# Research Project Portfolio
# Volume Two

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## Clinical Practice Reports

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Research Project Portfolio Volume Two Contents Page

# ‘Paul’ - Clinical Practice Report FPB

**Contents**

## Case overview and reasons for referral

'Paul'[1], a 44-year old British Caucasian male, was internally referred by his community psychiatric nurse (CPN) to the psychology team, within the secondary service recovery team for complex mental health needs, to receive help for his symptoms of post-traumatic stress disorder (PTSD). PTSD is an anxiety disorder developed from exposure to a traumatic event (NICE, 2005). Paul had no prior psychological therapy.

Diagnosing PTSD is pathologising understandable emotional reactions to traumatic events (Sumerfield, 2001). Paul finds diagnosis useful therefore his difficulties have been conceptualised using the DSM-IV-TR (American Psychiatric Association [APA], 2000a)[2]. For 24 years Paul experienced symptoms of PTSD, including anxiety, nightmares, hypersensitivity to threat and intrusive images. The DSM-IV-TR (APA, 2000) (see appendix A for PTSD criteria) rather than the ICD-10 (World Health Organisation, 1992) has been used due to its less sensitive nature when diagnosing PTSD (Rosner & Powell, 2009; Peters, Slade & Andrews, 1999). Paul experienced a traumatic event on his 20th birthday. He attended a football match, since termed the 'Hillsborough disaster'; he was trapped in the Leppings Lane section, but rescued by being pulled onto the upper tier. Paul has regular contact with his CPN in the Recovery Clinic. He had made progress, but still experienced flashbacks, nightmares and being constantly "super alert, on guard". This distress was impacting on his daily life; he experienced anxiety when leaving the house and was unable to tolerate being in crowded places. I have seen Paul for 9 sessions, where we worked from a Cognitive-Behavioural-Therapy (CBT) perspective, focusing on his anxiety, shame and guilt.

[1] Informed consent gained, information will be anonymous, pseudonyms used throughout the report to maintain confidentiality.

[2] (DSM-V) (American Psychological Association, 2013) was not in production, the changes made to the criteria for PTSD would not change Paul's diagnosis.

## Literature review

### Epidemiology

It is estimated that PTSD lifetime prevalence ranges between 6.8% to 7.8% in community samples (Kessler, Berglund, Demler, Jin & Walters, 2005; Mendes, Mello, Ventura, Passarela, & Mari, 2008). Men are half as likely to meet criteria for PTSD (Leahy, Holland & McGuinn, 2012. Social factors may influence disclosure, eg, women sharing their experience more than men (Simmons & Granvold, 2005).

A common precipitator is natural disaster/life-threatening accidents (Schnurr, Friedman & Bernardy, 2002), where direct exposure, longer duration or perceived threat of death indicate higher risk to developing PTSD. Severity of the trauma has been linked to post-event lack of social support. (Brewin, Andrews & Valentinel, 2000; Ozer, Best,Lipsey, & Weissl, 2003). Kessler, Sonnega, Hughes and Nelson (1995) found that a third of people who develop PTSD have symptoms for three years or longer putting the person at risk for additional problems, eg, comorbid substance-misuse, where prevalence was higher in men than women [alcohol abuse, men=51.9%, women=27.9%, Dunner, (2001); other substance abuse, men=34.5%, women=26.9 Schoenfeld, Marmar, & Neylan, (2004)].Paul reported he abused alcohol and substances. Avoidance is noted as a ‘core symptom’ (pg. 6) of PTSD, is often used as a coping strategy thus perpetuating the problem (NICE, 2005).

### Aetiology

Theories have developed to explain the symptoms, development and maintenance of PTSD including biological factors (Grey, 2007; Stein, Jang, Taylor, Veron, & Livesley, 2002) and psychological factors (Brewin, Daglesh & Joseph, 1996). I will critically discuss two psychological theories.

*The Behavioural theory of PTSD*

Early theories drew on the ideas of classical conditioning (Keane, Zimmerling, & Caddell, 1985). Mowrer's (1960) two-factor learning theory has been used to explain the clinical symptoms of PTSD (Kilpatrick, Veronen, & Best, 1985). The theory proposes that emotions experienced during the trauma, become linked to all our senses that arise during the trauma. These become cues that prompt anxiety, increasing over time as part of two processes. (1) generalisation; where similar cues to the original elicit anxiety; and (2) higher-order conditioning, where originally neutral cues evoke anxiety due to association. This includes words, images and thoughts. The second stage proposes that developed learned responses, such as, avoidance through such substance misuse, reduce anxiety and therefore increasing that behaviour (operant conditioning).This becomes a coping strategy and maintains PTSD symptoms as habituation to the memory does not occur.

Although the behaviour theory explains the re-experiencing and avoidance symptoms of PTSD it has been criticised as; being too simplistic (Bisson, 2009), failing to adequately explain persistent hyper-arousal and the fluctuation re-experiencing and avoidance/numbing often seen within PTSD (Leahy, Holland & McGinn, 2012) and lacking, as reported by patients with PTSD, their altered sense of meaning (Foa & Riggs, 1994).

*The Cognitive theory*

Cognitive theory has become prevalent in recent models of PTSD. Beck (1976) founded cognitive therapy for depression and has since been developed for a range of disorders such as anxiety (Clark, 1999). The cognitive theory suggests that the interpretation of the event not the event itself defines the reaction to it (Bisson, 2009) and the development of PTSD (Ehlers & Clark, 2000). The PTSD model develops the classical cognitive theory where people who suffer from PTSD acquire negative appraisals about external threat, eg, feeling nowhere is safe, and internal threat, feeling unable to cope. Misinterpretation of situations occurs and where the traumatic memory generates the feeling of current threat, it is accompanied by the negative

appraisals of what happened. This relates to Paul's experience and how it may have developed for him.

**Treatment**

Literature and NICE (2005) suggest using either Eye Movement Desensitisation Reprocessing (EDMR) or Trauma Focussed-CBT (TF-CBT) at any time after the event (Ehlers, 2005; Gillespie, Duffy, Hackmann & Clark, 2002; Resick, Nishith, Weaver, Astin & Feuerl, 2002). Both methods have been found to be effective in significantly reducing PTSD symptoms and more effective than waiting list or other treatments, eg, exposure alone (Bisson, Whlers, Matthews, Pilling, Richards & Turner, 2007; Bryant, Moulds, Guthrie, Dang, & Nixon, 2003). PTSD treatment can impact secondary comorbid disorders, such as, substance misuse so it no longer meets diagnostic criteria (Blanchard et al, 2003).

The Ehlers and Clark (2000) TF-CBT model for PTSD is the seen as the most comprehensive and dominant model within the field of PTSD (Bennett-Levy, Butler, Fennell, Hackman, Mueller & Westbrook, 2004; Westbrook, Kennerly & Kirk, 2007). The model covers multiple components, eg, the negative appraisal of the trauma, thought suppression, rumination, safety behaviours and avoidance (Dunmore, Clark, & Ehlers, 1997; 1998; 1999; Foa, Molnar & Cashman, 1995). However Dalgleish (2004) highlighted this model fails to distinguish between 'hot' and 'cold' cognitions deemed as common in PTSD and Taylor (2006) suggested this model was too complex. However the model provides a framework for the processes following a traumatic event. These areas cover the aspects Paul described in his symptoms and how he was managing his symptoms. (1) negative appraisal of the trauma, (2) poor contextualisation of the trauma memory and, (3) maladaptive coping strategies that prevent recovery (Ehlers and Clark 2000). NICE (2005) emphasise the use of exposure and cognitive restructuring to treat PTSD.

**Assessment**

I followed the Ehlers & Clark (2000) assessment to gather information. To assess his motivation, Paul was asked about his reasons for accessing support at this time

*Behaviour in session*

Paul attended his first session with Anne his partner. He was visibly nervous, sat with his head bowed and legs shaking. I reflected my observations and we discussed how difficult it might be sharing his experience for the first time. Using empathy and listening skills made Paul more relaxed and able to discuss some of his presenting problem. He was very emotional, crying throughout.

*Family*

Paul grew up as an only child living with his parents. He was close to his mother. Paul's father frequently worked away from home. He and his father would spend quality time together on the "two holidays a year" they took as a family. Later he was close to both his parents. Paul was close to his wider family (mother had 9 siblings) such as his Cousins, Aunts and Uncles. After the Hillsborough disaster family and friends "believed the papers and media who blamed the Liverpool fans" making Paul feel excluded and isolated from them.

*Onset of difficulties*

After the event he had further traumatising experiences when his extended family left him with the feelings of "guilt" and "shame". "After a while you start to believe the things people are saying". This has impacted on Paul's core beliefs.

*Presenting Problems*

Paul described his main problems as getting flashbacks, smells from the day such as, "the sweet shop I walked past", "the smell of death", intrusive memories, "like a video-playing a film", "it zooms in on different faces", nightmares and becoming anxious when going out if places become crowded, he feels unable to cope. Increased media coverage triggers this. Consequently

this has negatively impacted his sleep. Paul mentioned he used distraction to cope, with his partner's help, and he smoked weed.

*Substance Misuse*

Paul mentioned he historically abused cannabis and alcohol. He continued smoking cannabis to block out his "unwanted images" and to "help me sleep". We discussed the impact on continued use. We also discussed that during therapy it would be beneficial not to use cannabis before sessions.

*Risk assessment*

During the first session a risk assessment was undertaken and monitored throughout sessions. Paul did not have suicidal thoughts or plans, nor did he self-harm.

*Protective factors*

Paul described a number of protective factors, important support not just for him, but also for the work to be undertaken in therapy. He mentioned "massive" support from his two best friends, Peter and John, who Paul's mother had described as her "adopted son". Paul said his partner, Anne, was "a vital source of support on a daily basis" describing this as "being the most supportive relationship I have ever been in".

**Psychometric assessments**

**Table 1: Psychometric assessments results, CORE-OM-34, PCL-S and SUDs**

| Assessment | Stage | Pre therapy |
|---|---|---|
| CORE-OM-34 | Risk Score | 10<br>low |
| CORE-OM-34 | Needs Score | 22.6<br>Moderate-severe |
| PCL-S | Trauma symptoms | 40 |
| SUDs | Belief rating | 10 |

*CORE-OM-34(Barkham, Mellor-Clark, Connell & Cahill, 2006)*

The CORE-OM-34 measures wellbeing, functioning, problems and risk on a 34 item five-point scale. It is reliable, valid and shows sensitivity to change (Evan et al. 2002). Paul scored in the clinical population range for all categories. The results indicated that Paul was in the right service to meet his needs ( see table X).

*Posttraumatic Stress Disorder Checklist (PCL) (Weathers & Ford,1996)*

The PCL self-report measure uses the DSM-IV symptoms of PTSD, to screen, aid diagnosis and meaningfully monitor clinical change in PTSD symptoms (Monson, Gradus, Young-Xu, Schnurr, Price, & Schumm, 2008) with good reliability and validity (Blanchard,Jones- Alexander, Buckley, & Forneris, 1996; Ruggiero et al.,2003). Paul's trauma was one 'stressful experience' requiring the PCL-S (specific). The event must meet the PTSD Criterion A[3] as Paul's trauma did. Paul scored 40 on this measure which highlights severe effects (see table 1 and appendix B).

The formulation and intervention focused on Paul's trauma using PTSD as the basis of the treatment plan which was agreed as the focus of our work.

[3] See appendix A for the PTSD criterion A information.

## Formulation

The Ehlers & Clark (2000) cognitive-behavioural model was used to formulate Paul's difficulties (see figure 1). We collaboratively developed the formulation together.

Paul's comfortable upbringing fostered an environment in which he developed a core belief that 'the world is a safe place'. He also believed that he could rely on other people, there were rules to follow but the police could be trusted and were there to protect him.

During Paul's life-threatening trauma, he became extremely fearful and anxious. His arousal was heightened and he had appraisals such as "I can't fill my lungs" and "How long before the life is squeezed out of me". Although he was trapped, his threat system was activated, his body responded in the flight mode. This was the safest response, freezing would have meant he was further trapped and the action he took eventually enabled him to be pulled from the crowd. Due to the level of stress, Paul was unlikely to process this memory in the normal way and resulted in fragmented memories. When Paul did have flashbacks and intrusive memories, they were associated with the same distress from the day.

Paul developed negative appraisals about himself ("I am to blame"), guilt ("I survived when others died", "I should have known something bad was going to happen"), about others ("you can't trust the police", "authorities lie"), and about the world ("the world is a dangerous place"). These beliefs were further confirmed by events occurring later such as lies in the newspaper, the reaction from his family and friends, the knowledge that it could have been prevented. These shattered beliefs led to Paul to feel anxious when he went out, as he felt vulnerable so was "more alert".

Responding to what happened, Paul developed maladaptive coping strategies, useful initially, but they developed into maintaining factors, preventing the updating of his trauma memory and stopping him from

challenging and changing his beliefs. Paul used distraction: he would try to keep his mind occupied watching television.  He avoided going to pubs, and if he was ever out in a crowded place, he would become anxious and leave. Paul mentioned he had found this useful as “I have never looked or realised things were linked that way”.

The aim of our work together was to help Paul move forward by enabling the memory to be stored appropriately, allowing him not to forget, but to make what happened become part of his life story and to stop causing disabling distress.

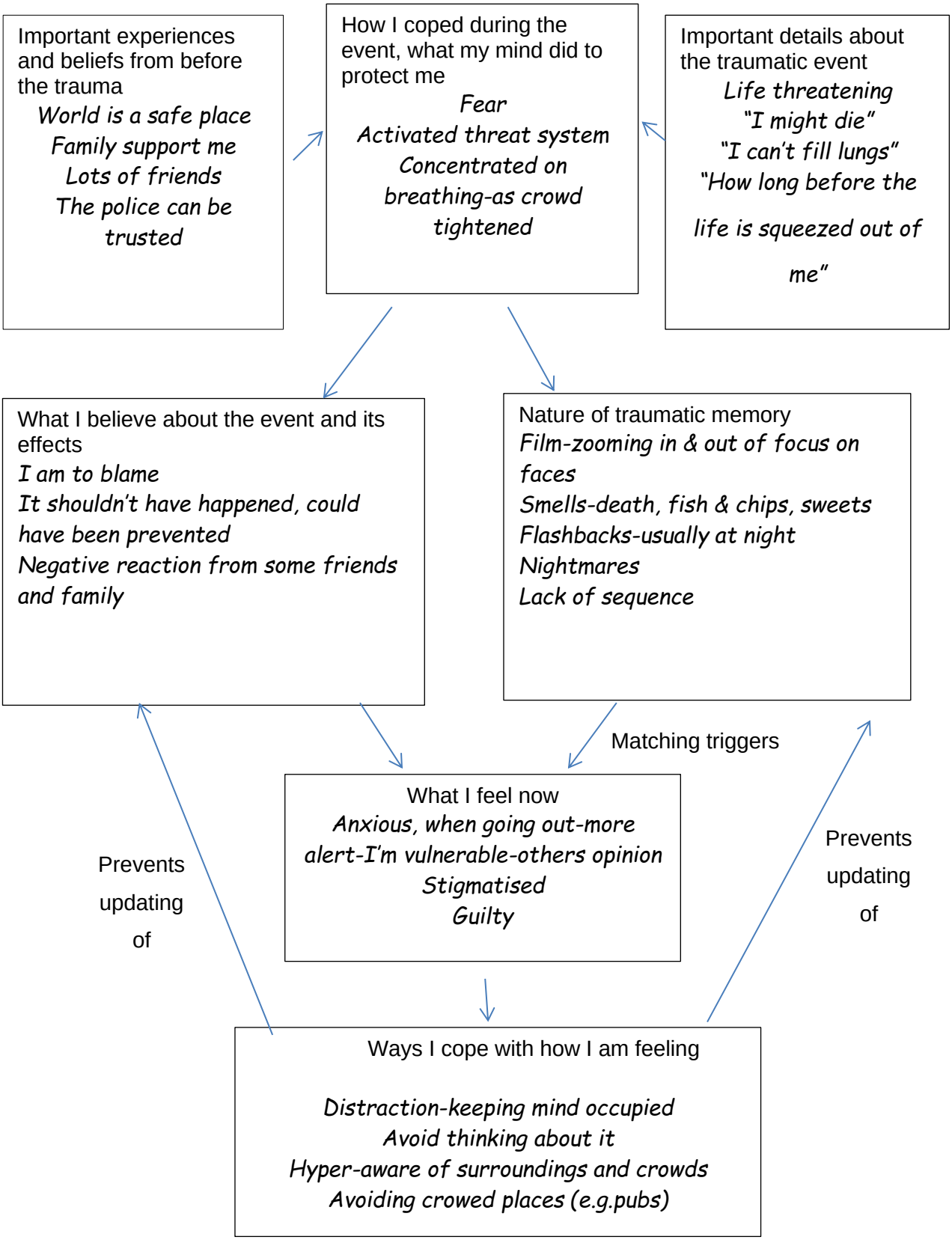



**Figure 1: Paul's Formulation**

## Intervention

The treatment plan utilised the Ehlers and Clark CBT model. Paul and I met for 9 sessions, 8-12 sessions are offered when the trauma has developed from a single event (Foa, Keane, Friedman & Cohen, 2009). Initially we met fortnightly as Paul could not deal with the emotions on a weekly basis. These became weekly for 90-minute sessions once we began the trauma work (NICE, 2005; Westbrook et al. 2007). The intervention targeted processing the trauma memory, altering negative appraisals and eliminating unhelpful coping strategies.

*Initial sessions*

Psycho-education was used to normalise Paul's experiences as evolutionary (Leahy, 2009).The ABC model (Ellis, 1977 as cited in Johnstone & Dallos, 2006) was used to help describe the links between thoughts, behaviour and emotions. The Ehlers and Clark (2000) model was also used to help Paul understand the links between his experiences and the impact they currently had. Paul described different scenarios in which he was 'hyper-vigilant', leading to discussion about functioning and fear responses. Paul said "I never thought about that" in later sessions when we discussed his trauma experiences he had said that knowing how our brain and body reacts in those situations had been powerful as he had felt guilty for his reaction which led him to be saved.

Paul mentioned a variety of problems including his emotional reactions to triggers he was not always aware of, sleep disturbance linked to nightmares and intrusive images and anxiety in crowded places. One area of work covered skills training. Part of this involved Paul identifying his triggers to become more aware of them. We also worked on grounding techniques to help Paul stay in the present. He identified a Zippo lighter he carried and flicked.

Paul found he could not control his emotions when he had memories about the trauma. This was why he used distraction as he was scared about

being upset and not having any control over the images and thoughts. We employed imagery relaxation which included a safe place. Paul found this exercise very useful, he adapted the story and used it to good effect on his own. Through practice he found he could use this at night to control how he felt on the occasions he could not sleep. We included progressive muscle relaxation later during exposure work when his nightmares increased and he could not complete the imagery.

*Middle phase stage*

Exposure work could be conducted as Paul's circumstances 'a stable living environment, good physical health, supportive relationship' provided a safe environment for this (Leahy, Holland & McGuinn, 2012 pg 283). These sessions were extended to allow Paul's anxiety to decrease before he left the session. We used narrative imaginal exposure within the session. Paul wrote his story in the first person. To ensure sufficient detail I asked questions to draw out his experience such as smells, what he could see, how he was feeling. During this time I also asked for SUD ratings to monitor Paul's distress level. During the exposure sessions I noted hot spots so we could also focus on those. Paul completed this as homework which he described as difficult. Initially he would not read until habituation occurred so education about what we were doing and why was re-iterated.

Paul also completed some in-vivo exposure to address his anxiety about crowded places. He completed these in a hierarchy of feared places, starting in the local social club and finally a crowded pub in town. In sessions we discussed his progress and discussed challenges such as leaving whilst anxious in the initial stages and ensuring he followed his coping plan.

*Final sessions*

The exposure work was beneficial however we also completed cognitive restructuring. This occurred within Paul's trauma narrative such as 'I should have known something was going to happen' and the guilt of surviving. Socratic

questioning elicited his negative thoughts to challenge. One technique was exploring evidence for and against these thoughts (Greenberger & Padesky, 1995). The thought challenging centred around Paul's feelings of guilt and shame.

*Ending*

Four criteria are suggested to be met before terminating therapy, Leahy et al (2012):

1. Symptoms remitted so that Paul no longer meets criteria for PTSD
2. Paul being able to discuss the trauma without emotional upset
3. Avoidance no longer interferes with functioning
4. Relevant cognitive distortions modified.

All four of these measures were met by the end of therapy. This led to our final session focusing on techniques Paul found useful and ensuring he felt able to employ the skills on his own. Paul had worked hard with his exposure and we discussed what to do in the future and how to concentrate on hot spots when they occur. We discussed what Paul felt a trigger may be. The anniversary is the main trigger, next April, so he has a folder with all the information and techniques needed. Paul found the relaxation and imagery valuable and therefore he will continue to use this. We discussed how important it was to continue with this as it is a skill he had to learn. Finally I sent a letter to Paul summarising the work we completed together and the progress he made.

## **Evaluation**

Paul found this model useful to link his experiences. He could see what was influencing what, where and why we could intervene. One of my strengths was helping Paul understand the concepts to be discussed by clearly deconstructing the model. Although critics suggest the model is too complicated, it worked for Paul.

Initially Paul did not produce homework when he had found it difficult. We discussed the issues around this which reinforced my skills to ensure understanding. Subsequently Paul was motivated to complete homework “it has been hard at times but I persevered” and continued work during a break in therapy.

*End of therapy Psychometric assessments*

Psychometric measures were administered at the start and end of therapy.

**Table 2: Psychometric assessments results, CORE-OM-34, PCL-S**

| Assessment | Stage | Pre therapy | End of therapy |
|---|---|---|---|
| CORE-OM | Risk Score | 10<br>low | 0<br>healthy |
| CORE-OM | Needs Score | 22.6<br>Moderate-severe | 27.4<br>low |
| PCL-S | Trauma symptoms | 40 | 26 |
| SUDs | Belief rating | 10 | 1 to 2 |

*CORE-OM-34 Results*

The improved results indicate removal of all risk from Paul’s behaviour. His needs’ scores for all categories significantly changing (see appendix C) scoring in the non-clinical population range.

*PCL-S Results*

Evidence suggests a change between 10-20 points is clinically meaningful (Monson et al, 2008). Paul’s trauma symptoms score dropped by 14 points (see table 2 and appendix D for checklist) indicating a clinically meaningful reduction in Paul’s trauma symptoms. Observations and reports from Paul support this. We discussed one point on the measure scoring a 3 ‘super alert’: Paul said he still checked for exits. Although heightened by Paul’s trauma experience it could also be a personality trait. Paul has done this from

age 10, when his father taught him to do so on holiday and he has ever since. However it does not cause the distress it did previously.

*SUD ratings*

Paul rated his distress throughout therapy to monitor change. This was used alongside the exposure work. His score dropped from 10, where his distress was unbearable, to 1 or 2, feeling basically good to a little upset not noticeable, when he read his narrative.

*Observation*

Paul mentioned he “felt like a different person”: he had no nightmares, intrusive images, or flashbacks. Occasionally he could not sleep, however this was not in relation to any symptomology of his PTSD. Paul was also able to go to the pub without experiencing anxiety when it was crowded.

Additionally, he stopped smoking cannabis to aid sleep and he had made an appointment with the job seekers so that he can start work again.

## Reflection

This final section focuses on my reflections of the work undertaken with Paul. It includes a cognitive formulation of my difficulties and what I learnt through the work using the ABC model (Ellis, 1977) (see tables 3 & 4).

Working with Paul I became anxious from the point of referral. I had never worked with somebody diagnosed with PTSD and knew it could be extremely complicated so I read extensively to prepare myself. This was due to my anxiety surrounding the potential to do harm, rather than usual preparation. NICE (2005) guidelines, mention that assessment should be comprehensive and by a competent individual. This again heightened my anxiety as I did not feel like a competent therapist at this point and did not feel skilled enough for this case. I found initially I was hesitant to work autonomously and utilised supervision to check everything I was doing was ‘right’, to gain reassurance I was not causing harm. My appraisals were, “This will be really complex”, “What

if I make him worse", "I am not good enough to do this" therefore "I am a bad therapist, if I am a bad therapist I should not be on the course". Additionally after meeting Paul he was a nice individual and I felt a need to help him.

I used observation in sessions and SUD ratings to get feedback on the progress of the trauma work and to monitor change. Discussing the case in supervision I became less anxious and more relieved as time went on. This seemed to be in relation to becoming more confident in discussing my hypotheses. Additionally my supervisor's feedback, that she was not worried about my work, meant I must not be doing harm. The impact of all these things made me think that I must have some skills to carry out therapy with this person. It was important to make Paul feel as comfortable as possible, to let him feel safe to share his experiences. This experience helped me manage my anxiety ensuring it did not impact on therapy. I feel this was through learning to use supervision effectively, having discussions and reflecting on my work which I had previously found difficult due to my background in more management supervision.

**Table 3: CBT formulation of anxiety using the ABC model**

| **Activating event** | **Beliefs** | **Consequences** |
|---|---|---|
| Allocation of referral of a service-user with PTSD | This will be really complex<br><br>What if I make him worse<br><br>I am not good enough to do this<br><br>I am a bad therapist – and so I should not be on the course | **Emotions**<br>Anxious<br><br>**Behaviours**<br>Reading up on PTSD<br><br>Hesitant in initial stages to work autonomously<br>so<br>Utilising supervision more for Paul<br>to<br>gain reassurance |

**Table 4: CBT formulation of updated learning using the ABC model**

| Activating event | Beliefs | Consequences |
|---|---|---|
| Discussion in supervision | I am able to talk about the case and my hypotheses<br><br>My supervisor is not saying how worried she is<br><br>I would not be allowed to carry on if I was causing harm<br><br>I must have some skills to carry out this therapy | **Emotions**<br>Less anxious<br>Relieved<br><br>**Behaviours**<br>Utilise SUD ratings within the sessions to obtain on-going feedback about progress from the service-user<br><br>Use my observation skills |

I believe Paul benefitted from techniques provided, “I feel like a different person”. However due to limitations of equipment within our service during exposure work we were unable to use audio recordings which are known to be powerful. We used the advocated writing method. It had limitations in that it took time to write, Paul could become slightly detached to the memory as he was concentrating on writing and worrying about spelling. It was reflected back that this was not important however it felt slightly disjointed which led me to feel slightly insecure in that initial stage. However it turned out to be a powerful piece of work and I feel comfortable carrying this work out in future. I feel I gained multiple skills working on this case not only working with Paul but also through reading around a topic and learning how to utilise supervision effectively.

## References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR)* (4th ed., text revision). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE system. *Counselling and Psychotherapy Research*, *6*(1), 3-15.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders. New* York: International Universities Press.

Bisson, J. I. (2009). Psychological and social theories of post-traumatic stress disorder. *Psychiatry, 8*(8), 290-292

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for posttraumatic stress disorder: Systematic review and meta-analysis. *British journal of Psychiatry, 190*, 97-104

Blanchard, E. B., Jones- Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behaviour Research and Therapy, 34,* 669-673.

Blanchard, E. B., Hickling, E. J., Devineni, T., Veazey, C. H., Galovski, T. E., Mundy, E., & Buckley, T. C. (2003). A controlled evaluation of cognitive

behavioral therapy for posttraumatic stress in motor vehicle accident survivors. *Behaviour Research and Therapy, 421*, 79–96.

Bennett-Levy, J., Butler, G., Fennell, M., Hackman, A., Mueller & Westbrook, D. (2004). *Oxford Guide to behavioural Experiments in Cognitive Therapy.* Oxford: Oxford University Press

Brewin, C. R., Andrews, B., & Valentine, J.D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in truam exposed adults. *Journal of Consulting and Clinical Psychology, 68(*5), 748-766.

Brewin CR, Dalgleish T, Joseph S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychol Rev, 101,* 670-686.

Bryant, R. A., Moulds, M. L., Guthrie, R. M., Dang, S. T., & Nixon, R. D. V. (2003). Imaginal exposure alone and imaginal exposure with cognitive restructuring in the treatment of posttraumatic stress disorder. Journal of Consulting and Clinical Psychology, 71, 706–712.

Dunmore, E., Clark, D. M. & Ehlers., A. (1997). Cognitive factors in persistent versus recovered posttraumatic stress disorder after physical or sexual assault: a pilot study. *Behavioural and Cognitive Psychotherapy, 25,* 147-159.

Dunmore, E., Clark, D. M. & Ehlers., A. (1998). The role of cognitive factors in posttraumatic stress disorder following physical or sexual assault: findings from retrospective and prospective investigations. Paper presented at Annual Conference of British Association of Behavioural and Cognitive Therapies. Durham, UK, July 9-11.

Dunmore, E., Clark, D. M. & Ehlers., A. (1999). Cognitive factors involved in the onset and maintenance of PTSD. *Behaviour Research and Therapy, 37,* 809-829.

Dunner, D. L. (2001). Management of anxiety disorders: The added challenge of comorbidity. *Depression and Anxiety, 13*, 57-71

Ehlers, A., Clark, D. M., Hackmann, A., McManus F., & Fennell, M. J. V. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behavioural Research and Therapy, 43*, 413-431.

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry, 180*(1), 51-60.

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic stress Studies (2nd Ed.). New York: Gilford Press

Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 8*, 675-690.

Foa, E. B., & Riggs, D. D. (1994). *Posttraumatic stress disorder and rape*. In R. S. Pynoos (Ed.), Posttraumatic stress disorder: A clinical Review (pp.133-163). Lutherville, MD: Sidran Press.

Gillespie, K., Duffy, M., Hackmann, A., & Clark, D. M. (2002). Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy, 40,* 345-357

Greenberger, D., & Padesky, C. A. (1995). *Clinician's guide to mind over mood*. New York: The Guilford Press.

Grey, N. (2007). Post-traumatic stress disorder: Treatment. In S. Lindsay, & G. Powell (Eds.), *The Handbook of Clinical Adult Psychology* (3rd ed.) (pp. 185-205).

Leahy, R. L. (2009).Anxiety free: Unravel your fears before they unravel you. Carlsbad, CA: Hay house.

Leahy, R. L., Holland, S.J.F., & McGinn, L.K. (2012). *Treatment Plans and Interventions for Depression and Anxiety Disorders* (2nd Ed.). New York: The Guilford Press

Johnstone, L., & Dallos, R. (2006). *Formulation in Psychology and Psychotherapy. Making Sense of People's Problems*. London: New York: Routledge Taylor & Francis Group

Keane, T. M., Zimering, R. T. & Caddell, J. M. (1985). A behavioural formulation of posttraumatic stress disorder in combat veterans. *Behaviour Therapist*, 8, 9–12.

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-consent distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry. 62* (6), 593-602.

Kessler, R. C., Sonnega, A., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General psychiatry, 52*, 1048-1060

Kilpatrick, D.G., Veronen, L.J., & Best, C.L. (1985). Factors predicting psychological distress among rape victims. In C.R. Figley (Ed.), Trauma and its wake (pp. 113-141). New York: Brunner/Mazel.

Mendes, D. D., Mello, M. F., Ventura, P., Passarela, C. M., & Mari, J.J. (2008). A systematic review on the effectiveness of cognitive behavioural therapy for posttraumatic stress disorder. *International Journal of Psychiatry in Medicine, 38,* 241-259.

Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., Price, J. L., & Schumm, J. A. (2008). Change in posttraumatic stress disorder symptoms: Do clinicians and patients agree? *Psychological Assessment, 20*(2), 131-138.

Mowrer, O. H. (1960). *Learning theory and behavior.* New York: Wiley

NICE (2005). The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26. Gaskell and the British Psychological Society

Ozer, E. J., Best, S. R., Lipsey,T. L., & Weissl, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129*(1), 52-73

Peters, L., Slade, T., & Andrews, G. (1999). A Comparrison of ICD10 and DSM-IV Criteria for Posttraumatic Stress Disorder Brief report. *Journal of Traumatic Stress, 12*(2), 335-343.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. Hournal of Consulting and Clinical Psychology, 70(4), 867-879

Rosner, R., &Powell, S. (2009) Does ICD-10 overestimate the prevalence of PTSD? Trauma and Gewalt, 28 (3), 2

Ruggiero, K. J., Del Ben, K., Scotti, J. R., & Rabalais, A. E. (2003). Psychometric Properties of the PTSD Checklist--Civilian Version. *Journal of Traumatic Stress, 16,* 495-502.

Schnurr, P. P., Friedman, M. J., & Bernardy, N. C. (2002). Research on posttraumatic stress disorder: Epidemiology, pathophysiology, and assessment. *Journal of clinical Psychology/ In session, Psychotherapy in Practice*, *58*, 877-889.

Schoenfeld, F. B., Marmar, C. R., & Neylan, T.C. (2004).Current concepts in pharmacotherapy for posttraumatic stress disorder. *Psychiatric services, 55,* 519-531.

Simmons, C. A., & Granvold, D. K. (2005). A Cognitive Model to Explain Gender Differences in Rate of PTSD Diagnosis. *Brief Treatment and Crisis Intervention, Oxford Journals*. 5(3):290-299

Stein, M. A., Jang, K. L., Taylor, S., Veron, P. A., & Livesley, W. J. (2002). Genetic and environmental influences on trauma exposure and posttraumatic stress disorder symptoms: A twin study. *American Journal of Psychiatry, 159,* 1675-1681.

Sumerfield, D. (2001).The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ, 322,* 95- 98.

Taylor, S. (2006). *Clinician's guide to PTSD: A Cognitive-Behavioural Approach.* The Guilford Press, New York.

Weathers, F. W. & Ford, J. (1996) Psychometric properties of the PTSD Checklist (PCL–C, PCL–S, PCL–M, PCL–PR). In Measurement of

Stress, Trauma and Adaptation (ed. B. H. Stamm). Lutherville, MD: Sidran Press.

Westbrook, D., Kennerly, H., & Kirk, J. (2007). *An Introduction to CBT skills and approaches* 2nd (Eds). London: SAGE Publications Ltd

World Health Organisation. (1992). *ICD-10 classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines*. Geneva: Author.

## Appendix A
## DSM-IV criteria for PTSD

Criterion A: stressor
The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behaviour.

Criterion B: intrusive recollection
The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal
Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

# Appendix B

## Paul's initial PTSD Checklist questionnaire

### PTSD Checklist (PCL)

Page 1 of 1

Patient Name: [redacted] Date: 3/6/13

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it,** please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was [redacted] (EVENT) on [redacted] (DATE)

**Instructions:** Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month.**

| BOTHERED BY | NOT AT ALL | A LITTLE BIT | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 1. Repeated disturbing memories, thoughts, or images of the stressful experience? | 1 | 2 | (3) | 4 | 5 |
| 2. Repeated, disturbing dreams of the stressful experience? | 1 | 2 | 3 | (4) | 5 |
| 3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)? | 1 | 2 | (3) | 4 | 5 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 1 | 2 | 3 | (4) | 5 |
| 5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience? | 1 | 2 | 3 | (4) | 5 |
| 6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it? | 1 | 2 | (3) | 4 | 5 |
| 7. Avoiding activities or situations because they remind you of the stressful experience? | 1 | (2) | 3 | 4 | 5 |
| 8. Trouble remembering important parts of the stressful experience? | (1) | 2 | 3 | 4 | 5 |
| 9. Loss of interest in activities that you used to enjoy? | 1 | (2) | 3 | 4 | 5 |
| 10. Feeling distant or cut off from other people? | 1 | (2) | 3 | 4 | 5 |
| 11. Feeling emotionally numb or being unable to have loving feelings for those close to you? | 1 | (2) | 3 | 4 | 5 |
| 12. Feeling as if your future will somehow be cut short? | 1 | (2) | 3 | 4 | 5 |
| 13. Trouble falling or staying asleep? | 1 | 2 | 3 | (4) | 5 |
| 14. Feeling irritable or having angry outbursts? | 1 | (2) | 3 | 4 | 5 |
| 15. Having difficulty concentrating? | 1 | 2 | 3 | (4) | 5 |
| 16. Being "super alert" or watchful or on guard? | 1 | 2 | 3 | 4 | (5) |
| 17. Feeling jumpy or easily startled? | 1 | 2 | (3) | 4 | 5 |

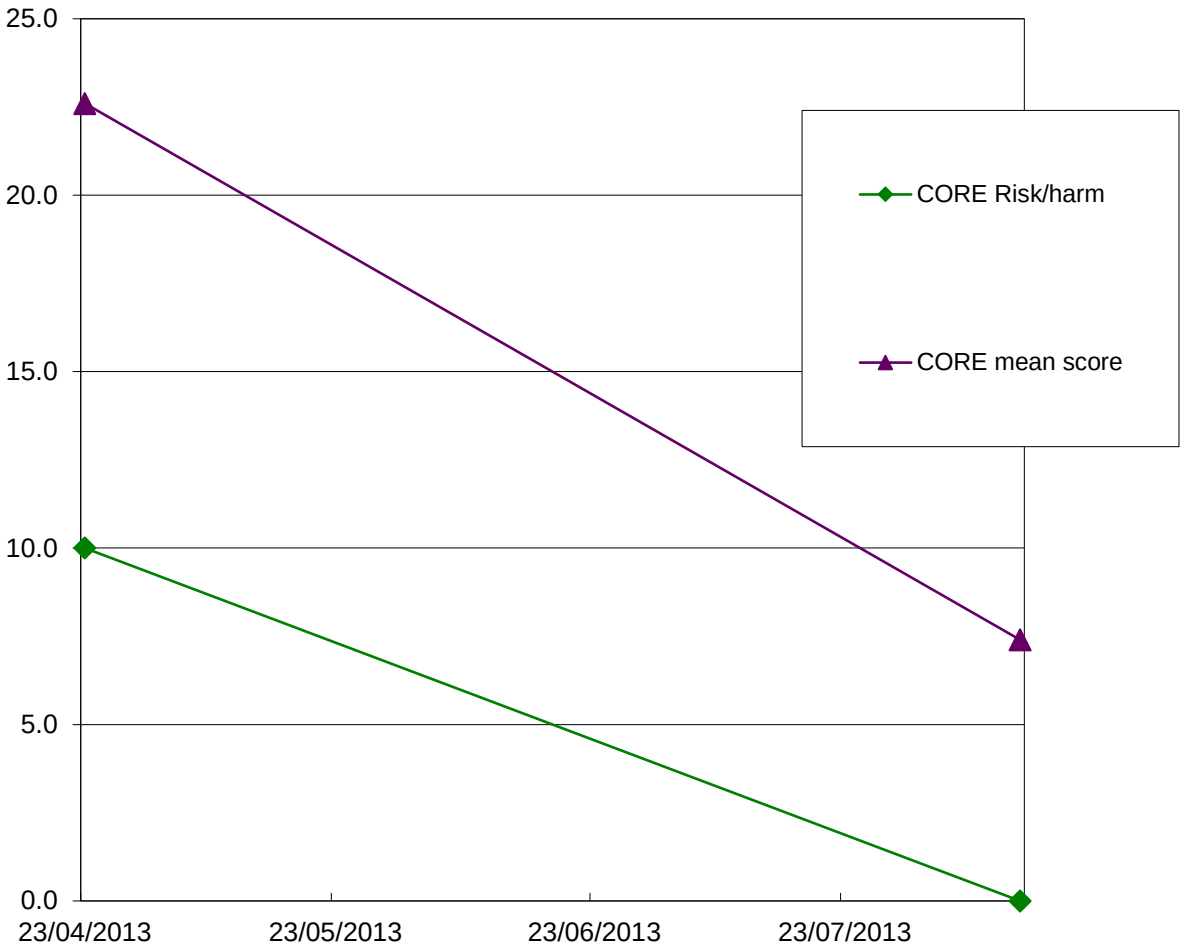
CO-OCCURRING DISORDERS PROGRAM: SCREENING AND ASSESSMENT



40 17

## Appendix C

### Graph of CORE scores



# Appendix D

## Paul's end of therapy PTSD Checklist questionnaire

### PTSD Checklist (PCL)



Patient Name: [redacted] Date: 13/8/13

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it,** please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was [redacted] (EVENT) on [redacted] (DATE)

**Instructions:** Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month.**

| BOTHERED BY | NOT AT ALL | A LITTLE BIT | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 1. Repeated disturbing memories, thoughts, or images of the stressful experience? | 1 | (2) | 3 | 4 | 5 |
| 2. Repeated, disturbing dreams of the stressful experience? | (1) | 2 | 3 | 4 | 5 |
| 3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)? | (1) | 2 | 3 | 4 | 5 |
| 4. Feeling very upset when something reminded you of the stressful experience? | (1) | 2 | 3 | 4 | 5 |
| 5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience? | (1) | 2 | 3 | 4 | 5 |
| 6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it? | (1) | 2 | 3 | 4 | 5 |
| 7. Avoiding activities or situations because they remind you of the stressful experience? | 1 | (2) | 3 | 4 | 5 |
| 8. Trouble remembering important parts of the stressful experience? | (1) | 2 | 3 | 4 | 5 |
| 9. Loss of interest in activities that you used to enjoy? | 1 | (2) | 3 | 4 | 5 |
| 10. Feeling distant or cut off from other people? | (1) | 2 | 3 | 4 | 5 |
| 11. Feeling emotionally numb or being unable to have loving feelings for those close to you? | (1) | 2 | 3 | 4 | 5 |
| 12. Feeling as if your future will somehow be cut short? | 1 | (2) | 3 | 4 | 5 |
| 13. Trouble falling or staying asleep? | 1 | (2) | 3 | 4 | 5 |
| 14. Feeling irritable or having angry outbursts? | (1) | 2 | 3 | 4 | 5 |
| 15. Having difficulty concentrating? | 1 | (2) | 3 | 4 | 5 |
| 16. Being "super alert" or watchful or on guard? | 1 | 2 | (3) | 4 | 5 |
| 17. Feeling jumpy or easily startled? | 1 | (2) | 3 | 4 | 5 |

Case Study ‘Aaron’ SYP A

**Contents**

## Case Overview and Reason for Referral

Aaron[4], is a 28 year old British Caucasian male, assessed as having a mild[5] intellectual disability[6](ID). Additionally he has a diagnosis of a progressive neurological condition HSP (Hereditary Spastic Paraparesis), which has resulted in Aaron being physically disabled. He was referred to the Community Learning Disabilities Psychology Service by his Occupational Therapist requesting psychological intervention due to 'experiencing symptoms of low mood'. Aaron has historically received input from the psychology team. This report describes the process of assessment, formulation, intervention and evaluation undertaken with Aaron. It followed a cognitive model of complex working with a comorbid presentation. It concludes with a reflection on my personal learning and an evaluation of my effectiveness as a therapist.

## Literature review

### Epidemiology

Research of prevalence rates of comorbid ID and mental health problems varies, debate suggests it can be up to 40% of this population (Borthwick-Duffy, 1994; Raghavan, 2012). Furthermore the debate highlights depression as the most common mental health problem experienced (Clarke,

[4] Informed consent gained, Aaron was deemed to have capacity to consent according to the Mental Capacity Act (2005), he had the ability to comprehend, retain and use the information in decision making, information will be anonymous and pseudonyms used throughout the report to maintain confidentiality.

[5] The term 'mild' will be used throughout the report for readership ease, although the current term is 'significant'.

[6] 'Intellectual disability' is the term that will be used to describe 'learning disability', 'developmental disability'.

1999, Cooper & Collacott, 1996; Lowry, 1998; Nezu, Nezu, Rothenberg, Dellicaipini & Groag, 1995). There are however problems with the empirical evidence of the epidemiology within this population. The reasons are said to be, research using biased samples with inadequate methods of identification (Smiley, 2005), sample selection, diagnostic methods (self-report, carers' reports, observation) and the chosen definition of psychiatric disorder and learning disability which can be diverse (Dagnan, Jahoda, & Kroese, 2007).

Evidence indicates having a physical illness and an ID increases the risk of depression by two to three times equating to 20% in this population (NICE,2009b). However, it should be noted that physical illness can complicate assessment as symptoms experienced manifest in both physical illness and depression.

**Aetiology**

It has been argued that people with ID are at greater risk of developing a mental health problem due to the potentially increased exposure to social disadvantage (Emerson & Hatton, 2007). Additionally, it is felt this group experience more losses and changes, low self-esteem, lack of support, control and poor coping skills (Priest & Gibbs 2004).

Theories have been developed to explain the symptoms, development and maintenance of depression. The methods usually used within the intellectual disabled population are; behavioural, cognitive, systemic and

psychodynamic (Oliver & Smith, 2005). I will now describe the two psychological theories of depression relevant to this case.

*The behavioural theory of depression*

The behavioural approach is based on operant conditioning theory where behaviour is deemed to be learnt through positive and negative reinforcement and punishment (Murphy, 1994). Therefore behavioural accounts of depression focus upon relationships between individual and context (Zettle, 2007). The behavioural model of depression informing the formulation and intervention reported here was described by Fersyer (1973). He argued that depression developed as a consequence of loss and the absence or decrease of positive reinforcement or the inability to obtain positive reinforcement. Also discussed is secondary coping strategies that maintain the depression, such as, avoidance which negatively reinforces and hinders positive reinforcement. If an individual experiences a person withdrawing from them, and therefore loses access where they once had positive reinforcement, there may be loss of a social opportunity, as social deprivation (Emerson & Hatton, 2007) produces reduced positive reinforcement as Fersyer (1973) states.

It is believed that an increase in positive encounters within behavioural therapy, such as, behavioural activation will alleviate the depression (Hopko, Lejuez, Le Page, Hopko, & McNeil, 2003; Martell, Addis, & Jacobson, 2001). There is limited research on the effectiveness of this technique for people with an ID therefore we have to look to the studies within the wider population which

have shown it to be effective (Jacobson, et al. 1996). The goal of this type of therapy is to increase rewarding behaviour through social and purposeful activities that individuals enjoy (Lewinson, Antonuccio, Steinmetz & Ter, 1984). This then improves their mood, however, the emphasis in this therapy is that you need to start doing things before you will feel better, to ensure you break out of passive and unrewarding behaviour. Behavioural activation has been found to be effective (Jacobson, et al. 1996).

*The cognitive theory of depression*

Cognitive theory focuses on a person's thought processes. It argues that emotions are the consequence of appraisal (Beck, 2008). Beck's depression theory (1976) suggests that depressed people think in a biased way, negatively interpreting events. He argued that in childhood a negative-biased thinking develops leading to a negative view of the world. This may occur through perceived loss, relentless tragedies, social rejection or criticism. Beck argued that the negative-biased thinking is activated in new situations resembling conditions where the biased thinking was learned. This biased thinking is maintained by the cognitive distortions held, which is how we view our self, the world and the future, as Beck (1967) coined, the negative cognitive triad.

For example, an individual with a negative view of themselves and the world may be in a situation where they are left out of a group; this may trigger negative thoughts about themselves, such as, worthlessness. CBT has been used as a therapy for people with physical illnesses (Morley, Eccleston &

Williams, 1999) Writers on the application of cognitive therapy for people with a physical illness have highlighted the following illness-related beliefs as pertinent causes of illness (they or others to blame), the duration and course of illness and how the illness will affect the 'patient's' life and significant others (Halford & Brown, 2009).

## Treatment

CBT is based on cognitive theory and incorporates behavioural techniques. It is an empirically supported psychological intervention for people with depression. It involves techniques for changing cognitive processes, for example, by helping to develop alternative adaptive thoughts, identifying and challenging negative automatic thoughts and the underlying assumptions, such as, viewing the self as worthless (Beck, 1976).

There is a large body of empirical evidence supporting the use of cognitive-therapy and the role of the process, identified by Beck (1976), in the general population (see, Dobson and Shaw, 1986; Fredrickson,1998; Segal, Gemar, Truchon, Guirguis & Horowitz, 1995; White, Davison, Haaga & White, 1992). Evidence supporting CBT use within the ID population is weaker. The majority of evidence uses case studies and case series which highlight success for a variety of mental disorders, including anxiety, depression, anger, PTSD, sexual offending and psychosis (Bhaumik, Gangadharan, Hiremath & Russell, 2011; Lindsay, 1999; Willner, 2005). Other authors argue we should assume that empirically supported psychological treatments tested in the general adult

population are suitable for use with people who are classified with borderline or mild ID (Bhaumik et al. 2011).

There are some practice recommendations for adapting CBT for people with mild ID (Whitehouse, Tudway, Look & Stenfert-Kroese, 2006; Willner, 2009) see Table 1.

**Table 1: Adaptations of CBT for ID (Willner, 2009)**

| Technique | Adaptation |
|---|---|
| 'Simplification' | Broken down interventions into small sections, shorter session lengths |
| Language | Reduce level of vocabulary, sentence structure, use simple words |
| Involve-caregivers, | Use carers to aid change, to help with homework |
| Disability approaches | Be aware of disability and address it, support positive self-view |
| Transference/counter transference | Stronger attachments, ensure structured boundaries |
| Directive therapy | More directive therapy, role of teacher as compared to guide |

Aaron has a mild ID: he is able to express his thoughts, feelings, emotions, thoughts of death and suicidal ideation which are required to undertake CBT (Smiley & Cooper, 2003; Meins, 1995; Marston, Perry & Roy, 1997; NICE, 2009a). The CBT model provides a framework to follow, including, initial work on behavioural aspects for example, addressing Aaron's inactivity and secondly work on the negative appraisal of self (Willner, 2009). Cognitions were a considerable part of Aaron's presentation therefore a cognitive-behavioural approach was deemed appropriate.

## Assessment

During assessment information was gathered from Aaron, his family and other professionals working with him. I used psychometric assessments, file review and clinical interview to elicit the information. To assess Aaron's motivation, he was asked if he wanted help at this time and we set goals jointly. Motivation and consent to therapy were assessed at each session. It was important when I interviewed Aaron to increase the difficulty of questions incrementally. I used simple open questions, such as, "can you tell me more about that?". Research has found, when questions are perceived as difficult, susceptibility increases (Bull, 1995; Sigelman et al, 1981). Dagnan and Chadwick (1997) felt adapted cognitive therapy needed to include three core activities in a cognitive-emotional assessment to be suitable for people with learning disabilities. These were identifying the antecedents, beliefs and consequences, engaging in collaborative empiricism and measuring change. Information was gathered addressing these three areas.

### Presenting problems

Aaron was referred for 'symptoms of low mood'[7]. Through the use of Socratic questioning Aaron described his problems as thinking "what's the point", "I can't do anything" which led to him to stay in bed and sleep more (social withdrawal/loss of positive reinforcement) he acknowledged this made

[7] If Aaron were to be diagnosed DSM V, he was experiencing symptoms of major depression (see Appendix A). Diagnosis and mild to moderate ID has been highlighted as appropriate (McBrien review, 2003).

him “feel bad”. He reported he would ruminate about the things he could not do and wished he could do more. He reported he had no energy or motivation. Using the laddering down technique Aaron stated, “I don’t have a life”.

**Relationships/Family/ Early experiences**

Aaron grew up in a busy house full of people (his mother, father, younger brother and lodgers). At the point of referral there were just Aaron and his father living together with much less social contact. He had friends but he did not see them very often and used social media sites to network occasionally. This changed during therapy when he moved into a livelier house with his brother’s family (wife and four children). This increased his opportunity to spend time with young people and to go out. When Aaron was in school he was bullied by other children and later coped with this by “fighting back”, founding this led him to be left alone.

Aaron reported that he was very strong when he was younger. He described being able to walk up the stairs on his hands (in the handstand position). He was very active and wanted to join the Army. His HSP has resulted in Aaron becoming physically disabled, losing his capacity to be independent, an ongoing part of his condition.

## Onset of difficulties

Over the past year Aaron's wheelchair use has developed from occasional to constant. His symptoms of low mood started when he had multiple falls during the day if he did not use his wheelchair. He has also required additional support in his daily living skills, such as, completing hygiene tasks. He described that he is "lazy", "not able to do anything", "getting weaker" and "not living".

I deduced from Aaron's file review that his low mood historically followed a pattern where he himself noticed a deterioration in his physical capabilities. His previous referral to psychology followed him being fully able to needing to use a wheelchair occasionally. The work focussed on identity and loss.

## Cognitions

Aaron's key cognitions influenced his low mood, maintained by the principal cognitive biases (shown in italics) described by Beck (1976). For example, Aaron would often refer to his age and that this was in conflict with the way he perceived he was treated. He reported he had wanted to move out like his brother. I used the laddering down technique to explore further what the key issue was for Aaron and this uncovered that he often felt vulnerable and like a child. He described that he sometimes felt he was being "grounded" (*Magnification and Minimisation*) and when he was in his wheelchair, he

perceived that “people treat me differently in the chair” (negative appraisal). These impact his view about himself as discussed later in the formulation.

**Risk assessment**

Risk assessments were completed which was especially pertinent because of the increased likelihood of Aaron’s suicide risk due to his physical health problems as epidemiological studies have reported (NICE, 2009b). Aaron disclosed low intent but continual thoughts of suicidal ideation. He also reported one historical suicide attempt. Whilst there was no immediate risk, this required monitoring. Aaron’s protective instincts towards others were a protective factor and he has alluded to this stopping him currently as he looks after his nieces and nephews.

**Psychometric assessments**

Depression was measured throughout therapy using the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983). This is a valid mainstream measure which Aaron had previously used. The Person Rated Outcome Measure (PROM) was also administered to obtain Aaron’s perception of therapy.

*HADS*

The HADS is a brief assessment of anxiety and depression with 14 items, seven on each subscale. It has good internal consistency, for anxiety between 0.80-0.93, and depression 0.81-0.90 (Lisspers, Nygren & Söderman, 1994). Snaith (1987) found coexisting general medical conditions do not bias results. Aaron scored 8 (see Table 2), highlighting mild depression, which is supported by information gained during clinical interview. However Aaron's answers were sometimes inconsistent with information he provided later in the session, which suggested he was more depressed than the HADS showed. This prompts questions about its validity.

**Table 2: Psychometric assessments results, HADS**

| | **Pre-therapy** |
|---|---|
| Anxiety | 6* |
| Depression | 8** |

Note: *0-7 Normal,** 8-11 Mild, ***12-14 Moderate, ****15-21 Severe
Scored on s 4 point scale

*PROM*

The PROM is an outcome measure devised by the Trust psychologists to obtain service-users' perceptions of the outcome of therapy. It comprises five items. The scoring range can be seen in Table 3. The results highlight Aaron felt unhappy, wanted to do more and low mood was a big problem.

**Table 3: Person Rated Outcome Measure (PROM)**

| Question | Pre-therapy |
|---|---|
| How do I feel?* | 2 |
| How am I getting on with the people important to me?* | 4 |
| Am I doing as much as I want to?* | 2 |
| How much of a problem is low mood?** | 1 |
| Do you feel better or worse? | n/a |

*The scores are on a scale 0-5 with 0 being very unhappy and 5 being very happy.
**The score is on a scale 0-10 with 0 being a big problem and 10 being a little problem.

## Formulation

A developmental CBT framework (Beck, Rush, Shaw & Emery, 1979), developed collaboratively, was used to formulate Aaron's difficulties (see Appendix B).

Aaron reported being bullied in school and found that when he fought back he was left alone. He then equated this with a need be strong, to defend himself. As his physical condition deteriorated Aaron found he was unable to do things. He stated he, "feel(s) weak" (negative automatic thought) and anxious about being vulnerable. This had impacted on his behaviour and his core beliefs.

Growing up Aaron viewed people with a physical disability as weak. He now worries what others may think about him having a physical disability. However, he often tries to hide this. If he hears negative comments Aaron's mood lowers which can trigger suicidal thoughts. For example, when a friend he met on a social network site made a derogatory comment about his disability, he later felt, "what's the point" and experienced suicidal ideation.

Aaron's interpretation of himself has been impacted by these experiences, where he has a negative cognitive bias. As Aaron noticed his deterioration he expressed negative appraisals about himself ("I am disabled and weak"), others ("no one will want to be around me") and the future ("there is nothing I can do", "what is the point of being here"). These beliefs were further confirmed by his rejection when bullied at school, and by people he met during online socialising. Aaron reported he enjoys spending time with others. He is a sociable person and benefits from mixing with others. Rejection, real and perceived, has a detrimental effect on his mental health.

The assessment highlighted that Aaron's low mood followed a pattern where Aaron would notice a deterioration, the sense of loss (trigger) and then would experience symptoms of depression. His coping strategy was avoidance (social withdrawal). He would avoid completing tasks that may make him appear 'weak' and he stopped completing activities that he enjoyed. Aaron has historically refused activities he reported as enjoying such as, 'wheelchair rugby'. Currently he would stay in bed, had disturbed sleep and would not complete any activity including personal hygiene tasks. He would think "what's the point", "I can't do anything", which furthered his desire to stay in bed. Staying in bed feeling depressed led him to have less energy and in turn feel 'weak'. This further led to the thoughts about being unable to do anything and nobody wanting to be around him, which upset him. Thus, his negative cognitive biases were maintained by inactivity, social isolation and loss of a lively household.

The formulation highlighted two areas that required work, inactivity and cognitive distortions. Aaron set his first goal as increasing his activity levels to decrease his low mood as he identified this was impacting him the most.

## Intervention

The treatment plan followed the literature and NICE guidelines (2009b) where the person has mild depression and chronic physical illness. An adapted CBT framework was followed. We had seven one-hour weekly appointments at Aaron's home. We would summarise the previous session's work and orientate ourselves to the focus of that particular session. The intervention was planned in two stages, one increasing his activity and secondly looking at loss.

**Table 4: Overview of work**

| Session | Intervention target | Overview |
|---|---|---|
| Initial sessions | Building a trusting therapeutic relationship | Getting to know you exercises,<br>Modelling a trusting relationship to discuss difficult issues |
| Initial sessions | Normalising depression | We discussed what depression was. Normalised Aaron's experience using the formulation- helping Aaron understand the links between his experiences and the impact they currently had |
| Initial sessions | Socialise to treatment | Set goals and discussed the aim of the intervention<br>Psycho-education about behavioural activation |
| Initial sessions | Sleep hygiene | Psych-education about sleep hygiene, e.g. useful bedtime routines e.g. not doing stimulating activities (such as watching T.V. or playing on x-box) |
| Middle sessions | Inactivity | Building motivational change and energy for additional work to be undertaken<br>Collected information about what Aaron was currently doing, what he used to do and what he would like to do.<br>Set weekly plans to include different activities. |
| Middle sessions | Lack of positive reinforcement | Identified activities Aaron valued, identified whether positive reinforcement followed activity |
| Final sessions | Endings | Completed BA work recap on theory<br>Ensured support in place for interim to new service<br>Sent a report with my formulation and recommendations for future work |

**Behavioural activation**

We discussed what behavioural activation was and why it might be useful for Aaron. This was done using concrete examples. We addressed what he was doing now and how inactivity made him feel. We devised a list of activities he liked, which I recorded. As Aaron had an avid interest in films we discussed how much he enjoyed activities on a scale of 1 to 5 stars, akin to film ratings. This seemed to work well for Aaron to conceptualise his level of enjoyment. We discussed the aim of BA, to set realistic achievable goals, including previously enjoyed activities that Aaron could commit to.

Together we made a plan to increase his activity with some involvement from Aaron's father to ensure certain activities could happen on certain days. To identify whether positive reinforcement followed activity, information was gathered from Aaron and external sources. As Aaron struggled with writing we agreed he could ask his father to help him complete his 'star rating' before and after the activity. As this used a lot of his father's time the information was not consistently recorded. Therefore we changed this to ensuring a discussion took place afterwards and that all activities Aaron completed went into the family diary just as his hospital appointments did. Aaron highlighted activities he did not enjoy by describing them as boring. When he liked an activity he would ask to do it again. These would be confirmed by the person involved, for example, going shopping was an activity Aaron enjoyed. His family would report his increased mood during and after the trip. We used these to document the positive reinforcement gained.

## Progress

Aaron started to see his low mood improve. He went out more and had a role collecting his niece and nephew from school, “I have to pick them up”. When we did some comparisons with Aaron before he started to do more he linked that when he is active and sociable his mood is improved compared to when he stays in bed doing nothing, “I feel better now I am more active”.

Aaron was slowly coming to terms with his physical disability and he became more aware of his limitations. A change produced during therapy was unrealistic activity suggestions decreased to become more realistic. We used psychometrics and outcome measures to monitor change and evaluate the therapy to be discussed later in the report. Aaron is now in a place where his negative appraisals about himself can be addressed.

## Planned work

Had Aaron not moved out of area we would have moved onto additional work. Table 5 shows an overview of the potential work planned.

**Table 5: Overview of cognition work**

| Target | Overview | Method |
|---|---|---|
| Socialisation/psycho-education | Orientate to CBT<br>Normalise his reaction to degenerative illness | Discuss goals and what we will target<br>Learning about the role of thoughts and appraisal in maintaining low mood |
| Identify positive coping strategies<br>and<br>risk assessment | Aaron expresses suicidal ideation and has a historical suicide attempt. He reported he would not commit suicide but it would need monitoring.<br>Explore what Aaron finds useful | Exploring positive coping strategies that work for Aaron such as, relaxation, distraction<br><br>Monitoring risk in sessions and through feedback from Aaron and family. |
| Negative appraisal of 'Physical disability' label | Exploring his current and historical thoughts about disability and view about himself having a disability (NATs)<br><br>Collect information about positive interactions and positive rewards | Socratic questioning<br>Thought diaries (assistance from family) or verbal discussion in therapy, potential role play to re-enact a recent problematic experience (Westbrook, Kennerley & Kirk, 2011).<br>Positive data log |
| Identify cog biases/NATs | Aaron displayed 'all or nothing thinking' he viewed things as either good or bad.<br>Aaron had 'Unrealistic expectations' occasionally such as, jobs that did not consider his disabilities, army. | Thought challenging evidence for and against them (Greenberger & Padesky, 1995)<br>Behavioural experiments to test thoughts |
| Target cognitions | If I am physically disabled, I am weak,<br>If I am weak I can't do anything,<br>If I can't do anything there is no point in living.<br><br>If I am weak and vulnerable then I will be | Thought challenging |

| | | |
|---|---|---|
| | alone, if I am alone there is no point being here. | |
| Target cognition | Guilt about past behaviour towards people with a disability and sadness about the future he feels he lost. | Re-appraisal of these instances |
| Address positive/negative-bias | Collect information about positive interactions and positive rewards | Positive data log |

*Potential Problems*

Working with Aaron I would anticipate the following as potential barriers. Aaron would require help to complete some interventions such as, thought diaries or behavioural experiments between sessions. Previously his father had little time to assist in interventions; hopefully Aaron will have more support in his new home. Carers would need educating to record Aaron's information verbatim and not 'correct' or interpret his comments. This would require monitoring.

## Evaluation

### End of therapy assessments

Psychometric measures were administered at the start and end of therapy.

*HADS, PROM & Person Rated Evaluation Measure (PREM) Results*

**Table 6: HADS psychometric assessment results**

| | Pre-therapy | Post-therapy |
|---|---|---|
| Anxiety | 6 | 4 |
| Depression | 8 | 0 |

**Note**: *0-7 Normal,** 8-11 Mild, ***12-14 Moderate, ****15+ Severe

**Table 7: PROM psychometric assessment results**

| Question | Pre-therapy | End of therapy |
|---|---|---|
| How do I feel?* | 2 | 4.5 |
| How am I getting on with the people important to me?* | 4 | 5 |
| Am I doing as much as I want to?* | 2 | 4 |
| How much of a problem is low mood?** | 1 | 8 |
| Do you feel better or worse? | n/a | Better |

*The scores are on a scale 0-5 with 0 being very unhappy and 5 being very happy.
**The score is on a scale 0-10 with 0 being a big problem and 10 being a little problem.

**Table 8: PREM psychometric assessment results**

| Question | End of therapy |
|---|---|
| What has been good about working with me? | “talking to somebody”, “learning about his disability” and “talking about films” |
| What could have been done better? | “Nothing I can’t think of anything” |
| If you had another problem would you come and see someone like me again? | “Yes” |

The HADS results show that Aaron is not experiencing anxiety or depression at a clinically significant level. The PROM also shows improvement in his low mood which was our initial aim. However, there is still a clinical problem as Aaron has a distressing response to falls (experiencing suicidal ideation surrounding his physical disability). This is an instant emotive reaction to the perceived set back. It may be that his generalised depression has gone but focussed cognitive work surrounding his disability would hopefully stop this

instant response. This does highlight, however, the validity of the psychometric measure HADS, as using this alone would suggest Aaron did not have a clinical problem.

*Observation*

Aaron reported that he now “had a life”, was going out more, had a routine, and a role he enjoyed, picking “the kids up” from school (active). Aaron acknowledges and accepts he has a degenerative disease, however, sometimes he wishes this was not the case. Aaron was able to identify his problematic behaviours, such as, staying up late and being tired meant he became overwhelmed more easily the next day when things arose that he would normally cope with. Aaron had a routine and was able to enjoy things again, appearing less depressed than when we first met.

## Reflection

The following section demonstrates my reflections and what I learnt from the work completed with Aaron, using the ABC model (Ellis, 1991) (see Tables 9 & 10 in Appendix C).

Working with Aaron I became anxious when he told me he was to leave the area which meant discharge from our service. The anxiety stemmed from fear about the work we had undertaken not being good enough and that the report I was to write would need to be perfect, including everything the new

service needed to know about him (responsibility bias). This was partly due to anxiety about not being able to complete our work together.

I thought that I was utilising supervision in a non-autonomous manner as I discussed this case more frequently. My negative appraisals were ‘I have not done enough work with him’, ‘If I am a bad therapist I may be causing harm’ ‘Which means that I am incompetent in my job’ (see Table 9 in Appendix C for full laddering).

I used evaluation measures to monitor change and received subjective feedback from Aaron about therapy. I believe Aaron benefited from the work we did together, “I have a life”. The techniques used helped him to recognise the impact making the changes had had on his mood. Using my skills as a psychologist to gather information, analyse and incorporate it into practice then collate what was needed for the report, increased my confidence in my abilities. This also made me feel less anxious. The experience further developed my reflective skills as a practitioner. I could see progression from my previous placement, as I now had confidence in reflecting on my work and behaviour and in utilising supervision. It also improved my anxiety management skills ensuring it did not affect therapy.

Due to the complexity of Aaron’s circumstances, his beliefs about himself are still having an impact on his mood. There was a sense of the work being unfinished due to his move out of area. Reflecting on this case I learnt that I have a responsibility bias and this initially had an impact on my work. I was

over-interpreting my influence on the ending of our work.  I also reflected on what makes therapy effective. Aaron was still experiencing distress at the end of therapy. Although in this case further work is needed, removal of all upset is not necessarily required. Aaron's level of distress, where he was having emotive reactions resulting in his suicidal ideation meant he required further help. However, I would now not strive to remove all upset but work towards removing disabling distress. Aaron has a degenerative disease and for him that is the worst thing because of the effects it has had on his life. He will at times become upset about this, which is manageable unless it turns into disabling stress. This has had an impact on reducing some of the responsibility I took as a therapist and increased my belief that I have competencies.

## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Beck, A.T. (1967). *Depression: clinical, experimental, and theoretical aspects.* New York: Hoeber. Republished as *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania Press).

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* London, England: Penguin Books.

Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American Journal of Psychiatry, 165*, 969–977.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: The Guilford Press.

Bhaumik, S., Gangadharan, S., Hiremath, A., & Russell, P.S. (2001). Psychological treatments in intellectual disability: the challenges of building a good evidence base. *The British journal of Psychiatry, 198*, 428-430.

Borthwick-Duffy S. A. (1994) Epidemiology and prevalence of psychopathology in people with mental retardation. *Journal of Consulting and Clinical Psychology, 62,* 17 – 27.

Bull, R.H.C. (1995). Interviewing people with communicative disabilities. In R. Bull, & D. Carson (Eds.), *Handbook of Psychology in Legal Contexts*. Wiley: Chichester.

Clarke, D. (1999). Functional psychoses in people with mental retardation. In N. Bouras (Eds.), *Psychiatric and behavioural disorders in developmental; disabilities* (pp.188-199). Cambridge: Cambridge University Press.

Cooper, S., & Collacott, R. (1996). Depressive episodes in adults with intellectual disabilities. *Irish Journal of Psychological Medicine, 13,* 105-113.

Dagnan, D., Chadwick, P. (1997). Cognitive behaviour therapy for learning disability. In B. Stenfert-Kroese, D. Dagnan, k. Loumidis. (Eds.), *Cognitive behaviour therapy for people with learning disability* (pp. 114-127)*. London:* Routledge.

Dagnan, D., Jahoda, A., Stenfert-Kroese, B. (2007). Cognitive behavioural therapy and people with intellectual disabilities. In A. Carr, G. O'Reilly, P. Walsh. & J. McEvoy, (Eds.), *The Handbook of Clinical Psychology and Intellectual Disability and Clinical Psychology Practice* (pp.281-300). London: Routledge.

Dobson, K.S., & Shaw, B.F. (1986). Cognitive assessment with major depressive disorders. *Cognitive Therapy and Research, 10,* 13-29

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal for Clinical psychology, 38, 215-219.

Ellis, A. (1991). The revised ABC's of rational-emotive therapy (RET). *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *9*(3), 139–172

Emerson, E., & Hatton, C. (2007). Mental health of children and adolescents with intellectual disabilities in Britain. *The British Journal of Psychiatry, 191*(6), 493-499.

Fersyer, C.B. (1973). A functional analysis of depression. *American Psychologist, 28*, 857-870.

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

Greenberger, D., & Padesky, C. A. (1995). *Clinician's guide to mind over mood*. New York: The Guilford Press.

Halford. J., & Brown,T. (2009). Cognitive-behavioural therapy as an asjunctive treatment in chronic physical illness. Advances in Psychiatric Treatment, 15, 306-317.

Hopko, D.R., Lejuez, C., LePage, J., Hopko, S., & McNeil, D. (2003). A brief behavioural activation treatment for depression:A randomized pilot trial within inpatient psychiatric hospital. *Behaviour modification, 27,* 458-469.

Jacobson N.S., Dobson K.S., Truax P.A., Addis, M.E., Koerner, K., Gollan *J.K., et al.* (1996). A component analysis of cognitive-behavioural treatment for depression. *Journal of Consulting and Clinical Psychology 64*, 295–304.

Lewinsohn, P., Antonuccio, D., Steinmetz, J., & Teri, L. (1984). The coping with depression course: A psycho-educational intervention for unipolar depression. Eugene, OR: Castalia.

Lindsay, W.R. (1999). Cognitive therapy. *Psychologist,12*, 238-241.

Lisspers, J., Nygren, A., & Söderman, E. (1997). Hospital Anxiety and Depression Scale (HAD): some psychometric data for a Swedish sample. *Acta Psychiatrica Scandinavia, 96,* 281–286.

Lowry, M. (1998). Assessment and treatment of mood disorders in persons with developmental disabilities. *Journal of Developmental and Physical Disabilities, 10*(4), 387-406.

Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). Depression in context: Strategies for guided action. New York: W. W. Norton.

Marston, G.M., Perry, D.W. & Roy, A. (1997). Manifestations of depression in people with intellectual disability. *Journal of Intellectual Disability Research, 41,* 476-480.

McBrien, J. A. (2003). Assessment and diagnosis of depression in people with intellectual disability

Meins, W. (1995). Symptoms of major depression in mentally retarded adults. *Journal of Intellectual Disability Research, 39,* 41-45.

Ministry of Justice. (2005).*Mental Capacity Act code of practice*. London: TSO.

Morley. S., Eccleston, C., Williams, A. (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain, 80,* 1-13.

Murphy, G. (1994). Understanding challenging behaviour. In E. Emerson, P. McGill, & J. Mansell (eds.), *Severe learning disabilities and challenging behaviours-designing high quality services.* London: Chapman and Hall.

Nezu, C., Nezu, A., Rothenberg, J., Dellicaipini, L., & Groag, I. (1995). Depression in adults with mild mental retardation – are cognitive variables involved? *Cognitive Therapy and Research, 19*(2), 227-239.

NICE (2009a) *Depression: The Treatment and Management of Depression in Adults (update).* National Clinical Practice Guideline Number 90. London: Author.

NICE (2009b) *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management*. National Clinical Practice Guideline Number 91. London: Author.

Oliver, B., & Smith P. (2005). Psychological interventions for people with learning disabilities. In E.G., Holt, S., Hardy, N. Brown. (Eds.), *Mental health in learning disabilities a reader*. (pp.41-48). Brighton: Pavilion

Priest, H., & Gibbs, M. (2004). *Mental Health care for people with learning disabilities*. London: Churchill Livingstone.

Raghavan, R. (2012). Intellectual disabilities and mental health. In R. Raghavan (Eds.), *Anxiety and depression in people with intellectual disabilities: Advances in interventions.* Hove:Pavilion publishing and media ltd.

Segal, Z.V., Gemar, M., Truchon, C., Guirguis, M., & Horowitz, L.M. (1995).A priming methodology for studying self-representation in major depressive disorder. *Journal of Abnormal Psychology, 104*, 205-213.

Seligman, M. E. P. (1981). A learned helplessness point of view. In L, Rehm. (Eds.), *Behavioural therapies for depression*. New York: Academic Press.

Smiley, E., & Cooper, S.A. (2003). Intellectual disability, depressive episode and diagnostic criteria for psychiatric disorders for use with adults with Learning Disability/Mental Retardation (DC–LD). *Journal of Intellectual Disability Research, 4*7(1), 62–71.

Smiley, E. (2005). Epidemiology of mental health problems in adults with learning disability: an update. *Advances in Psychiatric treatment, 11*, 214-222.

Snaith, R. P. (1987). The concepts of mild depression. *British Journal of Psychiatry* 150, 387-393.

Westbrook, D., Kennerly, H., & Kirk, J. (2007). *An Introduction to CBT skills and approaches* 2nd (Eds). London: SAGE Publications Ltd

White, J., Davison, G. C., Haaga, D. A. F., & White, K. (1992). Articulated thoughts and cognitive distortion in depressed and nondepressed psychiatric patients. *Journal of Nervous and Mental Disease, 180,* 77-81

Whitehouse, R.M., Tudway, J.A., Look, R., Stenfert-Kroese, B. (2006). Adapting individual psychotherapy for adults with intellectual disabilities: a comparative review of the cognitive-behavioural and psychodynamic literature. *Journal of Applied Research of Intellectual Disabilities, 19*, 55-63.

Willig, C. (2009). Introducing qualitative research in psychology adventures in theory and method 2nd ed Open University Press: McGraw Hill, England.

Willner, P. (2005). The effectiveness of psychotherapeutic interventions for people with intellectual disabilities: A critical overview. *Journal of Intellectual Disability Research, 49,* 73-85.

Willner, P. (2009). Psychotherapeutic interventions in learning disability: focus on cognitive behavioural therapy and mental health. *Psychiatry*,*8*(10). 416-419.

Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using acceptance and commitment therapy in treating depression.* Oakland, CA: New Harbinger Publications

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavia, 67,* 361-370.

## Appendix A

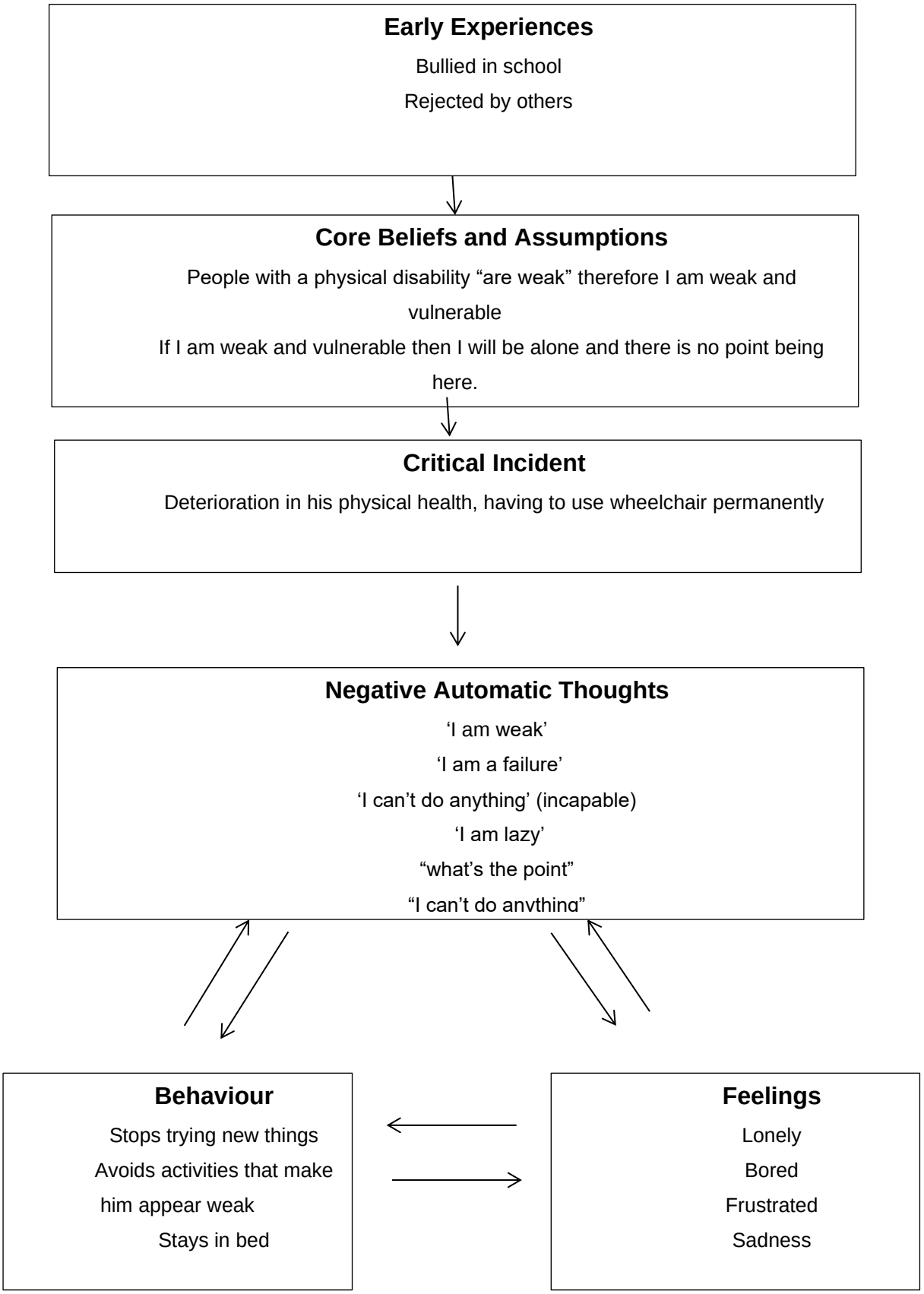
Major Depressive Disorder -DSM V- Diagnostic Criteria, American Psychiatric Association (2013)

| **Diagnostic criteria** | |
|---|---|
| A | Five or more of the following symptoms have been present during the same 2-week<br>period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure.<br>(**Note:** Do not include symptoms that are clearly attributable to another medical condition.)<br>1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)<br>2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)<br>3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)<br>4. Insomnia or hypersomnia nearly every day<br>5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)<br>6. Fatigue or loss of energy nearly every day<br>7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)<br>8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)<br>9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide |
| B | The symptoms do not meet criteria for a mixed episode. |
| C | The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. |
| D | The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism). |
| E | The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. |

**Note:** Criteria A-C represent major depressive episode.

**Appendix B**

Beck (1979) Depression Model



## Appendix C

ABC model formulation

**Table 9: CBT formulation of anxiety using the ABC model**

| Activating event | Beliefs | Consequences |
|---|---|---|
| Referring service-user to a different Trust | I have not done enough work with him<br><br>I have not collected enough information<br><br>What if the report is not good enough<br><br>I need to give them all the information<br><br>If I don't give them everything I am not good enough to do this<br><br>If am not good enough I am a bad therapist – and may cause harm<br><br>If I cause harm, I am incompetent in my job | **Emotions**<br>Anxiety<br><br>**Behaviours**<br>Reading over all session notes<br><br>Spending lots of time writing up the report. Writing more drafts than usual worrying about words used and the format.<br><br>Utilising supervision to discuss the work completed and the report. |

**Table 10: CBT formulation of updated learning using the ABC model**

| Activating event | Beliefs | Consequences |
|---|---|---|
| Discussion in supervision | I have been utilising supervision throughout the case to discuss my hypotheses and work undertaken<br><br>My supervisor has been supportive and not said she thinks my method needed to be changed<br><br>My supervisor was pleased with the report written, I would not be allowed to send a report that was not up to standard and did not contain all the relevant information<br><br>I have been working autonomously I must have some skills to carry out the appropriate | **Emotions**<br>Less anxious<br>Increased confidence (in abilities)<br><br>**Behaviours**<br>I went to discuss the final report with the service-user to ensure happy with the information and not misrepresented<br><br>Prepared the information as I would normally and followed my end of therapy checks, information up-to-date and all documentation filled in, for example, risk assessment. |

| | | |
|---|---|---|
| | therapy and write reports to document what we have done with recommendations<br><br>It is not all my responsibility | Use of supervision to reflect |

## Assessment of Personal Effectiveness (APE)

Evaluation of personal effectiveness is an important part of psychologists work. Evaluating effectiveness provides opportunities to improve practice. Exploring the relationship between therapist and service-user and its impact on working together has long been a part of practice (see Freud, 1958). This relationship has been analysed to view the impact it has on service-user recovery (outcomes). Empirical research has evidenced that a positive therapeutic relationship[8] is one of the best predictors of service-user outcomes (see Orlinsky, Rønnestad,& Willutzki 2004). Thus, evaluating this relationship within therapy is important. It has been argued that therapist prediction about the potential success of therapy outcomes is not as accurate as service-users', as analysed using rating scales (Bachelor & Horvath, 1999). This conflict between the two appears feasible, if a service-user does not think therapy is going to work, there is the potential for disengagement resulting in the ending of therapy before work has been addressed. Research has highlighted the importance of a good relationship and accurate measurement. In order to achieve this it is important to get feedback from the service-users worked with. Duncan, Miller and Sparks (2004) suggested that for professionals to get the most direct impact on mental health change requires affecting the service-users' perception of the alliance. The report will focus on APE in relation to the therapeutic relationship.

[8] The term 'therapeutic relationship' will be used throughout for terminology related too, 'working alliance', 'therapeutic alliance'

## Method

I followed the service's practice administering measures to obtain outcome and evaluation information about service-users subjective accounts of therapy. Three male service-users aged between 21-28, with an intellectual disability participated. Questionnaires were administered pre-therapy, session one (PROM) and post-therapy, final session (PROM and PREM)[9]. The PROM was completed independently, but due to writing abilities and confidence I transcribed responses for the PREM.

## Results

Table 1 in Appendix A shows outcome information from the service-users to provide background information. Most showed an improvement in how they felt, what they were doing and the initial problem they came to therapy to address. The PREM comprises three questions see Table 2 for the results.

[9] See Appendix A and B for a Table of the questions and results PROM and the questions asked in PREM.

**Table 2: Person Rated Evaluation Measure (PREM) results**

| **What has been good about working with me?** |
|---|
| Service-user 1: “talking to somebody”, “learning about his disability” and “talking about films” |
| Service-user 2: “it’s been useful”, “easy to talk to” and “good advice” |
| Service-user 3: “nice to see me” |
| **What could have been done better?** |
| Service-user 1: “Nothing I can’t think of anything” |
| Service-user 2: “I can’t think of anything” and “I don’t know” |
| Service-user 3: “I don’t know” |
| **If you had another problem would you come and see someone like me again?** |
| Service-user 1: “yes” |
| Service-user 2: “yes” |
| Service-user 3: “yes” |

## Analysis

The data received could not be analysed using a specific research method as the information gathered was sparse and a meaningful analysis would not be achieved. Following qualitative data good practice, using meaningful data could not be met (Elliot, Fischer, & Rennie 1999; Willig, 2009). Therefore I will be reflecting on the data collected and discuss the limitations of the tool used to gather data.

All information gained from participants appears to be positive, suggesting we had positive encounters. The responses do not highlight any improvements for therapy and they all would receive help from a psychologist again if they needed it. In relation to working with me, it seems we potentially had a good therapeutic relationship. They highlighted speaking to me was a good thing, working with me, “talking to somebody” and “easy to talk to”. The

quote “nice to see me” suggests that they viewed our relationship as positive and no improvements were highlighted. There is no mention of techniques used within therapy. However drawing conclusions from this data would be tenuous due to the limitations it poses.

## Evaluation

The results allude to service-users who have had a positive experience of therapy and building a therapeutic relationship. There were problems with the data collection, both the method and the effectiveness of the PREM.

I collected the dictated responses. There are multiple problems with this. The first is the likelihood of socially desirable responses. This may be due to me as the subject in question whilst documenting their responses. Additionally, as the end of therapy had been reached, a good relationship built, potentially the service-user did not want to make a negative or constructive comment at this stage. There is also the possibility of increased acquiescence in the sample population. It would have potentially been beneficial to ask someone, such as the carer, to complete the form or perhaps leave the measure at the final session to be posted or collected. However there is potential to receive incomplete data.

The measure itself did not provide adequate information. The Service’s requirements were to gain information from the service-user to help improve future practice. The questions posed were perhaps too vague. They were left

open so that anything could be mentioned but perhaps it would be more useful, to ask specific questions pertaining to therapeutic relationship such as, ‘how much have I helped?’, ‘what was it about me helped?’ It has been argued that session-by-session (progress) feedback such as, receiving outcome and therapeutic relationship information, improves service-user outcomes, including, being more likely to stay in therapy longer, less likely to deteriorate and twice as likely to attain clinically significant change (Castonguay, Barkham, Lutz, & McAleavey, 2013; Shimokawa, Lambert, and Smart, 2010; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). Johnson, Miller and Duncan (2000) designed a tool with good reliability and validity with a Cronbach’s coefficient alpha α=0.88 and test retest 0.70. Issues surrounding, wanting to please the therapist would still be present.

This project has highlighted the pitfalls with data collection at one time point, including inability to use feedback to refine practice during therapy. There would potentially be other techniques to evaluate effectiveness, such as, being observed in session as the additional person could be reflective. This may need to be used in conjunction with service-user-ratings due to the literature highlighting the conflicting ratings between therapist and service-user. There is potential to use drop-out rates, however it would be hard to know the circumstances of the drop-out if only using numbers and data collection may pose difficulties.

In conclusion, to evaluate effectiveness I would use session-by-session ratings due to the benefits proposed and documented as the most effective, include additional data such as, observation and feedback.

## References


Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B.L. Duncan, & S. D.Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178).Washington, DC: APA Press.

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin & Garfield's Handbook of psychotherapy and behaviour change* (6th ed.). New York: Wiley.

Duncan, B., Miller, S., & Sparks, J. (2004). *The heroic client: A revolutionary way to improve effectiveness through client directed, outcome informed therapy*. San Francisco: Jossey Bass.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal for Clinical psychology, 38, 215-219.

Freud, S. (1958). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. London: Hogarth Press (Original work published 1913).

Johnson, L. D.,Miller, S. D., & Duncan, B. L. (2000). *The Session Rating Scale 3.0.* Chicago: Author.

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2003). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307-390). New York: Wiley.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-

analytic review of a psychotherapy quality assurance system. *Journal of Consulting & Clinical Psychology, 78,* 298–311.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem solving strategies in routine practice. *Journal of Counseling Psychology, 50*, 59-68.

Willig, C. (2009). Introducing qualitative research in psychology adventures in theory and method 2nd ed Open University Press: McGraw Hill, England

## Appendix A

PROM questions and responses

**Table 1: Person Rated Outcome Measure (PROM) results**

| | Service-user 1 | | Service-user 2 | | Service-user 3 | | Service-user 3 carer | |
|---|---|---|---|---|---|---|---|---|
| Question | Pre-therapy | End of therapy | Pre-therapy | End of therapy | Pre-therapy | End of therapy | Pre-therapy | End of therapy |
| How do I feel?* | 2* | 4.5* | 3* | 2* | 5* | 5* | 5 [i] | 7[i] |
| How am I getting on with the people important to me?* | 4* | 5* | 4* | 1* | 5* | 4* | 7 [i] | 8[i] |
| Am I doing as much as I want to?* | 2* | 4* | 2* | 5* | 4* | 4* | 7 [i] | 8[i] |
| How much of a problem is low mood?** | 1** | 8** | 0** | 4** | 0** | 5** | 8 [i i] | 4[ii] |
| Do you feel better or worse? | n/a | Better | n/a | The same | n/a | Better | n/a | The same |

*The scores are on a scale 0-5 with 0 being very unhappy and 5 being very happy.
**The score is on a scale 0-10 with 0 being a big problem and 10 being a little problem.
[i] The scores are on a scale 0-10 with 0 being very unhappy and 10 being very happy.
[ii] The score is on a scale 0-10 with 0 not a problem and 10 a big problem.

## Appendix B

The questions used in PREM

The original document had symbols to accompany the questions.

What has been good about working with me?
What could have been done better?
If you had another problem would you come and see someone like me again?
Yes or no

**Case Study April SYP B**

# Table of Contents

## Case Overview and Reason for Referral

April[10] is a 12 year old girl who was referred by her GP (General Practitioner) to the Clinical Psychology team at the hospital. The referrer requested a psychological intervention to help with April's anxiety and behavioural difficulties. The following report details the process of a systemic assessment, formulation, intervention and evaluation undertaken with both April and her parents and concludes with personal reflection.

## Literature Review

### Epidemiology

Research suggests that anxiety is the most common mental health difficulty amongst children and adolescents (Bernstein & Borchardt, 1991). During these developmental stages anxiety can present as separation-anxiety-disorder (SAD), phobias, generalised anxiety disorder (GAD), obsessive-compulsive-disorder (OCD) and post-traumatic-stress-disorder (PTSD) (APA, 2013; Carr, 1999; WHO, 1992). Prevalence studies estimate a 5-19% incidence of anxiety disorders in children and adolescents (Costello, Egger & Angold, 2004; National Institute of Mental Health; NIMH 2004), with symptoms usually emerging by six years of age (NIMH, 2004) as experienced by April.

It has been argued that anxiety can often manifest differently within the developmental trajectory of childhood and adolescence (Morris & Kratchowill, 1991; Ollendick, King & Yule, 1994; Schroeder & Gordon, 1991) (see appendix A for extended table). The course of anxiety can also be complicated by high rates of co-morbidity; indeed research suggests that up to 79% of anxious young people present for treatment with co-morbid disorders (Kendall, Brady & Verduin, 2001; Verduin & Kendall, 2003). Most noticeably, it has been shown that one-third of children who present with SAD often present with GAD (Kendall Brady & Verduin, 2001; Masi, Mucci, Favilla, Romano & Poli, 1999). Although April primarily presented with SAD, she also appeared to fit several of

[10] Informed consent gained. Pseudonyms used throughout the report to maintain confidentiality.

the criteria for GAD, and was also at the age where these disorders are believed to manifest (see Appendix A and B).

## Aetiology

The literature pertaining to the effectiveness of anxiety interventions is less established in the child and adolescent population as opposed to adults (Carr, 2009a; b). The following section is a description of two theories relevant to this case in explaining how anxiety may develop.

### Attachment theory

Attachment theory (Bowlby, 1973) purports that a crucial part of child development is their attachment to adult caregivers. Bowlby (1973) argues that children are born with an instinctive drive to seek close proximity to adult caregivers in order to be protected from harm. When caregivers cannot provide a secure relationship, a child may develop non-healthy coping strategies and an insecure attachment style. Indeed, anxiety has been described as a fundamental condition underlying an insecure or ambivalent attachment (Bowlby, 1973; Warren, Huston, Egeland & Sroufe, 1997). Whilst it has been argued that inconsistent or overprotective care-giving stimulates chronic anxiety in the attached child (DeKlyen, & Greenberg, 2008), the relationship between anxiety in childhood and attachment requires further investigation (Cassidy, 1995).

There has been further research into the role of attachment figures in the development of SAD (see Mannnis & Bradley, 1994; Thurber, 1996). However information about the onset, relationships and attachment patterns is unclear. Bowlby (1988) suggested that the development of SAD occurred from our basic human instincts of survival. A child responding to separation from their caregiver is the same as our survival feared response when we noticed changes in movement or marked changes in light or sound. When separation is suggested or threatened it creates intense anxiety. It can however also arouse anger especially in children and adolescents, as it did with April. The response of the young person aimed to stop the attachment figure from leaving but this

can become dysfunctional. Whilst an attachment approach was considered for April the prevalence of the family relational difficulties highlighted a need for a systemic approach.

## Systemic Theory

Systemic theory moved the conceptualisation of difficulties from an intrapersonal (viewing problems as occurring from within the person) to an intrapersonal perspective (viewing difficulties as occurring within family systems) (Bateson, 1972, Minnuchin, 1978). The structural approach focused on the patterns/interactions in the family structure (Minnuchin, 1974) whilst the Milan approach (Selvini Palazzoli et al, 1978; 1980) emphasised the meanings each part of the system (family) had for one another's actions and the communication patterns that emerged. This feedback from one another is believed to influence patterns of interacting (Hedges, 2005). The shift to a social constructionist approach viewed difficulties as developing through language and cultural contexts (Dallos & Draper, 2010). Although structural, Milan and social constructionist take somewhat different approaches; difficulties are seen to arise through circularity as opposed to linearity (Cecchin, 1987; Watzlawic, Weakland &Fisch, 1974), emphasising feedback processes where a range of individuals' actions and meanings affect one another (Bateson, 1972). A therapist takes a position of neutrality and curiosity to enable multiple perspectives and change (Cecchin, 1987). Although systemic therapy has seen changes over time, the different approaches share the same theoretical underlying principle of understanding psychological difficulties/distress within the context of social relationships (Boston, 2000).

Whilst the effectiveness of anxiety treatments is more established for adults than children and adolescents (Carr, 2009a; b), a recent review conducted by Carr, (2000) found evidence to support the effectiveness of systemic interventions for a range of disorders, including anxiety. This supports other reviews such as Shadish and Balwin's (2003) meta-analysis of family therapy for children, adolescents and adults, which also supported the efficacy

of this approach. Whilst little evidence is known for the specific variations of systemic therapy (Asen, 2002; Cotterell & Boston, 2002), common ground is evident amongst the different systemic interventions with no apparent difference in outcome (Baucom, Shoham, Mueser, Daiuto & Stickle, 1998).

According to Vetere and Dallos (2003), a systemic approach is deemed appropriate if there are clear precipitative factors within the family, evident relational difficulties or client awareness of connections between their difficulties and relational issues within the family or other systems. At the time of assessment it became evident that there were some relational difficulties within the family and therefore systemic therapy was deemed appropriate. Following Vetere and Dallos' (2003) guidance, the systemic approach was therefore considered appropriate. It should be noted that this model although systemic in addressing interpersonal constructs where change takes place, it is lacking in its intellectual coherence with no clear section belonging to one systemic approach.

Assessment

Whilst systemic therapy makes less of a distinction between assessment, formulation and intervention (Dallos & Draper, 2010), they will be discussed separately for this report.

It became evident that April's difficulties needed to be explored in the context of her family. The assessment was ongoing, however a substantial portion of information was gathered during the first four sessions. Some sessions were conducted with the whole family and some with just April's parents (June and Stuart). Clinical interviews were conducted guided by systemic principals (e.g. patterns in communication, circular questioning, being impartial in order to obtain multiple perspectives) (Vetere & Dallos, 2003) to elicit the information. In order to map out relationships between family members circular questions were used (e.g. who would notice when you get anxious? When April doesn't want to leave and mum says we have to go what happens next?). Reflexive questions were designed to elicit family beliefs (e.g. asking

each member of the family to consider how another member may feel in the same situation), in addition to pressures within the family including exceptions of when they felt the difficulties did not occur (e.g. have there been times that hasn't been the reaction?) (Donovan, Mastroyannopoulou, & Cobner, 2002). I used my skills in active listening, empathy and respect to build relationships. The family were asked to observe their interactions and 'incidents' that occurred. Additional information was gathered through liaison with other professionals working with the family and I conducted a file review for additional information.

Risk assessment

During the first two sessions June and Stuart were talking in a very negative and open manner which may have been interpreted by April as them believing she is a failure. Whilst it may have not been intended in such a way, there was some concern regarding how this may affect April if this sort of conversation occurred regularly. Therefore, this was addressed in a separate session with mum and dad in order to discuss how such conversations may be perceived by April.

**Table 1: The assessment format**

| Assessment component | Aim |
|---|---|
| Review of letters in Aprils file | To examine<br><br>Information from referrer, any historical information about impact of anxiety on family, previous psychological help, risk assessments |
| Interview with Mum and April | To explore<br><br>Triggers to her anxiety; beliefs held about others; relationships with others; coping strategies to manage anxiety; feelings towards anxiety; contextual factors, childhood history |
| Interview with Mum, dad and April | To explore<br><br>Relationships, patterns of talk; exceptions, worries now and the future |
| Interview with mum and dad | To explore<br>Beliefs about the triggers for April's anxiety; their relationship with April; current ways of relating to April and April's responses; coping strategies; contextual factors, time line. |

## Formulation

Conceptualisation of April's anxiety followed the integrative formulation proposed by Dallos and Draper (2010) which uses a uses a five-part systemic formulation (1) the problem deconstruction, (2) contextual factors, (3) beliefs and explanations, (4) problem maintaining patterns and feedback loops and (5) emotions and attachments which draws on a range of systemic principles. Whilst the five different components do not necessarily fit into the different strands of systemic theory, there is overlap between the sections and the different schools. In line with systemic approaches, a formulation was developed of the difficulty rather than the diagnosis (Vetere & Dallos, 2003).

### (1)The problem deconstruction

April's GP defined the problem as SAD and challenging behaviour. April's parents saw the problem as SAD and as something that lies within April and something *she* needed to change. They saw her as defiant, angry, stubborn and resistant to change, citing a key difficulty as April "*not trying to help herself*" which they found very "*frustrating*". April believed she was anxious sometimes but "*people are just getting on at her*". April appeared worried that if she did complete a task then there may be an expectation for her to continue doing this when she was experiencing anxiety.

June and Stuart also felt that April was isolating herself (e.g. spending time in her room, not replying to texts). June believed April should prove her wrong and try more. Both felt April was "*doing it on purpose now*", believing it had become habit rather than true anxiety (she is not anxious but feels should be).

### Exceptions to the problem and competencies

The family described some exceptions to the problem. For example, they had been on nice holidays; April had also walked home from school by herself. June and Stuart have described April as, funny, clever, loving, kind, helpful and

trusting. April had been able to leave the house to play at a friend's in the past and had even stayed overnight.

(2) Contextual factors

April displayed her anxious behaviour wherever she was and did not appear to mind others seeing her reactions. She currently only attends school if her mum is to take her in. However April displayed avoidant behaviour (staying in bed till the last minute to try and not go in), or anxious behaviour, which escalated to aggression. April's anxiety usually presented itself before school but also before going out on trips e.g. staying at friends' houses.

Grandma and Granddad place no boundaries when they look after April and "let her get on with it", "do whatever she wants" including picking her up and taking her places in the car. April feels safe at home and prefers to be in the house. When her parents go out for the night grandma and granddad have to come to the family home as April will not sleep out. grandma and granddad's boundaries are different and therefore their experiences with April are different.

(3) Beliefs and explanations

Jane and Stuart believe that April is missing out they believe she is isolating herself and if she does that then she will lose all her friends and become depressed as she gets older, possibly leading to self-harm.

April believes that her anxiety is a part of who she is and questioned the point in changing if she is managing to do the things she wants to do. She is also experiencing anger and frustration being constantly asked to "go to the shop to show you can do it." However, June believes that although she is anxious like she was when she was younger, "you just get on with things even when you don't like it."

June appears to have a discourse about adolescence for a teenage girl, relating to April needing to be more independent and sociable e.g. seeing

friends all the time, going into town to window shop and inviting friends over. April does not share this discourse.

(4) Problem maintaining patterns and feedback loops

There is a main feedback loop that occurs in most situations. This is when they must leave the house to go anywhere or when they ask April to do something. The following section will show the feedback loop between April and June although dad has described a similar feedback loop (see figure 1).

There seems to be a pattern of anger/frustration from both April and her parents in regard to April's perceived problem. When they are getting ready to leave the house June becomes anxious as she anticipates problems with April. April becomes anxious and scared when told they are to leave the house. April will then say she does not want to go and when repeatedly told they are going she will either say she is not going or not come into the hallway. This is interpreted as defiance and rejection by June who becomes frustrated. April continues to display distress and June then tries to rush the situation, sometimes physically pulling April out of the house. April displays anger at this point to which June perceives as rejection. This feeds back into the anxiety June feels about the situation and what others will think.

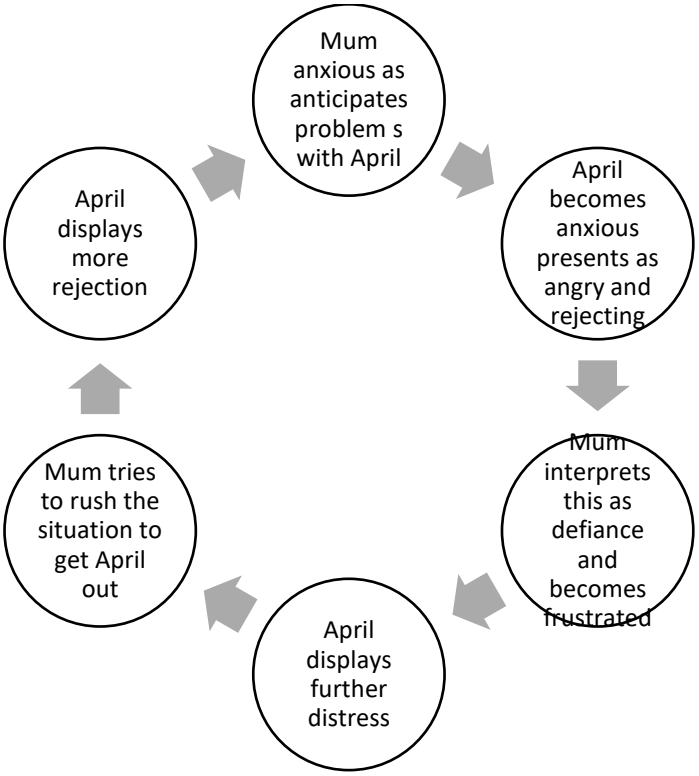



**Figure 1: Feedback loop of April's anxiety**

(5) Emotions and attachments

When April was a baby she suffered from Febrile convulsions[11] although these are common it led to Jane and Stuart feeling isolated, overwhelmed and not supported as no-one would look after April. Until April started school she hadn't been away from her parents. At nursery her grandma would stay and then her mum would stay for the afternoon. April had to be pulled off mum when she went to school in the past. Early experiences are believed to become a part of a person's 'working model', set of expectations, beliefs and reflections about the self and others (Bowlby, 1973; 1988).

April and her parents have had a few significant relocations. They have moved to and from Australia and UK multiple times. These occurred at some transitional stages in April's life (aged four, five, six and nine). April found it

[11] A febrile seizure is a fit that occurs when a child has a fever. (NHS Choices, 2014)

difficult to make friendship groups when in Australia as the children were older. She has a few friends now.

June and Stuart feel their relationship with each other and April has been impacted. They feel alone, tired and unsupported by family and let done by professionals. They would like the best for April, but feel they are met with resistance. At the moment they feel hopeless. April experiences this as rejection at times as she is constantly reminded of her difficulties and that “there is something wrong with me.”

Intervention

Working with this family June and Stuart wanted April to have individual sessions. There were multiple reasons for conducting the sessions with the whole family. As Vetere and Dallos (2003) highlight, identifying the client’s preferred coping style as to which method would be more effective. April preferred systemic due to her anxiety. Furthermore as highlighted in the assessment, the relational difficulties could be addressed with a systemic intervention. We aimed to meet weekly however this did not happen due to the families availability and holidays. We met six times over three months with sessions lasting one hour. (see table 2 for an overview). The intervention consisted of four sessions of formulation, which also formed part of the intervention. Due to time restraints of placement and school holidays I had not finished working with this family. We held a handover session where I passed the work onto my supervisor. However I will discuss the work completed and what I would have done had the work been able to progress.

Facilitating new connections between beliefs, behaviour and relationships is the aim of the intervention (Vetere & Dallos, 2003). The goals of the treatment were to; (1) help make sense of April’s difficulties in relation to the family and (2) to explore the possibility of different relationships within the family. As with the formulation an integrative systemic approach was used in the intervention using elements from the different schools of systemic theory.

A strategic intervention was used by introducing new information into the system. This occurred through psycho-education (a combination of structural techniques and behavioural interventions (Anderson, 1983; Leff et al, 1982). The family was educated about anxiety. This related to what anxiety is, why it occurs and how it can be experienced both physiologically and emotionally. This helped to normalise April's reactions and provided a conceptual change in relation to how anxiety is experienced in different situations (re-framing, Dallos & Draper, 2010).

There were elements of a structural intervention (Minuchin et al, 1975) thinking about the subsystems and the boundaries where information flows from April to her parents. This can occur where the parents are not attuned (Zimberoff, & Hartman, 2002) to April's need. If the boundaries are differently experienced with perhaps treating April like an older child whilst April perhaps felt younger due to the difficulties she was experiencing difficulties can arise. June did highlight she felt April was naïve in some aspects. This would be further explored in later sessions.

The formulation was shared with a focus on the feedback loops/maintaining patterns to aid in the understanding. This formulation was discussed to enable the different beliefs surrounding the anxiety as experienced by the different members of the family. Alternative perspective questions were asked, such as, When you do not want to leave the house and mum is thinking you will be late for school what do you think she might be feeling? and vice versa for June. This helped both April and June to consider what the other experienced in the same situation. June could see how April's anxiety could be influencing how she reacted and what she might be feeling in that moment.

The beliefs that the different family members held about anxiety was understood. The next stage of the work was going to use a strategic approach (Hayley, 1963; Watzlawick et al., 1974). This can help identify behaviours aimed at supressing the symptom like avoidance which instead perpetuates it. For example, the anxious resistant behaviours may elicit parent's overprotective desires or punitive actions which in turn affect the interactions they have. Work

would have continued to use the circular questioning to enable the family to see how problems are being maintained by the patterns in their interactions, active questioning (e.g. if I were there what would I see?) and directive tasks for June and Stuart to carry out.

It may be that April does require some individual work learning some skills to help manage her anxiety and looking at some of the cognitions she may have. However it was felt that the priority was family work and if changes were made in the system they may be better placed to undertake successful changes. Individual psychological help with April was completed in the past with some success.

**Table 2: Overview of Sessions**

| Session | Attendees | Overview |
|---|---|---|
| 1 | June and April | Initial clinical interview information gathering |
| 2 | June and Stuart | Information gathering |
| 3 | June, April, Stuart | Information gathering<br>Observing communication<br>Psycho-education |
| 4 | June, April, Stuart | Observing communication<br>Circular conversations<br>Other person perspective |
| 5 | June and Stuart | Line graph anxiety |
| 6 | June and April | Review of therapy so far<br>Formulation<br>Evaluation<br>Handover |

Potential Problems

The problems I foresee are June and Stuart initially not being able to move from a position that the problem lies in April, that “all they need is for her to learn some skills and they can move on”. As a therapist I would have had to use my skills to ensure I stayed impartial and open to hearing everyone’s

perspectives and the ability to align with each member of the family. Due to presentation in previous sessions this would require monitoring as in this case becoming an advocate for April and aligning with her position could occur.

Evaluation

The systemic intervention holds a number of different constructs from the multiple goals obtained from the different family members therefore a different approach is taken to evaluation. Vetere and Dallos (2003) highlight the need to question how the work was guided and change facilitated. Furthermore the effectiveness of systemic intervention can be seen in the change of ideas, meanings and discourses in the family (Haydon-Laurelut, 2009). Had I collected baseline data for example a BAI measure I would possibly not be holding a neutral position.

Evaluation of the work would have been in the last session with the whole family where curious conversations to provide multiple perspectives on any change noticed could occur. I would have also used observations within sessions regarding how they communicated with each other and discussions between the family members.

I did conduct an evaluation in my last session of the work we had carried out. At the start Jane could not see others viewpoints. She reported that in the past she had viewed April's reactions as defiant and strong willed. However she felt after the psycho-education (introduction of new information) about anxiety that it had helped to normalise the anxiety reactions. This in turn aided the understanding of anxiety and how it is different for everyone which the family had not previously discussed. It enabled June and Stuart to think about April's perspective more. Mum reported that April had gone to the shop which she was "refusing" to do before. I wondered if the interactions between them all around this situation had changed to a less confrontational exchange compared to the past patterns of interacting.

Progress

June and April described more positive interactions, such as days out as a family and shopping trips. Their interactions within the session could still be negative which I believe will change over time with the continued work. However there was less discussion about ‘incidents’ in the sessions. Additionally, I observed that April’s tone of voice was louder in the sessions and she sat up straighter. June looked to April to let her speak rather than speaking for her in the last session.

## Reflection

I have predominately worked using a CBT framework in the past which meant it felt a little daunting using a systemic framework. Although I am interested in this way of working I felt exposed and lacking experience. I found it quite a different way to work even in the way questions are asked. In CBT socratic questioning and using the downward arrow to find the root of the difficulty is used. This is in contrast to the circular questioning and more the relational exploration of systemic, which I did enjoy.

I in turn have reflected on my position within that system. I found it quite challenging working with the three people in the room all providing differing opinions. The ability to concentrate on what is being said facilitate and try and use questions and introduce new ideas felt quite a challenge. One of the hardest parts I found with this case was the neutrality component. I felt that I could easily align myself to April as at times it felt like everyone was getting at her and the family firmly rooted the problem in her. Initially June was quite a difficult person and it could be hard to observe some of her interactions. This meant I had to use supervision to ensure I was keeping a neutral stance and discuss with my supervisor if I was picking up on one point of view. However as I was aware of the possibility of an alignment with April I had to check the impact this then had on the system. In one session I think I overcorrected the alignment and got pulled into the problem lies within April. It took a lot reflection with the session too to ensure I kept in a neutral stance. To try and ensure I kept a neutral stance I concentrated on ensuring circular questions were used

and alternative perspective questions and scenarios were highlighted. This may have been done more than I would in the future or with another family. I learnt that it can be hard to facilitate multiple opinions and self-reflection both in session and afterwards and supervision is key.

## References


Anderson, C. M. (1983). A psychoeducational program for families of patients with schizophrenia. In W. R. McFarlane (Eds.), *Family Therapy in Schizophrenia,* New York: Guildford.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (Fourth Edition).* Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (Fifth Edition).* Washington, DC: American Psychiatric Association.

Asen, E. (2002). Outcome research in family therapy. *Advances in Psychiatric Treatment, 8*, 230-238.

Bateson, G. (1972). *Steps to an ecology of mind*. New York: E.P. Dutton

Baucom, D.H., Shoham, V., Mueser, K.T., Daiuto, , A.D., & Stickle, T.R. (1998). Empiracally supported couple and family interventions for marita distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66*, 53-58.

Bernstein, G. A. & Borchardt, C. M. (1991). Anxiety disorders of childhood and adolescence: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(4), 519-532.

Boston, P. (2000). Systemic family therapy and the influence of post-modernism. *Journal of Continuing Professional Development, 6*, 450-457.

Bowlby, J. (1973).*Attachment and Loss, Vol. 2: Separation Anxiety and Anger.* London: Hogarth.

Bolby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge Classics.

Carr, A. (1999)*The handbook of child and adolescent clinical psychology: A contextual approach.* London: Routledge

Carr, A. (2000). Evidence based practice in family therapy and systemic consultation I: Child focused problems. *Journal of Family Therapy, 22*, 273-295.

Carr, A. (2009a). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 31*, 3-45.

Carr, A. (2009b). The effectiveness of family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 31*, 46-74.

Cassidy, J. (1995). Attachment and generalised anxiety disorder. In d. Cicchetti & S. Toth (Eds.), *Rochester Symposium on developmental Psychopathology: Vol 6. Emotion, Cognition and Representation* (pp.343-370). Rochester, NY:University of Rochester Press.

Cecchin, G (1987). Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. *Family Process, 26*(4), 405-13

Costello, E.J., Egger, H.L.,&Angold, A. (2004). Developmental epidemiology of anxiety disorders. In: T.H. Ollendick, J.S. March, (Eds). *Phobic and Anxiety Disorders in Children and Adolescents: A Clinician's Guide to Effective Psychosocial and Pharmacological Interventions* (pp.61-91). New York: Oxford University Press.

Cottrell, D. & Boston, P., (2002). Practitioner review: The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry, 43*(5), 573–586

Dallos, R., & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice*. UK: McGraw-Hill International.

DeKlyen, M., & Greenberg, M.T. (2008). Attachment and psychopathology in childhood. In J. Cassidy and P. R. Shaver (2nd Ed.), *Handbook of Attachment: Theory, Research and Clinical Applications* (pp.637-665). New York: The Guilford Press

Donovan, M., Mastroyannopoulou, K., & Cobner, R. (2002). Guidelines for systemic case reports and presentations. *Clinical Psychology*, *9*(1), 28-32.

Haydon-Laurelut, M. (2009). Systemic therapy and the social relational model of disability: enabling practices with people with intellectual disability. *Clinical Psychology & People with Learning Disabilities*, *7*(3), 6-13

Haley, J. (1963) *Strategies of Psychotherapy*. New York: Grune and Stratton.

Hedges, F. (2005). *An Introduction to systemic therapy with individuals. A social constructionist approach: Basic texts in counselling and psychotherapy.* New York: Palgrave Macmillan.

Kendall, P.C., Brady, E.U., &Verduin, T.L. (2001). Comorbidity in childhood anxiety disorders and treatment outcome. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 787-794.

Leff, J., Kuipers, L., Berkowitz, R., *et al* (1982). A controlled trial of social intervention in schizophrenic families*. British Journal of Psychiatry*, *141*, 121–134.

Manassis, K.. & Bradley, S.J. (1994). The development of childhood anxiety disorders: Toward an integrated model. *Journal of Applied Developmental Psychology, 15,* 345-366.

Masi, S.G., Mucci, M., Favilla, L., Romano, R., &Poli, P. (1999).Symptomology and comorbidity of generalised anxiety disorder in children and adolescents. *Comprehensive Psychiatry, 40,* 210-215.

Minuchin, S. (1974). *Families and family therapy*. London: Tavistock.

Minuchin, S. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge: Harvard University Press.

Minnuchin, S., Baker, L., Rosman, B. L., Liebman, R., Milman, L., & Todd, T. C. (1975). A conceptual model of psychosomatic illness in children. *Archives of General Psychiatry, 32,* 1031-1038.

Morris, R.J., &Kratchowill, T. R. (1991). Childhood fears and phobias. In T. Kratochwill& R. Morris (Eds.), *The Practice of Child Therapy* (2nd ed., pp.76-114). New York: pergamon.

Muris. P., Merckelbach, H., Mayer, B., et al. (1998). Common fears and their relationship to anxiety disorders symptomatology in normal children. *Personality and Individual Difference*, 24 (4), 575–8.

National Institute of Mental Health (NIMH) (2004). Children's Mental health awareness: Anxiety Disorders in Children and Adolescents Fact Sheet. Retrieved in 1 August 2014, http://www.nimh.nih.gov/health/publications/anxiety-disorders-in-children-and-adolescents/index.shtml

NHS Choices (2014). Febrile seizures. Retrieved on 1 August 2014, http://www.nhs.uk/conditions/febrile-convulsions/pages/introduction.aspx

Ollendick, T., King, N., & Yule, W. (1994). International Handbook of Phobic and Anxiety Disorders in Children and Adolescents. New York: Plenum.

Schroeder, C., & Gordon, B. (1991). Assessment and Treatment of Childhood Problems: A Clinicians Guide. New York: Guilford.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., *et al* (1978) *Paradox and counterparadox: A new model in the therapy of the family in Schizophrenic Transaction*. New York: Jason Aronson.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., *et al* (1980) Hypothesizing-circularityneutrality; three guidelines for the conductor of the session. *Family Process, 19,* 3–12.

Shadish, W.R., & Balwin, S.A. (2003). Meta-anlysis of MFT interventions. *Journal of Marital and Family Therapy, 29,* 547.

Thurber, C. A. (1996). Separation anxiety disorder and the collapse of anxiety disorders of childhood and adolescence. *Anxiety Disorders Practice Journal, 2,* 115-135.

Verduin, T., & Kendall, P. C. (2003). Differential occurrence of comorbidity within childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 32,* 290-295.

Vetere, A., & Dallos, R. (2003). Working systemically with families: Formulation, intervention and evaluation. London: Karnac.

Warren, S.L., Huston, L., Egeland, B., & Sroufe, L.A. (1997). Child and adolescent anxiety disorders and early attachment. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 637-644.

Watzlawick, Weakland, J., & Fisch, R. (1974) *Change: Principles of Problem Formation and Problem Resolution*. New York: W.W. Norton.

World Health Organisation. (1992). ICD-10 classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines. Geneva: Author.

Zimberoff, D., & Hartman, D. (2002). Attachment, detachment, nonattachment: Achieving synthesis. *Journal of Heart-Centered Therapies, 5(1),* 3-94

## Appendix A

Normative anxiety and fears in childhood and adolescence

(Morris & Kratochwill, 1991; Muris, Merckelbach, Mayer, *et al*., 1998)

| **Age** | | **Development Conditioned Periods of Fear and Anxiety** | **Psychopathological Relevant Symptoms** | **Corresponding DSM-IV Anxiety Disorder** |
|---|---|---|---|---|
| Early infancy | Within first weeks | Fear of loss, e.g., physical contact to caregivers | - | - |
| | 0–6 months | Salient sensoric stimuli | – | – |
| Late infancy | 6–8 months | Shyness/ anxiety with stranger | | Separation anxiety disorder |
| Toddlerhood | 12–18 months | Separation anxiety | Sleep disturbances, nocturnal panic attacks, oppositional deviant behaviour | Separation anxiety disorder, panic attacks |
| | 2–3 years | Fears of thunder and lightning, fire, water, darkness, nightmares | Crying, clinging, withdrawal, freezing, eloping seek for security and physical contact, avoidance of salient stimuli (eg, turning the light on), pavornocturnus, enuresis | Specific phobias (environmental subtype), panic disorder |
| | | Fears of animals | – | Specific phobias (animal subtype) |
| Early childhood | 4–5 years | Fear of death or dead people | – | Generalized anxiety disorder, panic attacks |
| Primary school age | 5–7 years | Fear of specific objects (animals, monsters, ghosts) | – | Specific phobias |

| | | | | |
|---|---|---|---|---|
| | | Fear of germs or getting a serious illness | – | Obsessive compulsive disorder |
| | | Fear of natural disasters, fear of traumatic events (eg, getting burned, being hit by a car or truck) | – | Specific phobias (environmental subtype), acute stress disorder, posttraumatic stress disorder, generalized anxiety disorder |
| | | School anxiety, performance anxiety | Withdrawal, timidity, extreme shyness to unfamiliar people and peers, feelings of shame | Social anxiety disorder |
| Adolescence | 12–18 years | Rejection from peers | Fear of negative evaluation | Social anxiety disorder |

## Appendix B

Separation Anxiety Disorder DSM -IV Diagnostic Criteria, American Psychiatric Association (1994)

| DSM IV criteria | Evidence from April |
|---|---|
| Developmentally inappropriate and excessive anxiety concerning separation from home or those whom the individual is attached, as evidenced by three or more of the following: | |
| Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated | Refuses to leave the house<br>Screaming and crying whenever she has to leave the house<br>Calls grandparents to come over to the house |
| Persistent and excessive worry about losing or about possible harm befalling a major attachment figure | Experiences specific worries with themes of death (by age 13, parents), |
| Persistent and excessive worry that an untoward event will lead to separation from major attachment figure (e.g. getting lost, being kidnapped) | Difficulty concentrating at school |
| Persistent reluctance or refusal to go to school or elsewhere because of fear of separation | Gets very angry easily<br>Will stay in bed so she has little time to get ready for school<br>Has had worries since she was very little |
| Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings. | She was unsure |
| Persistent reluctance or refusal or refusal to go to sleep without being near a major attachment figure, or to sleep away from home | Will not sleep away from home even at family members houses<br>Grandparents come to the family home if they look after her and she needs sleep |
| Repeated nightmares about separation | Mostly stays at home, does not visit friends as much as anxious, no longer |

| | |
|---|---|
| | participates in after school clubs, guides or scouts due to being anxious |
| Repeated complaints of physical symptoms(headaches, stomach aches, nausea and vomiting) when separation from major attachment figures occurs or is anticipate | Experiences anxiety symptoms on a daily basis |
| The disturbance lasts for at least 4 weeks | Ongoing since April was a toddler |
| It occurs before 18 years | Criteria met |
| The disorder causes clinically significant distress or impairment of social or academic functioning | Interferes with school work – can be very distressed so she is either taken out of class or does not go to class. |
| The disorder does not occur exclusively during the course of a psychotic disorder and is not accounted for by panic disorder with agrophobia | Criteria met |

## Appendix C

Generalised Anxiety Disorder DSM V- Diagnostic Criteria, American Psychiatric Association (2013)

| DSM 5 criteria | Evidence from April |
|---|---|
| Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance) | Has had worries since she was very little<br>Experiences anxiety symptoms on a daily basis<br>Experiences specific worries with themes of death (by age 13, parents), |
| The individual finds it difficult to control the worry | Feels she has no control over worry |
| The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months): **Note: Only one item is required in children** | |
| Restlessness or feeling keyed up or on edge | Often paces the house at home, feeling like 'I don't know what to do with myself' |
| Being easily fatigued | |
| Difficulty concentrating or mind going blank | Difficulty concentrating at school |
| Irritability | Gets very angry easily |
| Muscle tension | She was unsure |
| Sleep disturbance (difficulty falling or staying asleep or restless, unsatisfying sleep) | |
| The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning | Mostly stays at home, does not visit friends as much as anxious, no longer participates in after school clubs, guides or scouts due to being anxious<br>Interferes with school work – can be very distressed so she is either taken out of class or does not go to class. |
| The disturbance is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another condition (e.g., hyperthyroidism) | Criteria met |

| | |
|---|---|
| The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness or anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder). | Criteria met |

## Assessment of Personal Effectiveness (APE)

An evaluation of personal effectiveness is important as it provides the opportunity to improve practice. Research suggests, as analysed through rating scales, that therapist's predictions of potential therapy success outcomes is not as accurate as service-users' (Bachelor & Horvath, 1999). I chose to use an evaluation of a graded exposure intervention for a specific anxiety. This was conducted by using quantitative measures of subjective experiences of anxiety and observation of behaviour.

### Background

Ellie[12] is a 15 year old white British female who suffers from Chronic Fatigue Syndrome (CFS) and Generalised Anxiety Disorder (GAD). Ellie was referred for psychological intervention to conduct work on managing her anxiety. Although Ellie's anxiety was generalised the most distressing and disabling was a specific anxiety about leaving the house and she was using avoidance techniques. Ellie's anxiety would often impact her CFS as the energy expelled through her anxieties led to her becoming more tired. The use of behavioural treatments for managing anxiety such as, exposure is empirically supported (Department of Health, 2001; National Institute for Health and Care Excellence, 2013). Therefore we designed a graded exposure intervention collaboratively to help manage and reduce her anxiety. Whilst conducting our work together the impact of anxiety on Ellie's CFS and vice versa had to be considered.

### Method

#### Measures

During initial sessions it was observed and discussed that Ellie experienced a nervous energy when she became anxious. This in the past resulted in pen clicking, chewing gum, tapping, picking the skin on her fingers and twiddling fingers. I provided Ellie with a stress penguin which she could squeeze without drawing attention to herself or damaging her fingers.

[12] Pseudo-name used for confidentiality

The measures I used to evaluate the effectiveness of the intervention were; subjective measures of distress (SUDs) reported by Ellie as we conducted the graded exposure, an objective measure of how many times Ellie would squeeze the stress penguin and a progress measure the walking distance from the house depicted by how she progressed up the hierarchy ladder (see table 1 below).

**Table 1: Hierarchy table, distance from house (safe place)**

| Session | Step | Distance in feet |
|---|---|---|
| 1 | Walk a quarter of the way down the street | 107 |
| 2 | Walk half way down the street | 215 |
| 3 | Walk to the end of the street | 430 |
| 4 | Walk around the corner | 450 |
| 5 | Walk around the corner half way to park gate | 500 |
| 6 | Walk to the park gate | 550 |
| 7 | Walk to the climbing frame in park | 650 |

**Intervention**

Firstly, I conducted psycho-education surrounding anxiety. This included what it was, normalising it as a reaction and explaining why it occurs. Secondly, we discussed the rationale for treatment. This included a description of graded exposure why it is used and how it may be helpful for Ellie. Thirdly, we collaboratively developed a hierarchy of needs. The first goal was broken down, we developed an exposure ladder with a number of experiments to build her confidence. Ellie would rate her anxiety on a scale from 1-10 where 1 was feeling comfortable and 10 was wanting to run-away from the situation. These SUD ratings were taken regularly but the numbers reported here are at the point we were furthest away from home when Ellie's distress was at its peak. Ellie would practice with me and practice in the week with her father two to three times a week. Finally, an introduction to diaphragmatic breathing was used to help make exposure acceptable to the Ellie. Although there is some discussion as to whether this is a replacement form of distraction (Craske, Rowe, Lewin, & Noriega-Dimitri, 1997 see for a discussion) it was felt important to use in this case.

## Results

An evaluation of the effectiveness of the graded exposure intervention to reduce Ellie's anxiety was conducted. This section graphically displays the changes in Ellie's anxiety levels (Figures 1-3).

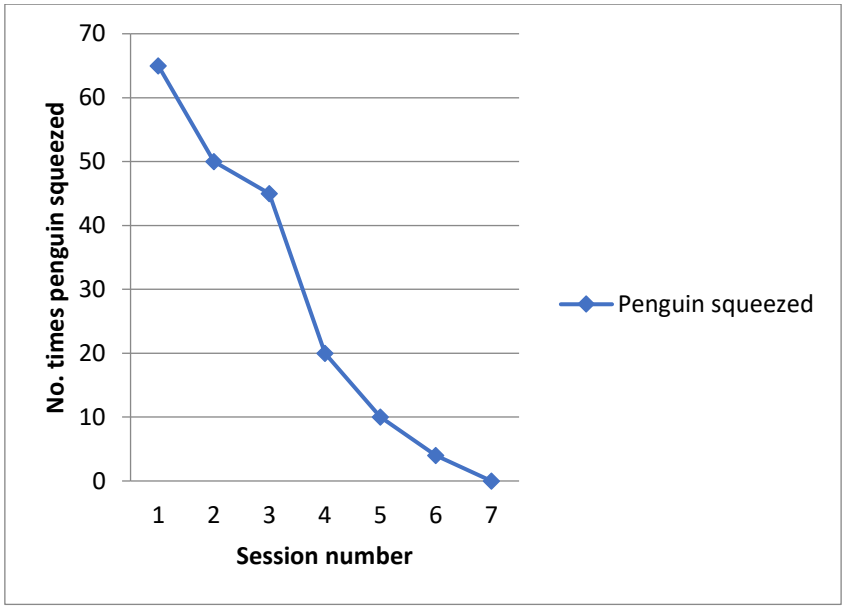



**Figure 1: Line graph showing number of times Ellie squeezed the penguin over the 7 sessions**

Figure one highlights that as the sessions progressed, Ellie's anxiety decreased from high anxiety with a need to squeeze the penguin multiple times to not needing to use the penguin at all the last session. Appendix A provides a table with further observational information about Ellie's squeezing habits in each session.

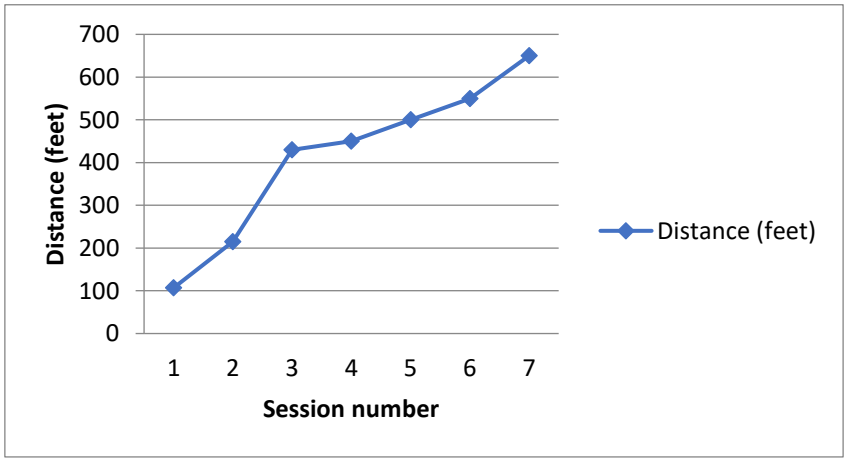


**Figure 2: Line graph showing distance walked from the house in feet over the 7 sessions**

Figure two shows Ellie was able to increase the distance she walked from her house (her safe place) as the sessions progressed. At the start of therapy Ellie would become very distressed if she could not see the house.

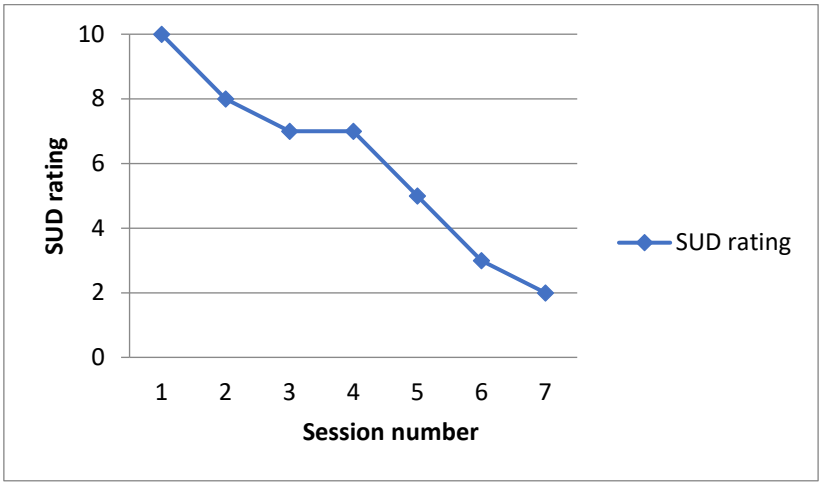



**Figure 3: Line graph showing the SUD rating Ellie gave the furthest point from home**

Figure three shows that Ellie's SUD ratings decreased as the sessions progressed. From 10 wanting to run away too 2 feeling ok in the situation and happy to stay there not feeling anxious.

## Discussion

The results for this intervention showed across the multiple measures of Ellie's anxiety, a reduction in her anxiety levels. As all these measures tended in the same direction it provides us with some confidence that the results are reliable. Thus, we can cautiously conclude that the intervention I delivered was effective in reducing Ellie's anxiety levels. Additional qualitative observations that potentially support the effectiveness of the intervention were; in line with the reduction of penguin squeezing, which was high pre-intervention and none existent post-intervention, her anxious breathing also decreased, her frantic talking decreased, at the start of therapy when Ellie was anxious she would speak frantically which changed to a calm pace, she was fiddling with her hands

less and she reported that she went into school for an exam and felt less nervous and able to concentrate on the exam not her anxiety.

There are some strengths and improvements to the evaluation. This intervention was heavily behavioural and research has found that the use of cognitive interventions alongside behavioural can enhance the treatment (Leahy, Holland, & McGinn, 2012). It may have provided us with an additional subjective measure of coping. Additionally, there was no stable baseline measure before the intervention was conducted which would enhance the analysis and measurement of change. Furthermore a three month follow-up to see if the results were maintained would enhance the evaluation. The use of a standardised measure of anxiety such as the Beck Anxiety Inventory (BAI, Beck & Steer, 1993) may have been a more reliable and valid tool for assessing change in anxiety. However the evaluation also has some strengths in that it is useful to use multiple measures not just one. As discussed the results showed agreement across the different measures suggesting confidence that the results are reliable.

## References


Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B.L. Duncan, & S. D.Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178).Washington, DC: APA Press.

Beck, A.T., & Steer, R.A. (1993). *Beck Anxiety Inventory Manual.* San Antonio: Harcourt Brace and Company.

Craske, M. G., Rowe, M., Lewin, M. & Noriega-Dimitri, R. (1997). Interoceptive exposure versus breathing retraining within cognitive—behavioural therapy for panic disorder with agoraphobia. *British Journal of Clinical Psychology, 36*, 85-99.

Department of Health. (2001). *Treatment choice in psychological therapies and counseling: Evidence based clinical practice guideline*. London: Author.

Leahy, R. L., Holland, S.J.F., & McGinn, L.K. (2012). *Treatment Plans and Interventions for Depression and Anxiety Disorders* (2nd Ed.). New York: The Guilford Press

National Institute for Health and Care Excellence. (2013). *Social anxiety disorder: recognition, assessment and treatment.* Retrieved August 1, 2014, from http://guidance.nice.org.uk/cg159.

## Appendix A

**Table 2: Observations of the penguin squeezing throughout the sessions**

| Session | Observations |
|---|---|
| 1 | Squeezing whilst talking about the exposure, during the exposure and afterwards. |
| 2 | Squeezing whilst talking about the exposure, during the exposure and afterwards |
| 3 | Squeezing before the exposure, during the exposure and afterwards |
| 4 | Squeezing during the exposure |
| 5 | Squeezed before intervention. Considered bringing the penguin but did not bring it |
| 6 | Considered bringing the penguin but did not bring it |
| 7 | Did not mention or bring the penguin |