explanatory model. *Journal of Policy and Practice in Intellectual Disabilities*, *11*(3), 192-199. https://doi.org/10.1111/jppi.12089

Hackett, A., & Strickland, K. (2018). Using the framework approach to analyse qualitative data: a worked example. *Nurse researcher*, *26*(3). https://doi.org/10.7748/nr.2018.e1580

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., ... & Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: a systematic review and

meta-analysis of observational studies. *The Lancet*, *379*(9826), 1621-1629. https://doi.org/10.1016/S0140-6736(11)61851-5

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

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., ... & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet*, *380*(9845), 899-907. https://doi.org/10.1016/S0140-6736(12)60692-8

Kolts, R. L. (2016). *CFT made simple: A clinician's guide to practicing compassion-focused therapy*. Oakland, CA: New Harbinger Publications.

Leaviss, J., & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. *Psychological medicine*, *45*(5), 927-945. https://doi.org/10.1017/S0033291714002141

Logeswaran, S., Hollett, M., Zala, S., Richardson, L., & Scior, K. (2019). How do people with intellectual disabilities construct their social identity? A review. *Journal of Applied Research in Intellectual Disabilities*, *32*(3), 533-542. https://doi.org/10.1111/jar.12566

Lopez, A., Rothberg, B., Reaser, E., Schwenk, S., & Griffin, R. (2020). Therapeutic groups via video teleconferencing and the impact on group cohesion. *Mhealth*, *6*. http://dx.doi.org/10.21037/mhealth.2019.11.04

Lucre, K., & Clapton, N. (2020). The Compassionate Kitbag: A creative and integrative approach to compassion-focused therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, e12291. https://doi.org/10.1111/papt.12291

McKenzie, K., Milton, M., Smith, G., & Ouellette-Kuntz, H. (2016). Systematic review of the prevalence and incidence of intellectual disabilities: current trends and issues. *Current Developmental Disorders Reports*, *3*(2), 104-115. https://doi.org/10.1007/s40474-016-0085-7

McManus, S., Meltzer, H., Brugha, T., Bebbington, P. E., & Jenkins, R. (2009). *Adult psychiatric morbidity in England: Results of a household survey*. Health and Social Care Information Centre.

National Records of Scotland. (2021, May 5). Scotland's Census 2011. Retrieved from https://www.scotlandscensus.gov.uk/ods-web/area.html

Nihira, K., Leland, H., & Lambert, N. (1993). *Adaptive behavior scale - residential and community (second edition): examiner's manual.* Austin, Tx: PRO-ED.

Office for National Statistics (2021, May 16). Exploring the UK's Digital Divide. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04

Proyer, R. T., Gander, F., Brauer, K., & Chick, G. (2021). Can Playfulness be Stimulated? A Randomised Placebo-Controlled Online Playfulness Intervention Study on Effects on Trait Playfulness, Well-Being, and Depression. *Applied Psychology: Health and Well-Being*, *13*(1), 129-151. https://doi.org/10.1111/aphw.12220

Rawlings, G. H., Gaskell, C., Rolling, K., & Beail, N. (2021). Exploring how to deliver videoconference-mediated psychological therapy to adults with an intellectual disability during the coronavirus pandemic. *Advances in Mental Health and Intellectual Disabilities*. https://doi.org/10.1108/AMHID-06-2020-0014

Scior, K., & Werner, S. (2016). *Intellectual disability and stigma*: stepping out from the margins Basingstoke: Palgrave Macmillan.

Scottish Government. (2021, March 13). Scottish Index of Multiple Deprivation 2020. Retrieved from https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC health services research*, *17*(1), 1-13. https://doi.org/10.1186/s12913-017-2031-8

Surley, L., & Dagnan, D. (2019). A review of the frequency and nature of adaptations to cognitive behavioural therapy for adults with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities*, *32*(2), 219-237. https://doi.org/10.1111/jar.12534

The Compassionate Mind Foundation (2021, March 16). Exercises. Retrieved from https://www.compassionatemind.co.uk/resources/exercises

Wechsler, D. (2011). *Wechsler Abbreviated Scale of Intelligence–Second Edition (WASI-II).* San Antonio, TX: NCS Pearson.

Werner, S. (2015). Public stigma and the perception of rights: Differences between intellectual and physical disabilities. *Research in developmental disabilities*, *38*, 262-271. http://dx.doi.org/10.1016/j.ridd.2014.12.030

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Appendices

Appendix 1: Author Guidelines for Journal of Applied Research in Intellectual Disabilities (JARID)

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at **https://mc.manuscriptcentral.com/jarid**

2. AIMS AND SCOPE

JARID is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

In order for a paper to be considered for publication, it must be about people with intellectual disabilities. Manuscripts which focus upon autism will be considered only when the focus is also upon intellectual disabilities. Papers which focus upon autism and exclude people with intellectual disabilities will not be considered.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision.

Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles, including Clinical Trials (see guidance within section 5), ***Review Articles*** and ***Brief Reports*** are accepted by the Journal. ***Theoretical Papers*** are also considered, provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Authors who are submitting original

articles where qualitative methods have been used must ensure that their choice of method is well justified and issues relating to methodological rigor are effectively addressed.

Articles and ***Theoretical Papers*** should not exceed 5000 words

Review Articles should not exceed 7000 words

Brief Reports should not exceed 2000 words

All word limits are inclusive of the abstract. References, Words in Tables, Captions/Legends, Figure and Figure captions/legends are excluded from the word limits.

As of December 2019, *JARID* no longer accepts Book Reviews.

4. PREPARING THE SUBMISSION

Use of Language

The language used to describe disability differs across countries, cultures and disciplinary fields, and continues to evolve. All manuscripts submitted to JARID must use language that promotes the value of all people as full members of our shared society. Pejorative language inclusive of euphemisms must not be used. For JARID this includes the use of older language that has been used to describe people with intellectual disabilities such as "retarded", "handicapped", or "mentally handicapped". Using any terms which are offensive, or patronising may lead to rejection of your submitted manuscript.

JARID recommends using person-first and/or identity-first language thoughtfully and appropriately. For example, the language used to describe both people with intellectual disabilities and autistic people has evolved based on recent advocacy efforts. When referring to people with autism, it is acceptable to use either identity-first language (e.g., "autistic people") or person-first language (e.g., people with autism"), while identity-first language is not used to describe people with intellectual disabilities, where person-first language is preferred. Thus, people with intellectual disabilities should be referred to as people with intellectual disabilities.

We have consulted with over 40 self-advocates through Learning Disability England which included the North West Self-Advocacy Group, as well as Self-Advocacy Together and asked them what language we should use when writing about people with intellectual disabilities.

People with intellectual disabilities said that they do not like to be referred to by acronyms or abbreviations. Authors must therefore not use an abbreviation to describe intellectual disabilities such as "ID" or "LD". Instead, use person-first language such as children, teenagers, adults, or people with intellectual disabilities, avoiding acronyms or abbreviations.

The terms "learning disabilities" and "learning difficulties", though used in some countries to refer to people with intellectual disabilities, can cause confusion among readers. These terms are not used by the journal to refer to people with intellectual disabilities. Authors must only use the term "learning disabilities or difficulties" where this refers to a specific learning disability/disorder– such as a specific learning difficulty in reading, written expression or mathematics. **If "learning disabilities" or "learning difficulties" are used, authors must not use an abbreviation.**

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

Title page

The title page should contain:
i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's **best practice SEO tips**);

ii. A short running title of less than 50 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Acknowledgments.

Authorship
Please refer to the journal's authorship policy the Editorial Policies and Ethical Considerations section for details on eligibility for author listing.

Acknowledgments
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement
Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File
As papers are double-blind peer reviewed the main text file should not include any information that might identify the authors.
The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);
v. Figure legends;
vi. Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

Abstract
All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study.

Keywords
Please provide up to six Keywords to aid indexing.

References
References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. For more information about APA referencing style, please refer to the **APA FAQ**. Note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one, and a DOI should be provided for all references where available.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:10.1176/appi.ajp.159.3.483

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive â€“ the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

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Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

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Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.
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their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

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For manuscripts reporting medical studies that involve human participants, a statement

identifying the ethics committee that approved the study and confirmation that the study conforms to recognized standards is required, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects**; or **European Medicines Agency Guidelines for Good Clinical Practice**. It should also state clearly in the text that all persons gave their informed consent prior to their inclusion in the study.

Patient anonymity should be preserved. Photographs need to be cropped sufficiently to prevent human subjects being recognized (or an eye bar should be used). Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form** available for use.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results.

Clinical trials should be reported using the CONSORT guidelines available at **www.consort-statement.org**. A CONSORT checklist should also be included in the submission material (**www.consort-statement.org**).

The Journal encourages authors submitting manuscripts reporting from a clinical trial to register the trials in any of the following free, public trials registries: **www.clinicaltrials.org**, **www.isrctn.org**.

Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

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Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; and
2. Been involved in drafting the manuscript or revising it critically for important intellectual content; and
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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• The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

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For queries about submissions, please contact the *JARID* Editorial Office.

Pat Clelland
patriciaclelland@gmail.com

Author Guidelines Updated December 2019

Appendix 2: Study Information Sheet

University of Glasgow | College of Medical, Veterinary & Life Sciences

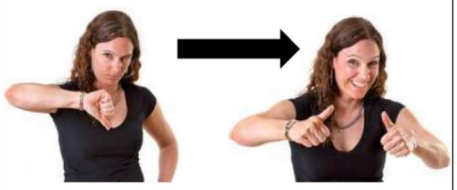
NHS Lanarkshire

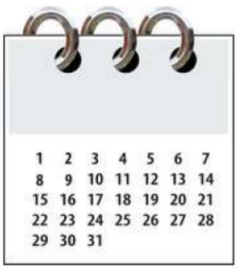
Study Information Sheet

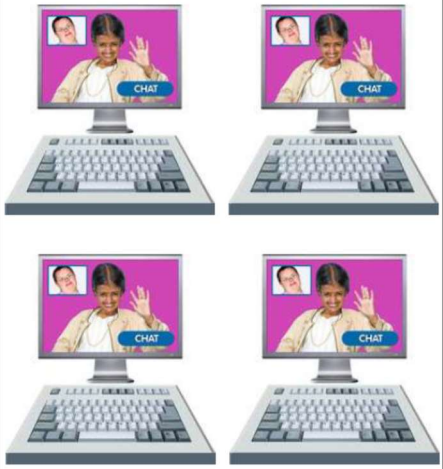
Study: A brief compassionate imagery intervention for people with an intellectual disability: A case series in a clinical setting.

Names of Researchers: Miriam Holm (Trainee Clinical Psychologist), Professor Andrew Jahoda (Clinical Psychologist), Dr Carol Pert (Clinical Psychologist), and Dr Ailsa Morison, (Clinical Psychologist).

	Please read this information sheet.
	You can ask someone to read it with you and talk about it together.
 	Take time to think about it.

	My name is Miriam Holm
	I am doing research at the University of Glasgow.
	This study is looking at a new way of coping called the Kind Helper.
	We want to find out if it can help people who have a learning disability to feel better.

	I would like to work with you on this research because: 1. You have a learning disability 2. You are having some difficulties coping
	This research will take place between June 2020 and February 2021.
	If you want to take part, this is what will happen:
	I will contact you to arrange a video call with you.

	In total, we will have 4 video calls together.
1    	At our first video call we will speak about the study. You can ask questions about it. This is to make sure that you understand what the study will involve. If you want to take part in the study you can tell me and I will fill in a form.

2  	At our second video call, we will have the first workshop. We will talk about kindness and a new way of coping with difficult feelings, called the Kind Helper. We will ask you to use this way of coping during the week.
3  	At our third video call, we will have the second workshop. We will continue learning about the Kind Helper. We will ask you to use this during the week again.

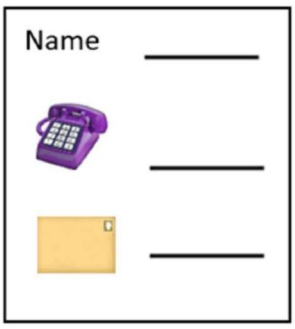
4 	At our fourth video call, I will ask you about how you found the Kind Helper work and if you thought it was helpful.
	I will record what you say. This will help me remember.
	Later, I will ask you to do two short games. These will help me to check information about your learning disability.
	Taking part in the study may bring up difficult feelings at times.
	It may also teach you a new way of coping with these difficult feelings which could be helpful in the future.

	What you say in the study will be kept private. Unless we are worried about someone's safety.
	You do not need to participate. You can say stop at any time if you do not want to continue. This will not affect the care you receive.
 Jimmy → Edward Sandra → Jessica	Once the research is finished it will be written up in a report. Other people will read this report. Your name will be changed to keep your privacy.

	You can contact me if you have questions.
	Miriam Holm Trainee Clinical Psychologist Community Learning Disability Team Psychological Services for Adults with Learning Disabilities Longdales Admin Building Kirklands Site Fallside Road G71 8BB
	PSALD@lanarkshire.scot.nhs.uk
	01698 855522

	You can also ask my supervisor questions.
	Professor Andrew Jahoda Mental Health and Wellbeing 1st floor, Administration Building Gartnavel Royal Hospital 1055 Great Western Road Glasgow G12 0XH
	Andrew.Jahoda@glasgow.ac.uk
	0141 211 0282

	Or you could speak to a psychologist from the Community Learning Disability Team who is separate from the study.
	Dr Ewan Culling Community Learning Disability Team Psychological Services for Adults with Learning Disabilities Longdales Admin Building Kirklands Site Fallside Road G71 8BB
	PSALD@lanarkshire.scot.nhs.uk
	01698 855522



If you would like to take part in this study please tell your Community Learning Disability Team staff member.

With your permission, they will give me your name, telephone number and address so that I can contact you.

Acknowledgments: Photosymbols 4

Appendix 3: Consent Form

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Lanarkshire

Consent Form

Information for participants			Researcher to confirm whether consent provided
	I have read the information sheet	Yes? ☑ No? ☒	
	I have had the chance to ask questions	Yes? ☑ No? ☒	
	I understand that I do not need to participate and I can say stop at any time if I do not want to continue This will not affect the service I receive	Yes? ☑ No? ☒	

	I give permission for the researchers to record our last meeting using a sound-recorder The recording will be deleted at the end of the study	Yes? No?	
  Jimmy → Edward Sandra → Jessica	I understand that the researchers will share with other people the things I say and do It will be written in a report and talked about in meetings My name will be changed to protect my privacy	Yes? No?	

 	I give permission for the researchers to contact my doctor and/or Community Learning Disability Team staff member	 Yes?  No?	

	I would like to participate in this study	 Yes?  No?	

To be completed by researcher:

Participant name:	
Researcher name:	
Date/time consent provided:	

1 copy for participant's medical records; 1 copy for study site file

Acknowledgments: Photosymbols 4

Appendix 4: Content of Sessions

Session 1

(Breaks offered across session)

<u>Part 1</u>

- Identification of current stressors
  - "*What kinds of things make you feel stressed at the moment?"; "What kinds of problems do you find hard to cope with?"*
    - Prompts
      - *In the last couple of weeks have you felt stressed (or sad, upset, worried, uptight, angry)?*
      - *In the next week is there anything coming up that you think could be stressful for you? (or make you feel sad, upset, worried, uptight, angry)*
  - List two or three situations in handout (page 3) to apply imagery to.
- Coping
  - *"People can have all sorts of problems in their lives, and people have different ways of dealing with them.*
  - *For example, one way people deal with problems is by blaming other people. This can make them angry and make the problem worse.*
  - *A way that other people cope is by getting help from others. Getting support can help people to feel better.*
  - *There are lots of different things that we can do to cope.*
  - *We are going to learn a new way of coping today."*
- Kindness
  - Aim of discussion to get participant to identify what it feels like when someone is kind to them.
    - *"How would you describe what kindness is?", "what comes to mind when you think of the word kindness?"*
    - *"Can you think of a time when someone was kind to you? Take a moment to imagine being in that situation again, what did it feel like? Could you feel it in your body? Where?". (*Could offer suggestions if required – e.g. *"did you feel better or worse? Did your body feel uptight or relaxed?"*)
    - Refer to handout (Types of Kindness – Page 4). Discuss each type of kindness and ask participant to circle which image(s) work best for them.
      - Can ask
        - *"What is it about this picture that makes you think of kindness?*
        - *How would you feel if that was you in the picture?*
        - *Can you think of a time when someone did this to you? What did it feel like (in your body)?"*
    - Refer to handout (How Kindness Makes Us Feel – page 7). Relate to any examples previously discussed.

            - Option – *"do you know anyone from TV or from films who is kind? What makes them kind? How would you feel if they were kind to you?"*
        - Summarise discussion (aim to do so by encouraging participant to contribute to summary)
- Practice of Soothing Rhythm Breathing
    - *"Before we start, we're going to try a short breathing exercise."*
    - Read handout (Breathing – Page 8) together.
        - *"Sit comfortably*
        - *Close your eyes*
        - *Breathe slowly and focus on your breathing*
            - *Smell the flower*
            - *Blow out the candle*
            - *Relax your body"*
    - Practice duration – 1-2 mins
- Kind Helper Exercise
    - *"We're going to learn a new way to cope when you are feeling stressed. It is called the Kind Helper.*
    - *What you do is you imagine someone who is kind. Someone who cares about you, understands you and is on your side. And you imagine that they are comforting you. The kind helper you imagine can be a person or an animal.*
    - *I will help you to do this. Shall we give it a go?"*
    - Refer to Data Recording Booklet Part A for questions to support participant to generate own Kind Helper. Document details of answers to answer Question 1 (i.e. how many participants are perceived to be able to generate a compassionate image?)
    - Support participant to write details of their Kind Helper in their handout. Could type words into chat function in Attend Anywhere for participant to copy if necessary.

<u>Part 2</u>

- "How was it?"
    - Discussion regarding participant's experience of the Kind Helper Exercise for completion of Data Recording Booklet Part B to answer Question 2 (i.e. what barriers and facilitators do participants report in relation to generating their compassionate image?)
    - *"Before the break you had a go at making up an imaginary Kind Helper in your mind.*
        - *It would be great to hear how you found it - could you tell me about it?*
        - *What was it like for you?*
        - *What did you like?*
        - *What did you not like?*
        - *Have you ever done anything like that before?"*
- Options if struggling to understand what kindness is and/or was not able to develop Kind Helper image:
    - Repeat discussion around kindness
    - Could provide own examples of kindness:
        - *I was upset at home. I saw a neighbour and he asked me if I was OK. It felt like he cared about me. After speaking to him I felt better and was smiling again.*

        - *I was stressed at college. My friend listened to me. It felt like she really understood me. It was helpful. I felt more relaxed afterwards. My muscles were more relaxed and my breathing was slower.*
    - Repeat Kind Helper Exercise
- Home Practice
    - *"The next step is to imagine X (Kind Helper's name) is next to you and comforting you to help you cope when you are feeling stressed."*
    - *"Try to imagine X to help you cope if you feel stressed or if any of the problems you wrote down happen this week."*
        - Read handout (Home Task – page 11) together
    - Check participant's understanding and support memory of home practice task by asking them to summarise – *"Could you tell me what I want you to try at home?*
    - Repetition of task:
        - *"Try to use X to help you cope with any stress and any problems that might come up this week. When you feel stressed try to 1) imagine X in your mind, imagine that X really understand you and cares about you; 2) think of the kinds words that X is saying to you to comfort you; 3) then take the time to notice what it feels like in your body.*
    - *"The next time we meet we will have a chat about how you found doing that – what you liked or didn't like about it"*
    - Option - if participant has not been able to come up with a Kind Helper, set task to come up with one (using the prompts in the blue circles in the My Kind Helper section of the handout) and discuss/complete at next session.

Session 2

(Breaks offered across session)

<u>Part 1</u>

- Review of Session 1 using handout
    - Things That Make Me Feel Stressed
    - Types of Kindness
    - How Kindness Makes Us Feel
    - Breathing – review steps and practice for 1-2 mins:
        - *"Sit comfortably*
        - *Close your eyes*
        - *Breathe slowly and focus on your breathing*
            - *Smell the flower*
            - *Blow out the candle*
            - *Relax your body"*
    - My Kind Helper
    - Home Task
- Review of the Week / Home Task
    - Discussion about the past week to establish whether the participant encountered any stressful situations and whether they used their image, as well as an exploration of how this felt for them if they did use it (i.e. whether it was helpful or not). The discussion will then move on to focus on barriers and facilitators.
        - Use of image

- *"How has your week been? Did you have any stressful situations? Last time you mentioned finding X, Y and Z stressful, did any of these come up for you in the past week?*
    - If yes – "*what happened? What did you do to cope?"*
    - If used Kind Helper – "*What did it feel like? What did you feel before vs after? Did you feel more X or less X afterwards? What did you like / not like about it? Was it helpful or not helpful?"*
    - If no – *"Did you think about doing anything else to cope? Did you think about using your Kind Helper?*
        - If no - establish why did not use (e.g. forgot to use, did not understand, did not think it would have helped, used another coping strategy)
- Barriers and facilitators
    - *"Was there anything that made it easier for you to use your Kind Helper?"*
    - *"Was there anything that made it harder for you to use your Kind Helper?"*

- Data Recording Booklet Part C completed to capture whether participants used their image since Session 1 and whether doing so was helpful for them. Part D completed to capture the barriers and facilitators to image application.

<u>Part 2</u>

- Keyring Making
    - Development of a keyring to serve as a visual memory aid.
    - Support participant to choose an image they feel represents kindness or their kind helper, via either:
        - Referring to images in handout
        - Googling an image described by participant and sharing the image via the screen sharing feature of Attend Anywhere
    - A keyring featuring their chosen image will be sent to the participant by post shortly after the session.
    - Participant encouraged to use the keyring as a memory aid for using their Kind Helper image to self-soothe and not to use merely as a "lucky charm".
- Home Practice
    - *"You can use this keyring to remind you to imagine X in your mind. The keyring by itself will not help you. It's just to remind you to use your new way of coping. When you see the keyring you can use that to remember to imagine X and the kind things X says to you. You can also use X at other times. It does not need to be only when you have the keyring."*Setting of the same Home Practice as in Session 1, but this time using the keyring as a visual memory aid.
    - Refer to Home Task page in handout
        - *Like last week, if X, Y, or Z happens or you feel stressed, try to 1) imagine your Kind Helper in your mind, imagine that X really understands you and cares about you; 2) think of the kinds words that X is saying to you to comfort you; 3) then take the time to notice what it feels like in your body.*
        - *I'm going to send you a keyring with the image you have chosen. You can use the keyring to help you remember to use your Kind Helper.*
        - *Next time we can talk about how it was for you.*

- Check participant's understanding and support memory of home practice task by asking them to summarise – *"Could you tell me what this week's home task is?"*

Review Session

(Breaks offered across session)

- Review of the Week / Home Task
  - Discussion about the past week to establish whether the participant encountered any stressful situations and whether they used their image, as well as an exploration of how this felt for them if they did use it (i.e. whether it was helpful or not). The discussion will then move on to focus on barriers and facilitators.
    - Use of image
      - *"How has your week been? Did you have any stressful situations? You mentioned finding X, Y and Z stressful, did any of these come up for you in the past week?*
        - If yes – "*what happened? What did you do to cope?"*
        - If used Kind Helper – "*What did it feel like? What did you feel before vs after? Did you feel more X or less X afterwards? What did you like / not like about it? Was it helpful or not helpful?"*
        - If no – *"Did you think about doing anything else to cope? Did you think about using your Kind Helper?*
          - If no - establish why did not use (e.g. forgot to use, did not understand, did not think it would have helped, used another coping strategy)
    - Barriers and facilitators
      - *"Was there anything that made it easier for you to use your Kind Helper?"*
      - *"Was there anything that made it harder for you to use your Kind Helper?"*
  - Data Recording Booklet Part E completed to capture whether participants used their image since Session 2 and whether doing so was helpful for them. Part F completed to capture the barriers and facilitators to image application.
- Semi-Structured Interview
  - Refer to Topic Guide
- WASI-II subtests
- De-brief

Coping with Problems

The "Kind Helper" Study

Booklet

This is the booklet for the "Kind Helper" research study. We will use it in our sessions, so you <u>don't</u> need to read it before. I'll be explaining it as we go along.

Contents Page

Things That Make Me Feel Stressed

Some of the things that make me feel stressed at the moment are:

_____

_____

_____

_____

_____

_____

_____

3

Types of Kindness

There are lots of different types of kindness.

Like **comforting** someone when they are upset...

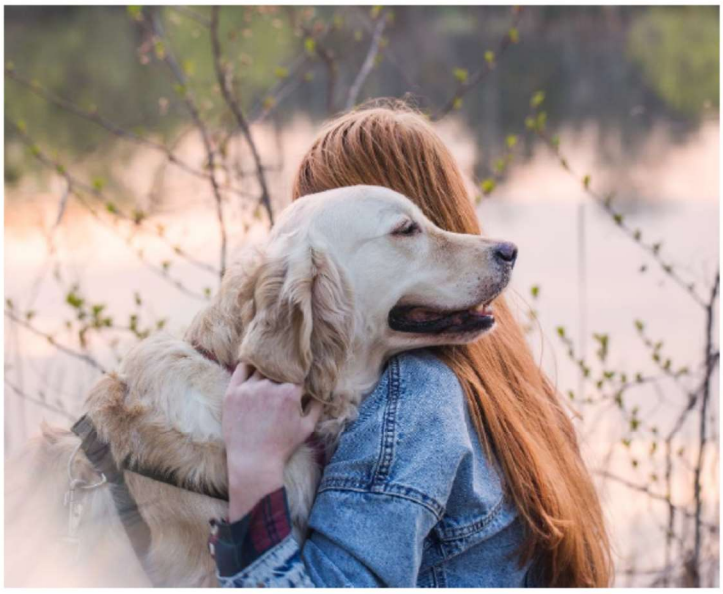
...or **listening** to someone if they need someone to talk to.

Even just **being there** for someone.

4

We can be kind **to animals**…

…and **animals** can be kind **to us**.



5

We can also be kind to **ourselves**.

Which pictures work best for you? (please circle)

6

How Kindness Makes Us Feel

Someone who is kind to us **cares** about us. They **understand** us and it feels **comforting**.

When someone is kind to us it can make us feel **calm** and **relaxed**.

This can lead to changes in our bodies. Our **breathing** may **slow** down and we may **relax** our **muscles**. We might even **smile** a little.

7

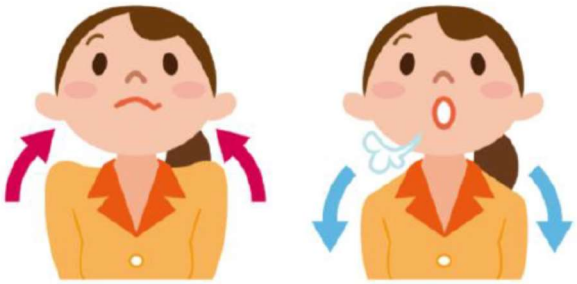
Breathing

Sit comfortably.

Close your eyes.

8

Breathe slowly and focus on your breathing.



Breathe in like you are smelling a flower. Breathe out like you are blowing out a candle. Relax your body.

1.  **Smell the flower**

2.  **Blow out the candle**

3.  **Relax your body**

9

My Kind Helper

My Kind Helper is…

Person, animal or fictional character?

What do they look like?

Their name is…

My Kind Helper's voice is….

Quiet or loud?
High or low?

They tell me…

What kind words do they say?

10

Home Task

If you feel stressed between now and our next session…

➡ **imagine** your **Kind Helper** in your mind

➡ think of the **comforting words** that your Kind Helper is saying to you

➡ notice **what it feels like** in your body

(This home task is for both sessions)

11

Acknowledgements: Photosymbols 4; Pixabay; Shutterstock.

Appendix 6: Participant Background Information Sheet

Name	
Gender	
Contact details	Address: Postcode: Telephone: • Consent to leave voice message?
GP details	Name: Practice: Address: Postcode: Telephone:
CLDT staff member details	Name: Designation: Email: Telephone:
Living arrangement	• Alone: • With family:

	• With partner: • With a housemate: • In a group home: • Other:
Scottish Index of Multiple Deprivation (SIMD)	
Diagnosis / description of mental health difficulty and/or learning disability	
Employment	• Employed: no • Unemployed:
Regular activities	
Date consent obtained	
Details of Welcome Session	Date: Time:
Details of Workshop Session 1	Date: Time:
Details of Workshop Session 2	Date: Time:
Details of Review Session	Date: Time:
Details of study findings requested?	

(to be sent by post)

Date details of study findings sent

(if applicable)

Appendix 7: Data Recording Booklet

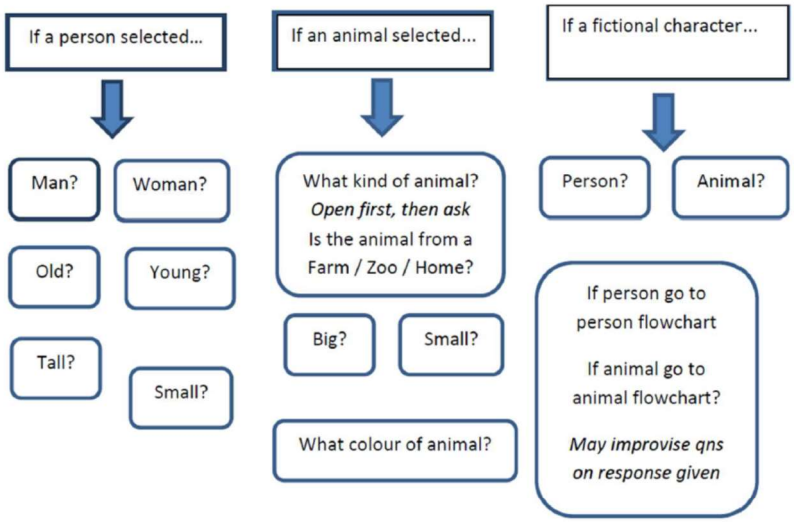
Participant number:

Data Recording Booklet

Part A

- **To be completed in Workshop Session 1 (or Workshop Session 2 if required)**
- **To answer Question 1 (i.e. how many participants are perceived to be able to generate a compassionate image?).**

1) Would your Kind Helper be a person, an animal or a cartoon/film character?



Date:

Participant number:

2) What else can you tell me about what your Kind Helper would look like?

Date:

3) What would your Kind Helper be called? (refer to Kind Helper as this name throughout rest of exercise)

Date:

4) If X was there beside you, comforting you (can refer to stressful situation identified by participant), what would their voice be like?
   - Quiet or loud?
   - High or low?
   - Anything else?

Date:

5) If X was there beside you, comforting you, (can refer to stressful situation identified by participant) what kind words would they say to you?

Date:

Participant number:

6) I'm going to say some (other) phrases and I want you to tell me if you think X would say these to you, if they were beside you, comforting you (can refer to stressful situation identified by participant).

I care about you
I'll be here for you no matter what
You can depend on me
I understand how you feel
I'm here to help you

Date:

7) What else can you tell me about X?

Date:

Participant number:

Part B

- **To be completed in Workshop Session 1 (or Workshop Session 2 if required)**
- **To answer Question 2 (i.e. what barriers and facilitators do participants report in relation to generating their compassionate image).**
- **See Content of Sessions document for wording of questions**

Barriers

Date:

Facilitators

Date:

Participant number:

Part C

- **To be completed in Workshop Session 2**
- **To (partly) answer Question 3 (i.e. how many participants report using their compassionate image to self-soothe when feeling distressed outside of sessions, and how many report finding this helpful?).**
- **See Content of Sessions document for wording of questions**

Used compassionate image to self-soothe?

Date:

Was it helpful?

Date:

Participant number:

Part D

- **To be completed in Workshop Session 2**
- **To (partly) answer Question 4 (i.e. what barriers and facilitators do participants report in relation to applying their compassionate image to self-soothe).**
- **See Content of Sessions document for wording of questions**

Barriers

Date:

Facilitators

Date:

Participant number:

Part E

- **To be completed in Review Session**
- **To (partly) answer Question 3 (i.e. how many participants report using their compassionate image to self-soothe when feeling distressed outside of sessions, and how many report finding this helpful?).**
- **See Content of Sessions document for wording of questions**

Used compassionate image to self-soothe?

Date:

Was it helpful?

Date:

Participant number:

Part F

- **To be completed in Review Session**
- **To (partly) answer Question 4 (i.e. what barriers and facilitators do participants report in relation to applying their compassionate image to self-soothe).**
- **See Content of Sessions document for wording of questions**

Barriers

Date:

Facilitators

Date:

Participant number:

Additional Notes: Welcome Session

Date:

Participant number:

Additional Notes: Workshop Session 1

Date:

Participant number:

Additional Notes: Workshop Session 2

Date:

Participant number:

Additional Notes: Review Session

Date:

	Topic Area	Sub-Areas	Example Questions	Tick once covered
1	Identification of salient components		What are the bits you remember most about our sessions? What else do you remember?	
2	Experience of generating the Kind Helper	General feelings	*[You came up with an idea for your Kind Helper…]* What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	
3	Experience of using the Kind Helper	General feelings	*[I asked you to imagine your Kind Helper when you felt stressed during the week…]* What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	
4	Experience of using booklet	General feelings	*[You got a booklet that we used in our sessions…]* What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	

5	Experience of using keyring	General feelings	*[You got a keyring with a picture that you chose…]* What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	
6	Experience of any additional components identified in Topic Area 1	General feelings	What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	
7	Usefulness of sessions		If someone else asked you if they should take part in the study, what would you say to them? Why? Since doing the study, have you noticed any differences in what you do when you're feeling stressed?	
8	Future use of Kind Helper		Next time you are faced with X, and you are feeling stressed, have you thought about what you could do to help? Is there anything from our sessions that you'll use in future? What are you going to do with the materials now? Do you think you'll keep going with the Kind Helper? What will you use it for?	
9	Experience of video-call delivery	General Feelings	*[We had our sessions on the computer…]* What was that like for you? How did that feel?	
		Likes/ Facilitators	What did you like about it? What helped?	
		Dislikes/ Barriers	What did you not like about it? What got in the way?	

Appendix 9: MRP Proposal

DClinPsy

MRP Proposal for Blind Review

Title:

A Brief Compassionate Imagery Group Intervention for People with an Intellectual Disability:

A Case Series within a Clinical Setting

Date of Submission: 30th September 2019

Version Number: 1

Actual Word Count: 3,657

Maximum Word Count: 3,000

A Brief Compassionate Imagery Group Intervention for People with an Intellectual Disability: A Case Series within a Clinical Setting

Abstract (Actual Word Count: 235; Maximum Word Count: 200)

Background

People with an intellectual disability (ID) are subject to widespread stigma, mistreatment and abuse, and experience considerable mental health difficulties. Compassion-Focused Therapy (CFT), a transdiagnostic psychological therapy aimed at reducing shame and self-criticism by developing one's capacity to self-soothe, may provide an effective intervention for individuals with an ID who are experiencing mental health difficulties.

Aims

This case series will focus on compassionate imagery, a key component of CFT. It aims to investigate whether adults with an ID who are experiencing mental health difficulties can meaningfully engage in a compassionate imagery intervention and use this technique to self-soothe when distressed. The study will also explore participants' views of these experiences.

Methods

Between 6-10 participants will be recruited from a psychological service in NHS Lanarkshire. Participants will be asked to attend a two-session group intervention through which they will be supported to develop and use a compassionate image. A mixed methods approach will be adopted. Data will be analysed descriptively through structured observations and diaries. Additionally, semi-structured interviews about their experience of attempting to use compassionate imagery will be subject to framework analysis.

Application

This study will add to the sparse but growing evidence base regarding the adaption of psychological therapies for people with an ID. It is hoped that this may pave the way for the provision of a wider range of therapeutic options to help improve the mental health of this underserved group.

Introduction

The prevalence of intellectual disabilities has been identified as being between 0.95% and 1.55% (McKenzie et al., 2016). Studies have suggested that people with an intellectual disability (ID) experience considerable mental health difficulties, with a prevalence rate of psychiatric disorders ranging from 13.9% and 74% (Buckles et al., 2013). Sadly this is, perhaps, unsurprising given the widespread stigma, mistreatment and abuse experienced by people with an ID (Scior and Werner, 2016, Gravell, 2012, Hughes et al., 2012, Jones et al., 2012). Many people with an ID feel "different", are aware of others holding negative views of people with such disabilities, and report experiencing feelings of shame, anger and powerlessness in relation to this (Logeswaran et al., 2019). Shame may play an important role in the development and maintenance of mental health difficulties in some individuals an ID (Clapton et al., 2018b). Self-criticism may also be a contributory factor (Esdale et al., 2015).

As outlined by Gilbert (2009) CFT is a transdiagnostic psychological therapy aimed at reducing feelings of shame and self-criticism. It draws from evolutionary and social psychology, attachment theory, neuroscience and Buddhism. It proposes that there are three affect regulation systems: 1) the threat system; 2) the drive system; and 3) the soothing system. It is hypothesised that in people with high levels of shame and self-criticism the threat system is

dominant, whilst the soothing system is underdeveloped. The aim of CFT is therefore to rebalance these systems by developing compassion. There is evidence that CFT can be an effective intervention for mood disorders, particularly for those high in self-criticism (Leaviss and Uttley, 2015).

Despite a dearth of studies investigating the effectiveness of psychological interventions for people with an ID there is growing evidence that these can be of benefit to this population group (Brown et al., 2011, Vereenooghe and Langdon, 2013, Evans and Randle-Phillips, 2018). Moreover, there are some early indications that CFT may be an effective intervention for adults with an ID who are experiencing mental health difficulties (Clapton et al., 2018a, Cowles et al., 2018; Patterson et al., 2019)

Compassionate imagery is a CFT technique which aims to foster one's ability to generate compassionate feelings. One example of compassionate imagery is developing a mental image of a compassionate other, such as a person or an animal, and exploring the feelings experienced when imagining this (Gilbert, 2009). Brougham (2018) explored the adaptation of Gilbert's (2015) Building a Compassionate Image exercise for individuals with an ID within a nonclinical sample. The study found that individuals with an ID were able to meaningfully engage with the task, indicating the relevance of conducting further research of this kind within a clinical sample.

Aims

This study will build on Brougham's (2018) research by exploring the adaptation of compassionate imagery for people with an ID within a clinical context, i.e. in a sample of individuals who have been referred to a psychological service due to experiencing mental health difficulties. Thus, the main aims of this study are to investigate whether adults with a mild to

moderate intellectual disability who are experiencing mental health difficulties can meaningfully engage in a compassionate imagery intervention and whether they are able to make use of this technique to self-soothe in times of need. The study also aims to explore participants' reflections of doing so, including their experiences of supports and of any barriers they may have faced. Although the compassionate imagery exercise in this study will largely resemble that used by Brougham (2018), the intervention will differ in that it will be delivered within a group setting, over two sessions, and with the use of diaries to be completed in-between sessions. It will also include the development of a visual representation of the image to serve as a memory aid.

Research Questions

The following questions will be explored:

1. Are the participants able to generate their own compassionate image?
    a. What is the nature (physical and nonphysical characteristics) of the images generated within session?
    b. Are participants able to identify one or more compassionate statements within session that they will imagine their image as saying to them?
2. Are participants able to use their compassionate image to self-soothe when feeling distressed outwith sessions?
    a. Do participants report using their compassionate image when feeling distressed?
    b. Do participants report a reduction in their distress when using their compassionate image?

3. What are participants' reflections on generating their own compassionate image in session and using it when feeling distressed outwith sessions?
    a. What are the participants' experiences of engaging with the materials (namely the Kind Helper exercise, the diaries and the visual prompt)?
    b. What barriers do participants report facing when:
        i. Generating and applying their compassionate image when distressed?
    c. What do participants find helpful when:
        i. Generating and applying their compassionate image when distressed?

Plan of Investigation

Participants

The study will aim to recruit 6-10 participants. They will be attending NHS Lanarkshire's Psychological Service for Adults with Learning Disabilities (PSALD) due to experiencing mental health difficulties. They will therefore be aged 16 or above.

This study will exclude individuals who are unable to provide informed consent, who have insufficient communication skills to engage with the tasks and who have sensory impairments which are likely to inhibit their ability to engage with the study materials. Individuals with a score that is greater than 70 on the WASI-II (McCrimmon and Smith, 2013) will also be excluded from this study, as this would indicate that they do not meet criteria for the diagnosis of an ID. In addition, the study will not include individuals who have a diagnosis of Autism Spectrum Disorder. This has been associated with difficulties in social information processing (Fletcher-Watson and Happé, 2019) which may interfere with the ability to imagine a compassionate

image. Finally, individuals who are known to have previously engaged in a piece of therapeutic work involving the development of a compassionate image will also be excluded from this study.

Recruitment

Participants will be recruited from PSALD in two ways:

1. Individuals attending the service's anxiety management group will be invited to attend information meetings with the researcher at the end of the anxiety management group sessions. This will allow those who are interested the opportunity to ask the researcher questions about the study and to receive an information pack. The PSALD staff who will be facilitating the anxiety management group will be asked to screen the individuals who have shown an interest using items from the Adaptive Behaviour Scale (ABS-RC:2) concerning their expressive and receptive communicative abilities (Nihira et al., 1993). They will also be asked to screen for the occurrence of challenging behaviours and the risk of self-harm.
2. The researcher will present the details of the study to PSALD staff at a team meeting and staff will be asked to consider the suitability of the individuals on their caseload. Should they identify an individual whom they feel are likely to benefit from a compassionate imagery intervention, staff will be asked to invite the individual to attend an information meeting with the researcher at the end of one of their appointments. This will allow those who are interested the opportunity to ask the researcher questions about the study and to receive an information pack. As above, staff will be asked to screen individuals who have shown an interest using items from the Adaptive Behaviour Scale (ABS-RC:2) (Nihira et al., 1993). They will also be asked to screen for the occurrence of challenging behaviours and the risk of self-harm.

The information packs provided at the information meetings will consist of an "easy read" Study Information Sheet which outlines the details of the study. This can be found in Appendix 1. The pack will also include a Participant Reply Form. This can be found in Appendix 2. Individuals will be asked to complete this by adding their contact details, should they be interested in taking part. They will be asked to complete the form either at home or at the end of their next PSALD appointment, and to return the completed form to PSALD staff. Once Participant Reply Forms have been received, individuals will be asked to attend a one-to-one meeting with the researcher in order for them to provide informed consent.

Measures

The following measures will be used in this study:

- Items from the Adaptive Behaviour Scale (ABS-RC:2) (Nihira et al., 1993) will be used by PSALD staff at screening to identify whether individuals have the level of communication skills required to participate in the study.
- Socio-demographic details will be collected prior to Session 1 by using the Participant Background Information Sheet, which can be found in Appendix 3. This will be completed by taking information from the Participant Reply Forms (Appendix 2) and information from participants' medical records.
- Participants will be asked to complete the Kind Helper Exercise worksheet during Sessions 1 and 2 with the help of the workshop facilitators. This is an updated version of the material used by Brougham (2018), which itself was an adapted version of Gilbert's (2015) Compassionate Image Exercise. The latter and the worksheet to be used in this study can be found in Appendices 4 and 5, respectively.
- Structured observations will be conducted in Sessions 1 and 2. The draft coding scheme for these can be found in Appendix 6.

- Participants, with the help of caregivers if necessary, will be asked to complete a diary between Sessions 1 and 2, and between Sessions 2 and 3. This can be found in Appendix 7.
- Semi-structured interviews will be conducted in Session 3. The draft topic guide for this interview can be found in Appendix 8.
- The Wechsler Abbreviated Scale of Intelligence Second Edition (WASI-II) (McCrimmon and Smith, 2013) will be administered to ensure that all participants meet the criteria of having an intelligence quotient score of <70. Participants may sense that the test is associated with correct/incorrect answers, and as there are no right/wrong responses in the main body of the study it is important that the nature of the WASI-II does not influence participants' views of what is being asked of them in the study. The test will be therefore be administered at the end of Session 3 to minimise this risk.

Procedures

As outlined above, participants will be screened by PSALD staff and will attend one information meeting and one consent meeting. The study will then require participants to attend two group sessions (Sessions 1 and 2) and one one-to-one session (Sessions 3). All three sessions will take place one week apart.

The compassionate imagery intervention will consist of two group workshops (Sessions 1 and 2), each lasting up to 2 ½ hours, including a break. There will be a maximum of 5 individuals per group. The workshops will be facilitated by the main researcher who is a trainee clinical psychologist and one qualified clinical psychologist who works in PSALD. The content of Sessions 1 and 2 can be found in Appendix 9.

Session 3 will be one-to-one sessions conducted by the main researcher and will consist of a semi-structured interview which will be audio recorded. A draft topic guide for the interview can be found in Appendix 8. As the interviews will be conducted by one of the intervention facilitators this is likely to lead to demand characteristics which will be a limitation of this study. Nevertheless, given the exploratory nature of this study it was felt important to obtain observations of participants when engaging with them during the workshops. Following the interview, the audio recording will be stopped and the WASI-II (McCrimmon and Smith, 2013) will be administered. Participants will also be offered a debrief at the end of Session 3.

Design

The study will be a mixed methods exploratory case series, consisting of both descriptive and qualitative components.

Data Analysis

Given the exploratory nature of this study, it is important that the sample size is small enough to allow for a detailed account of participants' experiences, whilst also being large enough for meaningful descriptive information to be obtained. A sample size of between 6-10 participants will therefore be recruited.

The research questions will be answered as follows:

- Question 1 will be answered through structured observations of Sessions 1 and 2 and will include data from the Kind Helper Exercise worksheet, which will be completed with participants in Sessions 1 and 2.
- Question 2 will be partly answered through structured observations of Session 2 and this will include data from the diaries that participants will be asked to complete

between Sessions 1 and 2, if necessary with the support of a caregiver. Question 2 will also be answered through the information collected at the semi-structured interview in research Session 3. This data will be analysed through framework analysis.

- Question 3 will be answered using the data collected in the Session 3 semi-structured interview which will be subject to framework analysis. This approach provides a systematic structure to identify and analyse themes (Hackett and Strickland, 2018).

Health and Safety Issues

The safety of both the participants and the researchers will be taken into consideration. Researchers will ensure both they and the participants understand the fire/safety procedures. Participants will be screened by PSALD staff to minimise risk, including the occurrence of challenging behaviours and the risk of self-harm. Data collection will take place during working hours so as to ensure the availability of staff who know the participants. Should a participant appear distressed, their participation will be discontinued. Consent will be sought at the beginning of the study to contact the participants' psychologist, GP and caregiver, should any difficulties arise. Participants will be offered a debrief at the end of Session 3 where they will be offered the possibility of receiving feedback regarding the findings of the study once it has been completed. If requested, this will be provided in an “easy read” format.

Ethical Issues

Ethical approval will be sought from an NHS Research Ethics Committee. The study will conform to the European Union General Data Protection Regulation (GDPR), the Declaration of Helsinki and the British Psychological Society's Code of Human Research Ethics.

It is vital that participants are able to provide truly informed consent. “Easy read” information sheets will therefore be provided. The readability of these sheets will be checked to ensure they can be easily understood by individuals with an intellectual disability. The Study Information Sheets (Appendix 1) will outline the potential risks and benefits that may be associated with participating in the study and will emphasise that participants are free to withdraw at any point should they wish to do so.

Photocopies of the Kind Helper Exercise worksheets and the diaries will be made. These, and the notes from the structured observations, will be anonymised and allocated identification numbers and stored securely within PSALD. Recordings of the semi-structured interviews will be stored on encrypted equipment borrowed from the University of Glasgow. These, along with the consent forms, will be the only material containing patient identifiable information and will be stored securely within PSALD.

Financial Issues

The University of Glasgow Equipment and Expenses form provides a draft summary of the equipment required for the study and the associated costs. Venues will be sought within NHS Lanarkshire and will be available free of charge. Researcher travel time to and from venues will either be reimbursed by NHS Lanarkshire or by the University of Glasgow. This is yet to be established.

Timetable

The following dates are approximations and have not yet been discussed in supervision:

- Submission to ethics committee – January 2020
- Data collection – March to September 2020
- Analysis and write up – September to November 2020
- Draft to supervisors – December 2020
- Thesis submission – February 2021

Practical Applications

In comparison with the general population, there is a paucity of research regarding psychological interventions for people with an intellectual disability. Thus, conducting research on adapting psychological therapies for this group is a step towards providing more equitable health care (NICE, 2016; Brown et al, 2011). This project will contribute to the development of an evidence-base regarding whether people with an intellectual disability who are experiencing mental health difficulties can improve their mental health through the application of CFT strategies. Should such an evidence-base point to CFT being helpful for people with intellectual disabilities, it may allow for the provision of a wider range of therapeutic options to help improve the mental health and wellbeing of this underserved group.

References

BROWN, M., DUFF, H., KARATZIAS, T. & HORSBURGH, D. 2011. A review of the literature relating to psychological interventions and people with intellectual disabilities: Issues for research, policy, education and clinical practice. *Journal of Intellectual Disabilities,* 15**,** 31-45.

BROUGHAM, L. 2018. Exploring the ability of individuals with an intellectual disability to generate and use a compassioante image. (Unpublished Doctoral Thesis). University of Glasgow, Glasgow, UK.

BUCKLES, J., LUCKASSON, R. & KEEFE, E. 2013. A Systematic Review of the Prevalence of Psychiatric Disorders in Adults With Intellectual Disability, 2003–2010. *Journal of Mental Health Research in Intellectual Disabilities,* 6**,** 181-207.

CLAPTON, N. E., WILLIAMS, J., GRIFFITH, G. M. & JONES, R. S. P. 2018a. 'Finding the person you really are … on the inside': Compassion focused therapy for adults with intellectual disabilities. *Journal of Intellectual Disabilities,* 22**,** 135-153.

CLAPTON, N. E., WILLIAMS, J. & JONES, R. S. P. 2018b. The role of shame in the development and maintenance of psychological distress in adults with intellectual disabilities: A narrative review and synthesis. *Journal of Applied Research in Intellectual Disabilities,* 31**,** 343-359.

COWLES, M., RANDLE-PHILLIPS, C. & MEDLEY, A. 2018. Compassion-focused therapy for trauma in people with intellectual disabilities: A conceptual review. *Journal of Intellectual Disabilities***,** 1744629518773843.

CUTHILL, F. M., ESPIE, C. A. & COOPER, S.-A. 2003. Development and psychometric properties of the Glasgow Depression Scale for people with a Learning Disability: Individual and carer supplement versions. *British Journal of Psychiatry,* 182**,** 347-353.

ESDALE, L., JAHODA, A. & PERT, C. 2015. Coping With Criticism and Praise. *American Journal on Intellectual and Developmental Disabilities,* 120**,** 258-268.

EVANS, L. & RANDLE-PHILLIPS, C. 2018. People with intellectual disabilities' experiences of psychological therapy: A systematic review and meta-ethnography. *Journal of Intellectual Disabilities***,** 1744629518784359.

FLETCHER-WATSON, S & HAPPE, F. 2019. *Autism: a new introdcution to psychological theory and current debate*. Routledge, London UK.

GILBERT, P. 2009. Introducing compassion-focused therapy. *Advances in Psychiatric Treatment,* 15**,** 199-208.

GILBERT, P. 2015. *Building a compassionate image*. Retrieved on September 28th 2019, from: https://compassionatemind.co.uk/uploads/files/building-a-compassionate-image.pdf

GRAVELL, C. 2012. Loneliness and cruelty: people with learning disabilities and their experience of harassment, abuse and related crime in the community. London: Lemos and Crane.

HACKETT, A. & STRICKLAND, K. 2018. using the framework approach to analyse qualitative data: a worked example. *Nurse Researcher, 26.*

HUGHES, K., BELLIS, M. A., JONES, L., WOOD, S., BATES, G., ECKLEY, L., MCCOY, E., MIKTON, C., SHAKESPEARE, T. & OFFICER, A. 2012. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet,* 379**,** 1621-1629.

JONES, L., BELLIS, M. A., WOOD, S., HUGHES, K., MCCOY, E., ECKLEY, L., BATES, G., MIKTON, C., SHAKESPEARE, T. & OFFICER, A. 2012. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet,* 380**,** 899-907.

LEAVISS, J. & UTTLEY, L. 2015. Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychological Medicine,* 45**,** 927-945.

LOGESWARAN, S., HOLLETT, M., ZALA, S., RICHARDSON, L. & SCIOR, K. 2019. How do people with intellectual disabilities construct their social identity? A review. *Journal of Applied Research in Intellectual Disabilities*.

MCCRIMMON, A. W. & SMITH, A. D. 2013. Review of the Wechsler Abbreviated Scale of Intelligence, Second Edition (WASI-II). *Journal of Psychoeducational Assessment,* 31**,** 337-341.

MCKENZIE, K., MILTON, M., SMITH, G. & OUELLETTE-KUNTZ, H. 2016. Systematic Review of the Prevalence and Incidence of Intellectual Disabilities: Current Trends and Issues. *Current Developmental Disorders Reports,* 3**,** 104-115.

MINDHAM, J. & ESPIE, C. A. 2003. Glasgow Anxiety Scale for people with an Intellectual Disability (GAS-ID): development and psychometric properties of a new measure for

use with people with mild intellectual disability. *Journal of Intellectual Disability Research,* 47**,** 22-30.

NIHIRA, K., LELAND, H. & LAMBERT, N. 1993. *Adaptive behavior scale-residential and community*, Pro-ed Austin, TX.

PATTERSON, C. W., WILLIAMS, J., & JONES, R. 2019. Third-wave therapies and adults with intellectual disabilities: A systematic review. *Journal of Applied Research in Intellectual Disabilities,* 1-15.

SCIOR, K. & WERNER, S. 2016. *Intellectual Disability and Stigma*, Springer.

VEREENOOGHE, L. & LANGDON, P. 2013. *Psychological therapies for people with intellectual disabilities: A systematic review and meta-analysis*.

Appendix 1

Study Information Sheet (draft - images to be added)

Study: The exploration of a brief compassionate imagery group intervention for people with an intellectual disability: A case series within a clinical context.

Names of Researchers:

Image of someone reading

Please read this information sheet.

Image of two people talking

You can ask someone to read it with you and talk about it together.

Image of clock

Take time to think about it.

Photo of researcher

My name is …….

Photo of university

I am doing research at the University of Glasgow.

Image of sad and happy face

This study is looking at a new way of coping called the Kind Helper.

We want to find out if it can help people who have a learning disability to feel better.

I would like to work with you on this research because

- You have a learning disability
- You are getting help from the psychology team for your mental health

Image of calendar

This research will take place between December 2019 and February 2021.

If you want to take part, this is what will happen.

We will meet 4 times in total.

1

The first time we meet it will just be the two of us.

And:

- image of someone asking a question to another person
- image of signature

- You can ask me questions about the research.
- If you want to take part in the research you can sign a form.

- This is to make sure that you understand what the research will involve.

2

The second time we meet will be in a small group with other people.

And:

- image of small group of people

- We will talk about kindness and a new way of coping, called the Kind Helper.
- I will ask you to use this way of coping during the week.

3

The third time we meet will also be in a small group with other people.

And:

- image of small group of people

- We will continue learning about the Kind Helper.
- I will ask you to use this again during the week.

4

The fourth time we meet it will just be the two of us.

And:

- image of two people talking
- image of Dictaphone
- image of puzzles

- I will ask you about how you found the Kind Helper work and if you thought it was helpful.
- I will record what you say. This will help me remember.
- Later, I will ask you to do some puzzles. This will help me to check

information about your learning disability.

Image of person with finger to mouth going "shhh"

What you say in the study will be kept private.

Unless I am worried about your safety.

Image of someone holding hand up to say "stop"

You can say stop at any time if you do not want to continue.

Image of book that says "report"

Once the research is finished it will be written up in a report.

Other people will read this report.

Your name will be changed to keep your privacy.

? and image of researcher

You can contact me if you have questions.

Image of envelope

…….

Trainee Clinical Psychologist

Mental Health and Wellbeing

1st floor, Administration Building

Gartnavel Royal Hospital

1055 Great Western Road

Glasgow

G12 0XH

Image of computer

……..

Image of telephone

……..

? and image of supervisor

You can also ask my supervisor questions

Image of envelope

……

……

Mental Health and Wellbeing

Gartnavel Royal Hospital

1055 Great Western Road

Glasgow

G12 0XH

Image of computer

……..

Image of telephone

……..

Image of reply sheet and pen

If you would like to take part in this research fill in the reply sheet and give this to your psychologist or therapist.

Appendix 2

Participant Reply Form (draft - images to be added)

Title of Study: The exploration of a brief compassionate imagery group intervention for people with an intellectual disability: A case series within a clinical setting

Researcher: ……..

I am interested in finding out more about this study and give permission for my details to be passed to the researcher who will then contact me (*tick box if agree*). ☐

My address:

_____

_____

My telephone number:

_____

My preferred method of contact is (*tick appropriate box*):

Post ☐ Telephone ☐

I give permission for a message to be left on my voicemail/answering machine (*tick appropriate box*):

Yes ☐ No ☐

Participant Name:_____

Participant Signature:_____

Date:_____

Appendix 3

Participant Background Information Sheet

Name	
Gender	• Male • Female
Date of birth	
Contact details	Address: Postcode: Tel:
Consent to contact by telephone	• Yes • No
Consent to leave voicemail/answerphone message	• Yes • No
Consent to contact by post	• Yes • No
GP details	Name: Practice: Address:

Carer details	Postcode: Tel: Address:
Living Arrangement	Postcode: Tel:: • Alone • With family • With partner • With a housemate • In a group home • Other
Scottish Index of Multiple Deprivation (SIMD)	
Involvement with PSALD	• Attended anxiety management group and to be discharged at end of study

	• Attended anxiety management group and to receive one-one therapy at end of study • Attended one-to-one therapy and to be discharged at end of study • Attended one-to-one therapy and to resume this at end of study • Other
Named PSALD clinician	
Diagnosis / Description of Mental Health Difficulty	
Diagnosis / Description of Learning Disability	
Employment	• Employed • Unemployed
Regular Activities	
Requests details of study findings (to be sent by post)	• Yes • No
Date consent given	
Details of Session 1	Date: Time:

Details of Session 2	Location Date: Time:
Details of Session 3	Location Date: Time:
Date details of study findings sent, if applicable	Location

Appendix 4

Gilbert's (2015) Building A Compassionate Image Exercise

Building A Compassionate Image

This exercise is to help you build up a compassionate image for you to work with and develop (you can have more than one if your wish, and they can change over time). Whatever image comes to mind, or you choose to work with note that it is your creation and therefore your own personal ideal what you would really like from feeling cared for and cared about.

However, in this practice it is important that you try to give your image certain qualities.

These will include:

Wisdom, Strength, Warmth and Non-Judgement

So in each box below think of these qualities (wisdom, strength, warmth and non judgement) and imagine what they would look, sound or feel like.

If possible we begin by focusing on our breathing, finding our calming rhythm and making a half smile.

Then we can let images emerge in the mind - as best you can – do not too try to hard if nothing comes to the mind, or the minds wanders, just gently bring it back to the breathing and practice compassionately accepting.

Here are some questions that might help you build an image: would you want your caring/nurturing image to feel/look/seem old or young; male or female (or non-human looking e.g., an animal, sea or light). Would your 'image' have gone through similar experiences to you?

Would they be like a friend or even part of a team that welcomes you to belong? What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement. Remember your image brings full compassion to you and for you.

- How would you like your ideal caring-compassionate image to look – visual qualities?
- How would you like your ideal caring-compassionate image to sound (e.g., voice tone)?
- What other sensory qualities can you give to it?
- How would you like your ideal caring-compassionate image to relate to you?
- How would like to relate to your ideal caring compassionate image?

Appendix 5

Kind Helper Worksheet

Not yet completed. Will be adapted from Brougham's (2018) flow chart.

Appendix 6

Structured Observation Coding Scheme (draft)

To answer Question 1:

- Did the participant identify an image in Session 1?
    - If not, did the participant do so at a later stage (e.g. at home following Session 1, or at Session 2).
- Did the participant identify characteristics of the image that appear congruent with compassion in Session 1?
    - If not, did the participant do so at a later stage (e.g. at home following Session 1, or at Session 2).
- Did the participant identify one or more compassionate statements for the image to say to them at Session 1?
    - If not, did the participant do so at a later stage (e.g. at home following Session 1, or at Session 2).

To (partly) answer Question 2:

- Did the participant complete the Session 1 Diary?
    - If so, and if the participant reported having had at least one day in which they felt bad, did their diary indicate that they used the compassionate image to self-soothe?
        - If so, how helpful did they report this as being (not at all, a little bit, or a lot)
    - If not, did they verbally report using their compassionate image to self-soothe?
        - If so, how helpful did they report this as being (not at all, a little bit, or a lot)
- (Question 2 will also be answered by the data collected at Session 3 from the Session 2 Diary and from the semi-structured interview)

Appendix 7

Home Task Diary

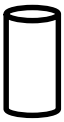
Week 1

Today is Monday

Mood

- Today I felt bad at least once  ☐
- Today I felt good all day  ☐

Kind Helper

- Today I used my Kind Helper image to self-soothe. This helped me:
  - Not at all  ☐
  - A little bit   ☐
  - A lot   ☐
- Today I did not use my Kind Helper image. ☐
  - This was

    because……

……

……..

Appendix 8

Interview Topic Guide (draft)

Introduction

- I am really interested in finding out how the study has been for your so far, especially how you have found the sessions and the Home Tasks. I'm going to ask you some questions about this and I'd like you to be as honest as possible! This is important because I want to understand what it's like for people doing this work. I don't mind if you tell me it was good or bad, what's important is that you are honest about your experience, because you are the expert here and I want to learn from you!
- I'm going to record this conversation so that I can remember all the interesting things that you say.

Main Body

- Can you tell me what the group sessions that we recently did were about and what you learnt?
- In Session 1 we focused on coming up with our own Kind Helper – How did you find this task, did you feel able to create your own Kind Helper image, or was this difficult for you? Can you tell me more about how you found it?
- In Session 1 we set a Home Task that was to try to use your Kind Helper image and to complete a diary every day. You were asked to write down whether or not you used your Kind Helper image. How did you find this Home Task? Did you use your Kind Helper image in the week after Session 1?
    - If yes - Can you tell me more about this? Was it helpful/unhelpful? Did you notice a change in your emotions when you used it? Did you notice a change in your physical sensations when you used it?
    - If not – Can you tell me more about this? What stopped you from using it?
- In Session 2 we focused on taking the Kind Helper image from our mind and putting it down on paper. We made a keyring with the image to help us remember to use our Kind Helper when we feel bad. How did you find this task, did you feel able to take the image in your mind and put it onto paper, or was this difficult for you? Can you tell me more about how you found it?
- In Session 2 we set the same Home Task to the week before, but this time you had your keyring. How did you find the Home Task after Session 2? Did you use your Kind Helper image in the week after Session 2?
    - If yes - Can you tell me more about this? Was it helpful/unhelpful? Did you notice a change in your emotions when you used it? Did you notice a change in your physical sensations when you used it?
    - If not – Can you tell me more about this? What stopped you from using it?

- I'd like to find out a bit more about the things that helped and the things that made it difficult for you to come up with your Kind Helper image and for you to use your Kind Helper image.

- Did anything make it difficult for you to come up with your Kind Helper image? Can you tell me more about this? [*consider: difficulty in understanding the concept of compassion/kindness, difficulty in choosing an image, difficulty in having a clear mental image, fear of compassion/kindness, contamination of compassionate/kind image]*
- Did anything make it easier for you to come up with your Kind Helper image? Can you tell me more about this?
- Did anything make it difficult for you to use your Kind Helper image outside of the sessions? Can you tell me more about this? [*consider: forgetting to use the image, difficulty in understanding the concept of compassion/kindness, difficulty in having a clear mental image, fear of compassion/kindness, contamination of compassionate/kind image]*.
- Did anything make it easier for you to use your Kind Helper image outside of the sessions? Can you tell me more about this?

- I'd like to find out how you found different parts of the study.
  - How did you feel about having the sessions in a group? Do you think it was helpful/unhelpful? Can you tell me more about this?
  - How did you feel about using the diaries? Do you think it was helpful/unhelpful? Can you tell me more about this?
  - At the beginning of Session 2 we reviewed what we learnt at Session 1. Do you think it was helpful/unhelpful? Can you tell me more about this?
  - In the second half of Session 2 we made keyrings of our Kind Helper image to help us to remember to use our Kind Helper when we feel bad. Do you think it was helpful/unhelpful to have a keyring? Can you tell me more about this?

- There are a few more things I would like to ask you about.
  - Did anybody support you to use your Kind Helper image outside of the sessions, like a parent, support worker or friend? What did they do? Was it helpful/unhelpful? Can you tell me more about this? Did you feel comfortable telling X about your Kind Helper image?
  - Can you think of anything that might have made it easier for you to come up with your Kind Helper image or use it outside of the sessions? Can you tell me more about this?
  - Do you think you will use your Kind Helper image in the future? Can you tell me more about this?
  - Is there anything else you would like to say about taking part in this study?

<u>Ending</u>

- Thank you very much for answering all my questions! It has been really helpful for me to learn about how you have found doing the study so far.

Appendix 9

Content of Compassionate Imagery Intervention (draft)

A two-session group intervention with a maximum of five participants per group, facilitated by one trainee clinical psychologist (main researcher) and one qualified clinical psychologist (PSALD staff member). Sessions will last no longer than 2 ½ hours, including a break.

Session 1

- Introduction to self-compassion and compassionate imagery
    - What is self-compassion?
    - Practice of Soothing Rhythm Breathing (Gilbert, 2015)
    - Imagery as a new way of coping (provide examples of common coping styles, e.g. seeking help from others, worry, avoidance. Describe imagery as an alternative way of coping)
- Break (tea/coffee etc available)
- Kind Helper Exercise Part 1
    - Development of Kind Helper image through the use of the Kind Helper Worksheet (Appendix 5).
- Setting of home task using Home Task Diary (Appendix 7).

Session 2

- Practice of Soothing Rhythm Breathing (Gilbert, 2015)
- Review of Session 1 and of Home Task.
- Break (tea/coffee etc available)
- Kind Helper Exercise Part 2
    - Opportunity to develop a visual representation of Kind Helper through drawing and/or printing images from the internet and making a wallet card or keyring.
    - Participants encouraged to use this as a memory aid for compassionate imagery and not as a "lucky charm".
- Setting of home task using Home Task Diary (Appendix 7).

Appendix 9 Reference

GILBERT, P. 2015. *Soothing Rhythm Breathing Practice.* Retrieved on September 30th 2019, from: https://soundcloud.com/compassionatemind/soothing-rhythm-breathing-practices/s-JA0g8?in=compassionatemind/sets/compassionate-minds

Appendix 10: Ethics Approval

South East Scotland
Research Ethics Committee 01

Research Ethics Service

2nd Floor, Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 465 5473

Enquiries to: Agnieszka Di Domenico Prada
Direct Line: 0131 465 5678
Email Agnieszka.Prada@nhslothian.scot.nhs.uk

16 June 2020

Ms Miriam Holm
Mental Health and Wellbeing
Administration Building, Gartnavel Royal Hospital
1055 Great Western Road
G12 0XH

Dear Ms Holm,

Study title:	**A Brief Compassionate Imagery Intervention for People with an Intellectual Disability: A Case Series in a Clinical Setting**
REC reference:	**20/SS/0041**
Amendment number:	**AM01**
Amendment date:	**05.06.2020**
IRAS project ID:	**277354**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee had no ethical concerns regarding the amendment.

In discussion the Committee agreed to seek clarification regarding several issues in the amendment. These issues were adequately addressed in your response email.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [Amendment Tool]	1	05 June 2020
GP/consultant information sheets or letters [GP Letter]	2	24 May 2020
Interview schedules or topic guides for participants [Draft Topic Guide]	2	24 May 2020
Other [Screening Guide]	2	08 May 2020
Other [Participant Reply Form]	2	24 May 2020
Other [Participant Background Information Sheet]	2	24 May 2020

Other [Draft Outline of the Compassionate Imagery Workshop]	2	24 May 2020
Other [Consent Form Version 2 24.05.2020 - Tracked Changes]	2	24 May 2020
Other [Draft Outline of the Compassionate Imagery Workshop Version 2 24.05.2020 - Tracked Changes]	2	24 May 2020
Other [Draft Topic Guide Version 2 24.05.2020 - Tracked Changes]	2	24 May 2020
Other [GP Letter Version 2 24.05.2020 - Tracked Changed]	2	24 May 2020
Other [Participant Background Information Sheet Version 2 24.05.2020 - Tracked Changes]	2	24 May 2020
Other [Participant Reply Form Version 2 24.05.2020 - Tracked Changes]	2	24 May 2020
Other [Plain Language Summary Version 2 08.05.2020 - Tracked Changes]	2	08 May 2020
Other [Proposal Version 2 29.05.2020 - Tracked Changes]	2	29 May 2020
Other [Screening Guide Version 2 08.05.2020 - Tracked Changes]	2	08 May 2020
Other [Study Information Sheet Version 2 29.05.2020 - Tracked Changes]	2	29 May 2020
Participant consent form [Consent Form]	2	24 May 2020
Participant information sheet (PIS) [Study Information Sheet]	2	29 May 2020
Research protocol or project proposal [Proposal]	2	29 May 2020
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Plain Language Summary]	2	08 May 2020

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

20/SS/0041:	**Please quote this number on all correspondence**

Yours sincerely,

Dr Lucy Kershaw
Chair

E-mail: sandra.wyllie@nhslothian.scot.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Appendix 11: R&D Approval

Professor Andrew Jahoda
Professor of Learning Disabilities
Institute of Health and Wellbeing
Administration Building,
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

R&D Department
Corporate Services Building
Monklands Hospital
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date 17 June 2020
Enquiries to Elizabeth McGonigal,
R&D Facilitator
Direct Line 01236 712445
Email elizabeth.mcgonigal@lanarkshire.scot.nhs.uk

Dear Professor Jahoda

Project title: A Brief Compassionate Imagery Intervention for People with an Intellectual Disability: A Case Series in a Clinical Setting

R&D ID: L19092

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire.

NAME	TITLE	ROLE
Miriam Holm	Trainee Clinical Psychologist	Principal Investigator

As you are aware, NHS Lanarkshire has agreed to be the Sponsor for your study. On its behalf, the R&D Department has a number of responsibilities; these include ensuring that you understand your own role as Chief Investigator of this study. To help with this we have outlined the responsibilities of the Chief Investigator in the attached document for you information.

All research projects within NHS Lanarkshire will be subject to annual audit via a questionnaire that we will ask you to complete. In addition, we are required to carry out formal monitoring of a proportion of projects, in particular those projects that are Sponsored by NHS Lanarkshire. In either case, you will find it helpful to maintain a well organised Site File.

For the study to be carried out you are subject to the following conditions:

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK and EU Data Protection legislation.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.show.scot.nhs.uk/cso/ or the Research & Development Intranet site: http://firstport/sites/randd/default.aspx.
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.
- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

Raymond Hamill – Senior R&D Manager

c.c.

NAME	TITLE	CONTACT ADDRESS	ROLE
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Enc 1 x Responsibilities as Sponsor Notes

Responsibilities as Sponsor

Site File

As an aid to the conduct of your study we have provided a Site File that you may wish to use. As Sponsor of the study we are required to carry out audit of all project, and to conduct detailed monitoring visits for a proportion (approximately 10%) - The study Site File should help you ensure that you have the relevant documentation to assist in this process. If your project is selected for monitoring, we will contact you well in advance to arrange a suitable time.

Our responsibilities as Sponsor are defined within the Research Governance Framework for Health and Community Care. A summary of these, along with those of the Chief Investigator, is provided in the following table for your information.

RESPONSIBILITIES OF CHIEF INVESTIGATOR	NHSL RESPONSIBILITIES AS SPONSOR
Obtain relevant / appropriate Research Ethics opinion. Obtain NHSL Research Management Approval. Ensure that the members of the research team have the necessary expertise, experience and education to perform their roles. Ensure the necessary resources are available for the study. Act in accordance with regulations set out by your professional body(s) and the conditions of your employment contract. Identify archiving arrangements at the study outset. Record and review significant developments that may affect the study, particularly those which put the safety of the individuals at risk or affect the scientific direction and report to the sponsor as appropriate. Record, report and review all untoward medical occurrence (adverse events or reactions) including classification of causality, seriousness and expectedness. Notify R&D and appropriate REC of significant news, changes, amendments and modifications to the study. Maintain a record of all incidents, providing an annual report to the sponsor. Inform REC and R&D of the study end. Maintain a log of archived documents and their location. Inform R&D of any publications arising from the study or dissemination of findings. Inform R&D of any potential Intellectual Property.	Assess adequateness of the independent, expert review. Ensure that the Chief/Principle Investigator has the necessary expertise, experience and education to conduct the study. Provide a formal written agreement of sponsorship conditions, and notification of confirmation of the sponsorship role. Provide NHS indemnity to the Chief Investigator and research team. Provide mechanisms and processes to exploit any potential Intellectual Property. Project monitoring commensurate with risk. Make available local, national and international guidelines, regulations and legislation governing research in the UK. Provide ongoing advice and guidance to promote quality study management and conduct. Determine the acceptability of the archive arrangements proposed by the Chief Investigator and, if the archive facility becomes unsuitable, provide alternative arrangements. Determine length of archive/retention period for essential study documents and subsequent destruction date