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Holistic therapy with disabled adults from a social and individual perspective: A service evaluation feasibility study

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Abstract

Aim: Disabled adults require better access to tailored psychological therapy. A purpose-developed intervention model was implemented at a nonprofit organisation in the UK. The aim was to consider the utility of this approach, designed to accommodate and thereby reduce psychological distress, and to inform future service evaluations, to effectively meet the needs of this client group.

Method: A one group pre and post-test design was employed on the retrospective routine collected data, for clients in receipt of 1-2-1 therapy. Fifty-three of the 91 clients (58%) completed the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) at pre and post-therapy. Common presenting issues for therapy included symptoms of depression, anxiety, coping strategies and spousal relationship issues. Data were subjected to descriptive analyses.

Results: At pretherapy, 91% (n = 83) were categorised as within the clinical range; 52% were either classified at a moderate (n = 23) or moderate-to-severe level (n = 24). A paired-sample t-test indicated a statistically significant difference in mean scores between pre- and post-CORE-OM assessments. Thirty clients (57%) met the criteria for reliable change in a favourable direction (improved), with 19 (36%) meeting the criteria for clinically significant change (recovered). Twenty-two clients (41%) remained unchanged in terms of clinical severity category and one client (2%) deteriorated.

Conclusions: A purpose-developed intervention model comprising a holistic, flexible therapy approach to some extent reduces psychological distress.

Keywords: therapy, counselling, disability, social model, impairment, CORE-OM

Introduction

Disabled people's mental health and emotional well-being are a neglected area of study; tailored service provision is sparse. For disabled people, access to therapy may not just be about physical accessibility. A proportion of disabled clients would like to see a therapist with an impairment or with experience of working with disability (Boyle et al., 2003; Newton, 2006).

Being disabled shares similarities with sexual minority; there are historical and present issues of stigma, prejudice and discrimination and, unlike racial minority for example, the disabled individual is usually the only one within their social circle (Olkin, 1999). Pink Therapy (Davies & Neal, 2000) is an established organisation working with sexual and gender diversity, but therapy for disabled people by comparison is in its infancy with few models or frameworks.

Most people use 'impairment' and 'disability' interchangeably and a clear distinction is difficult (Watermeyer, 2013). Many disabled people do not identify as such (Watson, 2002), and anecdotally dislike being addressed as 'disabled' or 'impaired'; this is supported by scholars who discuss the negative connotations of these terms (Shakespeare, 1994; Watermeyer, 2013). However, the absence of suitable alternatives means that 'impairment' in this study is referred to as a 'medically classified bio-physiological condition' (Barnes & Mercer, 2010, p. 11) and 'disability/disabled' is referred to as 'the disadvantage or restriction caused by a contemporary social organisation which takes no or little account of people who have ... impairments and thus excludes them from the mainstream of social activities' (Oliver & Barnes, 1998, p. 18).

Disability and impairment can evoke complex thoughts, feelings and behaviours, many of which operate unconsciously and primitively (Livneh, 1982; Watermeyer, 2013). This,

and the fact that it is the only minority group any individual can wake up belonging to (Olkin, 1999; White, 2011), can make it a difficult topic to discuss: the community of persons with disabilities has open enrolment – anyone can join at any time by acquiring a disability. This perhaps is exactly what contributes to the need to distance ourselves, the knowledge that this, too, could happen to me. (emphasis in original) (Olkin, 1999, p. 32).

The need for disability therapy

Historically, therapy models were developed during the 20th century, in an era often segregating disabled people (Barnes, 1991). It is proposed that this segregation, combined with our universal fear of difference, creates a strong power imbalance (McLeod, 1998; Watermeyer, 2012). Scholars have highlighted that impairment continues to be perceived as negative, provokes anxiety and is associated with lower quality of life, diminished sexuality and death (Livneh, 1982; Marks, 1999; Shakespeare, 1994; Watermeyer, 2013). Indeed, there are indications that a preference for ‘able-bodied’ over ‘disabled’ may already exist by the time children begin primary school (Weinberg, 1978). Studies conducted on nondisabled people’s perception of disabled people, however, suggests that people react either extremely positively or negatively (Antonak & Livneh, 2000). These extremes may be considered as ‘splitting’; a defence against the ambiguity of disability (Watermeyer, 2013). This defence mechanism is illustrated through the ‘supercrip’ stereotype who can do or overcome anything (the Paralympics) and the ‘poor, sufferer’ stereotype (sometimes portrayed by charities); both of which distract from the everyday complexity and ambivalence being disabled can bring.

Therapists are subject to the same negative connotations, images and symbols around disability and impairment as others in society (Olkin, 1999). Therefore, it is conceivable that without adequate training such inherent biases and stereotypes would prevail and limit therapeutic effectiveness (Reeve, 2014; Watermeyer, 2013). In one study, few therapists considered impairment and disability as a resource for fulfilling one's potential (Smart & Smart, 2006), and in another, high death anxiety in the therapist was linked to attitudes towards disabled people, suggesting that the service provided would be affected (Fish, 1986).

Reeve (2002) suggests that disability equality training is insufficient to redress the power imbalance which being disabled evokes, and maintains that many therapists are unaware of their attitudes towards disability. Without this awareness, therapists can reproduce the oppression clients experience in society. For instance, therapists: endorsing the prohibition of anger or seeing anger as denial of impairment; endorsing the 'supercrip' by encouraging positive thinking; expressing disbelief at the refusal to have medical treatment to improve impairment; or being educated by the client about what living in a hostile environment entails (Olkin, 1999; Reeve, 2002, 2014; Withers, 1996).

Several scholars argue that because there are few disabled therapists and tutors in the UK, existing therapy practises are not being challenged from within the profession (Parritt, 2012; Reeve, 2014; Withers, 1996). This view is corroborated when examining current research studies which continue to focus on individual impairment. Swain, Griffiths and Heyman (2003) commented that therapy still fails to explore the social and political issue of disability, while Oliver (1995) asserts that much of the emotional distress disabled people experience stems not from their inability to adjust to their impairments, but from the failure of the environment to take their needs into account.

Disability models

Oliver and Barnes (2012) and Kristiansen, Vehmas and Shakespeare (2009) describe this social model as well as other models, active in the lives of disabled people, such as the tragedy, medical and moral model (Table I). Whilst the social model has been an important vehicle for political change for disabled people compared to individual models, it has also been criticised by Thomas (2001) and Morris (1992) for not recognising personal and emotional aspects of disability. Additionally, Watermeyer (2013), Olkin (1999) and Marks (1999) appeal for a move towards a more integrative model which reflects the structural barriers, yet also values the emotional and subjective lives of disabled people and their experiences of oppression and impairment. This has led to the inclusion of theoretical ideas such as critical psychoanalysis (Watermeyer, 2013).

A specialist service

The service evaluation was conducted in a social enterprise which supports disabled adults and their families, established in 2009. The organisation's ethos, based on Watermeyer's (2013) critique of the social model when applied to psychology, has been helpful in finding ways to respond to common client issues and needs. Clearly understanding the processes behind clients who terminate therapy, often because of external issues such as transport or personal assistant/carer (hereafter called PAs) problems, has led to a different service delivery and organisational processes; for example, offering emotional support via instant messaging, Skype, email or text when 'in-person' therapy was not possible.

Additional training beyond generic therapy training helps therapists uncover their own relationship, bias and prejudices towards impairment and disability as well as the

client's. It also educates therapists around disability history and models, and the impact of stress, trauma and third-party involvement on well-being. Regular supervision is used to reflect on how these aspects can impede client progress. Usually, the disabled person is surrounded by able-bodied people in their family and neighbourhood and consequently they are often isolated; lack of social support and role models can result in fewer learning opportunities and experiences (Olin, 1999). Therapists therefore work holistically, drawing on other disciplines such as education and coaching. Finally, therapists develop skills in boundary flexibility, by including third parties in therapy or using extensive therapist disclosure and advocacy. A further example of this flexibility includes maintaining regular pretherapy contact with clients, sometimes for several years, so they can address finances, health, transport and PA issues prior to starting therapy. For some clients with 'severe' impairments, a one hour session with the therapist can involve an entire day in terms of getting up, travelling and setting up equipment, and can often cost significantly more than just the therapy fee because of payments for PAs. The organisation allows for this large investment of time, energy and money by adjusting session content and frequency.

Research aims

The organisation aimed to bridge the gap between therapy and disability studies and apply a more holistic disability model to therapy, to enable service development, improve staff training and enhance utility of the approach.

Method

Clients and setting

The service is largely funded by charity and council grants and client contributions. Clients either self-refer or are referred by the improving access to psychological therapy (IAPT) service or disability organisations. Services are delivered at a designated location, via Skype, telephone or in the client's home. Clients received up to 15 subsidised 1-2-1 sessions. Eligibility criteria include clients being over the age of 18, with a physical impairment (occasional referrals are accepted for clients with mild learning difficulties) or a spouse or family member. Contributions were at least five pounds per session. Clients' suitability for therapy was evaluated during an assessment as part of the admission protocol. Therapists explored whether clients could understand, remember and communicate back what was discussed, to evidence levels of awareness and insight. Clients with more severe cognitive impairments, and thus deemed unsuitable for talking therapy, were referred to their GP. Eight female therapists (75% Caucasian of working age) provided therapy at the time of the evaluation. Seven person-centred or integrative therapists were qualified to at least diploma level, while one was a student therapist.

Outcome measure

The primary outcome measure was the clinical outcomes routine evaluation – outcome measure (CORE-OM; Evans et al., 2002); a 34-item self-report measure of psychological distress. The response format is a five-point (0–4) scale. A total score is derived by aggregating the item ratings and dividing by the number of completed items. Higher scores indicate greater levels of psychological distress. CORE-OM has a good level of inter-item reliability, internal and test–retest reliability (0.75–0.95),

convergent validity with other outcome measures, and has good sensitivity to change (Evans et al., 2002).

Ethical considerations

The service evaluation was conducted in accordance with Bond's (2004) Ethical Guidelines for Researching Counselling and Psychotherapy and BACP's Ethical Framework for the Counselling Professions (2016). Therapists were mindful of collecting data whilst avoiding maleficence to disabled people who experience frequent intrusion into their personal lives due to assessments (Hales, 1996; Olkin, 1999). Of concern was the issue of dual relationships: collecting data from clients whilst offering them therapy, and therapists' personal connections to clients' stories of impairment and disability, which were addressed in team and board meetings and supervision.

Procedure

In a written agreement and verbal briefing, time was taken to ensure clients had capacity to provide informed consent: that they understood the purpose of data collection to assist in developing a tailored approach and chart client progress. They were also briefed about anonymity and confidentiality, as well as their rights to withdraw data from the service evaluation. An opportunity was given to explore client or therapist ambivalence around data collection, after which an attempt was made to collect a pre and post-therapy CORE-OM for all clients. The CORE-OM was administered prior to the first session, either at the point of referral, whilst on the waiting list or during the first session. It was also administered in the penultimate session or following termination. Clients' demographics, including gender, age, marital status, ethnicity, religion and impairment, were collated pretherapy or during assessment. Clients'

clinical information such as presenting issues and reasons how and why therapy was terminated, was also recorded.

Design and data analysis

A one group pre and post-test design were employed on the retrospective routine collected data, for clients receiving 1-2-1 therapy. To compare the average scores, independent t-tests were used to ascertain any differences in pretherapy subscale and total scores, amongst clients that completed therapy and those that did not. To compare the average scores between the two time points (pre and post-therapy), dependent t-tests were used to ascertain differences in clients' subscale and total scores. The magnitude of difference in scores was denoted by the t-value converted into an r-value (Rosnow & Rosenthal, 2005) for an effect size. Cases of clinical improvement and deterioration in psychological distress were calculated using clinically significant change and reliable change (RC) indices (Barkham et al., 2001) and categorised as 'recovered', 'improved' 'unchanged' and 'deteriorated'.

Results

Sample demographics, impairments and presenting issues

Between August 2011 and September 2015, 107 clients were referred for 1-2-1 therapy. Data were available for 91 clients to evaluate baseline information about changes in levels of psychological distress; 53 clients (58%) completed CORE-OM at both pre and post-therapy by which change in distress is evaluated. Clients that only completed CORE-OM pretherapy are referred to as ‘noncompleters’, clients with a post-therapy CORE-OM are referred to as ‘completers’.

The sample comprised 42 (46%) male and 49 (54%) female clients and the mean age was 44 years (SD = 13.0). Most clients (n = 72, 79.1%) identified as Caucasian. Less than half the clients (n = 38, 41.8%) were single, and 38.5% (n = 35) were in a committed relationship, with the remainder being either divorced (n = 4, 4.4%), separated (n = 1, 1.1%), widowed (n = 4, 4.4%) or relationship status not known (n = 9, 9.9%). Clients’ orientation in religious faith was unknown or inapplicable for more than half of clients (n = 65, 71.4%), 18 clients were Christian (19.8%), six clients were Muslim (6.6%), one client was Hindu (1.1%), and one client was Buddhist (1.1%).

A large proportion of clients had an acquired physical impairment (n = 39, 42.9%) or a chronic physical illness (n = 29, 31.9%). Other client impairments in the sample included the following: congenital physical impairment (n = 14, 15.4%), learning difficulties (n = 4, 4.4%), visual impairment (n = 2, 2.2%), physical impairment – other (n = 2, 2.2%) and unknown (n = 1, 1.1%) (Appendix 1).

All 91 clients had at least one presenting issue recorded; 86 (94.5%) clients had two presenting issues, and 70 (76.9%) clients had three presenting issues. The most common presenting issues were as follows: symptoms of depression (n = 37, 41%) and

anxiety (n = 26, 29%), spousal relationships (n = 25, 27%), coping strategies (n = 24, 26%) and loss (n = 21, 23%).

Waiting times and number of sessions attended

The waiting time between referral and initial assessment was 4.6 weeks (SD = 6.0), and the number of therapy sessions attended was 11 (SD = 7.3) over 14.7 (SD = 10.2) weeks before termination of therapy.

Psychological distress at pretherapy

Pretherapy assessment of psychological distress identified 83 (91%) clients within the clinical range as defined by CORE-OM. The mean CORE-OM total clinical score at pretherapy was 18.8 (SD = 6.6), translated as psychological distress being at a moderately severe level. Of the four CORE-OM domains, subjective well-being clinical total scores (M = 25.2, SD = 8.3) were highest, followed by problems/symptoms (M = 22.8, SD = 8.4), functioning (M = 19.3, SD = 7.2) and risk/harm (M = 5.8, SD = 7.5) clinical total scores.

Pretherapy scores and severity of psychological distress between samples

There were no significant differences in domain and total scores between samples at pretherapy assessment (Table II).

Psychological distress post-therapy

Post-therapy assessment of psychological distress identified 53 (58%) clients within the clinical range as defined by CORE-OM. The mean CORE-OM total clinical score at post-therapy was 12.3 (SD = 7.2), translated as psychological distress being at a mildly severe level. Of the four CORE-OM domains (Figure 1), subjective well-being clinical total scores (M = 18.0, SD = 13.0) were higher, followed by

problems/symptoms ($M = 15.3$, $SD = 9.6$), functioning ($M = 12.8$, $SD = 7.0$) and risk/harm ($M = 2.3$, $SD = 4.7$) clinical total scores.

Evaluating change in psychological distress

Scores between pre and post-therapy on all four CORE-OM domains and the total were statistically significantly different, with a decrease in scores post-therapy. Effect sizes were large, representing a substantive finding (Table III).

Post-therapy, 19 (35.8%) clients met the criteria for clinical significance (CS) and RC and were thus considered as 'recovered'. In addition (Table IV), 11 (20.8%) clients met the criteria for RC only and were considered as 'improved'. Less than half of clients ($n = 22$, 41.5%) remained 'unchanged' and one (1.9%) client 'deteriorated' in terms of psychological distress.

Therapy termination

Fifty-three clients completed therapy and therapy termination was as follows: agreed beforehand in person ($n = 41$, 77.4%); agreed at final session in person ($n = 3$, 5.7%); agreed by phone/letter between sessions ($n = 3$, 5.7%); without proper notice by client ($n = 3$, 5.7%); unknown ($n = 2$, 3.8%) and client never attended ($n = 1$, 1.9%). Thirty-five clients did not complete therapy. Reasons for termination included the following: did not attend/cancellations ($n = 18$, 47.4%); end of allotted sessions ($n = 4$, 10.5%); found another service ($n = 2$, 5.3%); did not want to pay contribution ($n = 2$, 5.3%); other ($n = 2$, 5.3%); unknown ($n = 2$, 5.3%); inappropriate referral to service ($n = 2$, 5.3%); able to manage without service ($n = 1$, 2.6%); illness ($n = 1$, 2.6%) and admitted to hospital ($n = 1$, 2.6%).

Discussion

Positive outcomes

The aim of this study was to consider the utility of the organisation's approach, inform future service development and contribute to the field of disability therapy literature, in order to more effectively meet the therapy needs of disabled people. Findings from this service evaluation indicate that 57% of clients for whom data were available, had improved or recovered.

The organisation's waiting time, with an average of 4.6 weeks, is encouraging in comparison with the NHS, where 62% of clients waited longer than three months (We Need to Talk Coalition, 2013). Data attrition of 42% is also favourable when compared to the CORE-OM benchmark of 61% (Mullin, Barkham, Mothersole, Bewick & Kinder, 2006), indicative of good administrative processes within the organisation. Data attrition, attributed to DNA's due to impairment effects or PA issues, resulted in mid therapy termination levels. This issue requires continuous reflection, as it does in most research (Roseborough, 2015).

Benchmarking

A dearth of comparative quantitative studies makes benchmarking difficult. Segal (2011) reports anecdotally that 59% of 27 clients improved or recovered, but this was a small sample. Reuber, Burness, Howlett, Brazier and Gruenewald (2007) found 49% of 63 clients with unexplained neurological symptoms improved after tailored psychotherapy. Neither study reflects the organisation's client group.

According to CORE-OM benchmarking, 57% is considered a 'low relative rate of improvement' (Mullin et al., 2006, p. 5). However, benchmarks are complex to analyse due

to factors such as client profiles, individual therapists and management (Mullin et al., 2006). Client profiles are particularly significant when benchmarking rates of change. Disabled clients' cases are complex as, on top of impairment-related issues, there can be a psychological impact stemming from being part of a stigmatised minority. Therapy outcomes can also be affected by client and therapist collusion in the often-unconscious processes surrounding disability (Livneh, 1982; Olkin, 1999; Watermeyer, 2012). Such complexity could mean clients make less progress, particularly in time-limited sessions. However, due to a lack of funding, the organisation was unable to offer longer term therapy. Additionally, the higher than average completion rate (58% compared with the CORE-OM benchmark of 39%) may make benchmarking with CORE-OM difficult (Gibbard & Hanley, 2008).

Limitations with self-report measures

There are limitations with any self-report measure; for instance, whether the client understands and interprets the questions correctly, response bias (tendency to respond a certain way) and providing answers the client thinks the therapist wants to hear (Heppner, Kivlighan & Wampold, 2003). Another issue is staff consistency in administering the questionnaire (Gardiner, McLeod, Hill & Wigglesworth, 2003).

Self-report measures can also motivate socially desirable responding (Crandall & Eshleman, 2003). Watermeyer (2014) discusses the confusing expectations towards disabled people. Other authors discuss 'passing': concealing your impairment to appear more 'normal' (Brune & Wilson, 2013) and Watermeyer (2013) discusses that coming for therapy could evoke feelings of guilt. These issues could all impact on both high and low

scores: this complex area needs examining further, if seeking confidence in the validity of self-report measures with this specific population group.

CORE-OM limitations

Disability-specific CORE-OM limitations also exist, which could explain the lower percentage of 'improved' clients. There are concerns that 'CORE has not been validated for clients with neurological conditions...' and that perhaps 'In the face of a deteriorating condition....maintaining current status can be counted an improvement' (Segal, 2011, p. 22). It is possible that the national data set on which CORE-OM is founded is not representative for those with physical impairments nor those with illness-related impairments. Adapted versions of CORE-OM, for instance for those with learning disabilities and young people (Barkham, Gilbert, Connell, Marshall & Twigg, 2005; Brooks & Davies, 2013), are indicative of this lack of representation.

Some clients stated the CORE-OM does not reflect difficulties getting out and maintaining activities and relationships due to access issues or impairment effects such as pain or fatigue. Some also commented that CORE-OM does not capture the distress caused by the lack of control and the impact of being disabled by society. Some CORE-OM items, for example: 'I have thought I am to blame for my problems and difficulties', may therefore have been impossible to answer and consequently left blank. Both exclusion and involvement with health and social care providers can cause stress, which in turn affects well-being (Watermeyer, 2013). Some CORE-OM outcomes did not match therapy progress if completed at such a stressful time. An adapted CORE-OM version may, therefore, be required for this population group or an alternative measure developed and validated.

Other limitations

For several clients, lack of change or deterioration was due to external grievances with their care home, which meant that client well-being deteriorated due to increased awareness of the constrained context. Other reasons included hospitalisation, third-party involvement or lack of personal funds, which meant clients were terminating before they were ready. As there were no significant differences between completers and noncompleters, it is possible that these external issues played a role for clients that terminated therapy prematurely. Twenty-six of 53 clients mentioned these issues on termination. Many clients had third-party intrusions; one parent (also the client's driver and PA) found the changes the client was making too difficult to deal with and stopped driving them to therapy. Therapy was terminated early before data could be collected. The sample on which this service evaluation is based was demographically unrepresentative. George (2015) suggests this could be because ethnic minorities present themselves less often for therapy as talking to an outsider can be perceived as unacceptable. Some clients who contacted the service but did not engage for financial reasons, were from cultural minority groups. This needs further exploration to ensure the service is accessible to a wider demographic. Finally, the results were based on one outcome measure with no follow-up data or control group, while the sample size was relatively small and comprised a broad range of impairments.

Conclusion

The issues discussed in this study encourage practitioners to think about how accessible and empowering their service to disabled people is and may give insight into those clients that terminate early. Significantly, the client and therapist's relationship with disability and impairment can impact on therapy success.

Approaching disability as both an impairment and a diversity issue can empower clients. Offering a flexible and holistic space for clients to explore the complexities and ambivalences of being disabled can counter the silencing and oppression often experienced.

The findings also augment understanding in the emerging field of disability therapy, highlighting several process and measurement issues to consider for this population group for a more robust and rigorous service evaluation. Additional funding is needed both to research and develop these processes and measurements and to facilitate longer term therapy with disabled people.

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Biographies

Melani Halacre is a BACP accredited therapist and supervisor and clinical director and founder of Spokz People cic.

Rahul Jalil is a Lecturer at Birmingham City University. Rahul provided data analysis support for this service evaluation study during his Research Facilitator role at BACP.

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Appendix A: Defined impairment category

Categories are not exclusive and can overlap.

Acquired physical impairment	<i>n</i>
Brain injury	27
Spinal cord injury	8
Meningitis	1
Polio	1
Stroke	1
Scarring and skin conditions	1
Total	39

Description: An external one-off event after birth.

Chronic physical illness	<i>n</i>
Multiple sclerosis	13
Complex regional pain syndrome	4
Arthritis	3
Fibromyalgia	2
Epilepsy	2
Osteoporosis	1
Parkinson's disease	1
Chronic obstructive pulmonary disease	1
Cancer	1
Connective tissue disease	1
Total	29

Description: Long-term diseases after birth.

Congenital physical impairment	<i>n</i>
Cerebral palsy	11
Spina bifida	2
Congenital growth defect	1
Total	14

Description: Irregular conditions from birth.

Learning difficulties	<i>n</i>
Learning disability	4
Total	4

Description: Reduced intellectual ability from birth.

Visual impairment	<i>n</i>
Visual impairment	2
Total	2

Description: Sensory impairment affecting eyes acquired or from birth.

Physical impairment – other	<i>n</i>
Mobility issues otherwise not categorised	2
Total	2

Description: Not categorisable in above options.

Unknown	<i>n</i>
Total	1

Description: Clients whose impairments were not known.

Table 1: Types of Disability Models.

Oliver & Barnes (2012); Kristiansen, Vehmas & Shakespeare (2009)

Model	The individual is...	What expectations does the model have of the individual?
Tragedy	a victim of circumstance, helpless, dependent	The person must grieve and adjust to their impairment
Medical	someone whose impairment or adjustment to it is the problem	The person must be fixed through aids and medicine to be as 'normal' as possible
Moral	impaired because of a punishment for bad deeds perpetrated by the individual or their ancestors	The person 'escapes' punishment through exorcism, sacrifice, rewards in the afterlife, rituals, ostracism, healing or death
Social	disadvantaged by physical, attitudinal and institutional barriers in the environment. These barriers prevent equal participation in society and are experienced on top of individual impairment	Society and the environment must change to remove the barriers for disabled people, not the individual

Table II: Pretherapy clinical outcomes in routine evaluation (CORE) clinical domain and total scores between samples.

CORE scale	Noncompleters <i>n</i> = 38	Completers <i>n</i> = 53	Difference
Subjective well-being	25.8 (8.5)	24.8 (8.2)	<i>ns</i>
Problems/Symptoms	23.4 (8.6)	22.3 (8.3)	<i>ns</i>
Functioning	19.9 (5.9)	18.9 (8.0)	<i>ns</i>
Risk/harm	5.5 (7.3)	6.0 (7.7)	<i>ns</i>
Total	19.3 (6.0)	18.5 (7.0)	<i>ns</i>

Ns, non-significant.

Table III: Pre and post-therapy clinical outcomes in routine evaluation (CORE) clinical domain and total scores for clients that completed therapy.

CORE scale <i>n</i> = 53	Pretherapy	Post-therapy	Difference	Effect size <i>r</i>
Subjective well-being	24.7 (8.2)	18.0 (13.0)	6.7*	.50
Problems/Symptoms	22.3 (8.3)	15.3 (9.6)	7.0*	.69
Functioning	18.9 (8.0)	12.8 (7.0)	6.1*	.66
Risk/harm	6.0 (7.7)	2.3 (4.7)	3.7*	.54
Total	18.5 (7.1)	12.3 (7.2)	6.2*	.74

* $p < .01$

Table IV: Clients' change status post-therapy by frequency.

Type of change post-therapy	<i>n</i> (%)
Recovered – passed clinical significance (CS) and reliable change (RC)	19 (35.8%)
Improved – passed RCI only	11 (20.8%)
Unchanged – passed neither	22 (41.5%)
Deteriorated – passed RCI in negative direction	1 (1.9%)
Total	53

Figure 1:

