

Research Project Portfolio
Volume 2

University of Nottingham
School of Medicine

Doctorate in Clinical Psychology

2020

**The Impacts of the Visible Differences in Appearance caused by Burn Injuries, and
Medical Tattooing as an Appearance based Intervention.**

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Thesis submitted in part fulfilment of the requirements for the degree of Doctor of Clinical
Psychology to the University of Nottingham

Table of Contents

FPB.....	6
Overview	7
Diagnosis	7
Epidemiology	8
Therapeutic Approach	8
Assessment (3 sessions)	9
Formulation	11
Intervention	14
Psychoeducation.....	15
Reflection	17
References.....	18
Appendices	22
SYP A Case Study	24
Overview and Referral.....	25
Diagnosis	25
Assessment	28
Formulation (two sessions).....	30
Intervention (9 sessions)	32
Outcomes.....	34
Reflections	35
References.....	37
SYP A APE	40
Overview	41
Background.....	41
Methods	42
Results.....	43
Discussion.....	44
Summary.....	45
References.....	45
SYP B Case Study	47
Overview	48
Capacity and Consent.....	48
Diagnosis	49
Treatment Approach	50

Analysis.....	51
Intervention	56
Evaluation	58
Reflections	59
References.....	61
SYB B APE	65
Overview/Background	66
Methods	66
Analysis.....	67
Results.....	67
Discussion.....	69
References.....	70
Appendices	72
Copy of Completed SSRI Form.....	73

Table of Figures and Tables

	Page
Figure 1: Co-morbid Formulation of Nina's Experience	12
Table 1: Session Plan	15
Table 2: Personal Action Plan	18
Figure 2: Lincoln's Formulation	31
Table 3: Overview of Therapy	32
Table 4: Action Plan	36
Table 5: The results of the analyses pre- and post- questionnaire	43
Figure 3: Sculpt of Ella's system at the time of psychological referral	52
Figure 4: Circularity indicating core patterns maintaining the problems	54
Table 6: Ella's intervention	56
Figure 5: Possible Feedback loop of questioning NS	60
Figure 6: Homeostatic Inertia	60
Table 7: Results of data analyses	67

Table of Appendices

	Page
Appendix 1: Summary of psychoeducation used with Nina	22
Appendix 2: Summary of CBT Techniques used with Nina	23
Appendix 3: Goal Progression Chart	72

FPB

Overview

Nina¹, 63, was referred to the Adult Mental Health Team (AMHT)² by her psychiatrist due to obsessive-compulsive disorder (OCD). Prior to this, she had received only pharmacological interventions, and her records demonstrated limited engagement.

Currently, she lives alone relying on neighbours for support, thereby avoiding exiting the house or locking the door – which triggers intrusive thoughts, and compulsive behaviours. Consequently, she only leaves her flat for critical appointments, and to walk her dog, making her isolated.

Nina requested a female psychologist so was allocated to the trainee. Thirteen one-hour cognitive behavioural therapy (CBT) informed sessions were completed, focusing on creating a collaborative formulation to understand thoughts, feelings and behaviours, and challenge unhelpful thoughts. Subsequently, Nina was discharged for non-attendance.

Diagnosis

Diagnostic categories aim to promote shared language (Mezzich & Ustun, 2002) which currently underpins NICE guidelines, standardised interventions and evidence-based practice (Campbell, 2007; NICE, 2000). However, the complexities of psychological distress create overlap between categories (Boyle, 2007), with the potential for inconsistent or inaccurate diagnosis, underdeveloped understanding of clients, and less effective interventions and outcomes (Bentall, 2003; BPS, 2000). Nina's difficulties could be categorised as OCD using DSM- 5³ (APA, 2013), but were also consistent with social anxiety disorder (SAD) and post-traumatic stress disorder (PTSD). Nina viewed her difficulties as OCD and wanted to understand her experiences, explore intrusive thoughts and change behaviours, so she could exit the house independently. Nina frequently named her experiences "anxiety" and "rituals" (A&R), and expressed stigmatisation related to the label OCD ("I don't want people knowing I have OCD"). She acknowledged pharmacological treatments had alleviated some difficulties but had not provided understanding of her experiences. Therefore, a CBT-based formulation was used to guide therapy. The trainee emulated Nina's language in therapy; however, when required, Nina's experiences are conceptualised as OCD.

¹ All names have been changed to ensure anonymity.

² The Adult Mental Health team comprises psychiatrists, clinical psychologists, social workers, mental health nurses, and occupational therapists.

³ Diagnostic and Statistical Manual of Mental Disorders-5th – the most recent edition.

Epidemiology

OCD has two components: (1) obsessions - intrusive, unwanted thoughts, images or urges that continually enter awareness (Nina's "anxieties"); and (2) compulsions - repetitive behaviours or cognitive acts that the sufferer feels compelled to do (Nina's "rituals") (BPS, 2006). Prevalence rates are between 1-3% (Abramowitz, 2006; BPS, 2006) and are stable across cultures and gender (Weissman, 1998). Mean age of onset is late adolescence (men) and early twenties (women), although it varies extensively (BPS, 2006). OCD frequently presents with depression and anxiety (BPS, 2006), and fluctuates in symptoms and severity over lifetime, where stress is a significant factor (APA, 2013). Nina is typical in her presentation, barring age of onset which, at 17, was younger than typical - coinciding with the involuntary adoption of her son⁴.

Therapeutic Approach

Eye Movement Desensitization and Reprocessing (EMDR) (De Jongh & Ten Broeke, 2009) conceptualizes psychiatric disorders as a manifestation of unresolved traumatic memories. Individuals focus on these memories while simultaneously engaging in eye movements and then associations to other materials (e.g. affect) are elicited. The memory is assumed reprocessed when it no longer elicits any affective or somatic distress (Marr, 2012). However, the literature on EMDR for OCD is limited (Marr, 2012): one study (N=4) showed a reduction in OCD symptoms (Marr, 2012), and another suggested EMDR was an effective augmentation to Exposure Response Prevention (ERP) (N=3) (Böhm and Voderholzer, 2010). Given the paucity of evidence, this approach was not considered further.

Cognitive Therapy (CT) understands OCD as the negative interpretations of intrusive thoughts, images, impulses and doubts creating distress and motivation towards neutralizing behaviours, suppression of thoughts, avoidance and searching for reassurance – underpinned by Beliefs relative to Inflated Responsibility (BIR) - the belief that one has power to bring about or prevent subjectively crucial negative outcomes (Salkovskis, 1996). The appearance and/or content of the thoughts are interpreted as evidence that the individual is responsible for the harm caused. This triggers negative mood and motivation towards neutralizing actions thereby increasing the likelihood of further intrusions and the perception of inflated responsibility creating a vicious cycle of negative thoughts and neutralizations. A meta-analysis evaluating interventions for OCD identified only three

⁴ Nina has two children, both boys. She placed her first son for adoption immediately after birth. Her second son, Evan, lived with Nina until he was 17 and remains in contact.

studies evidencing the efficacy of CT alone (Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008) so the approach was not considered further.

CBT proposes that beliefs mediate an individual's reaction to the event and that dysfunctional thinking leads to dysfunctional behaviours (Albert Ellis, 1991; Westbrook, Kennerly and Kirk, 2011). OCD occurs when an individual's responses to obsessional thoughts are negatively reinforced (i.e. overt and covert rituals/neutralising responses reduce the anxiety). Neutralising responses prevent habituation to the anxiety and, thus, maintain the problem. In ERP, clients (i.e. Nina) are exposed to the stimulus ('door locking') and neutralising behaviours are prevented (checking behaviours). Thus, clients (Nina) would habituate to the anxiety and gather evidence which disproves the feared consequences and dysfunctional beliefs ("Something bad will happen to my son (Evan)") (Abramowitz, 2006; Wells, 2011).

The recent meta-analysis highlighted the effectiveness of CBT-ERP (Rosa-Alcázar, et al., 2008), and NICE advocates CBT-ERP as a treatment for OCD (NICE, 2005). Furthermore, CBT emphasises the importance of therapeutic relationship in engagement, and allows for exploration of vulnerabilities and precipitating and modifying factors (Westbrook et al, 2011). Nina liked this approach. For complex presentations such as Nina's, the literature highlights the importance of understanding underlying mechanisms of symptomatology (Waller et al, 2007). Given Nina's history of non-engagement and aiming to understand her behaviours, it was agreed that a CBT assessment, formulation and intervention focusing on past and present events would be most meaningful. However, ERP can be aversive (Van den Hout, Engelhard, Toffolo and Uijen, 2011) with high drop-out rates (Simpson, Zuckoff, Page, Franklin & Foa, 2008). A meta-analysis of ERP dropout showed overall attrition (refusal + dropout) was 18.7%, although these figures are comparable for PTSD (18.3%), depression (17.5%) and for CBT across disorders (26.2%). Although the effectiveness of Motivational Interviewing (MI) in promoting engagement with CBT-ERP is inconsistent (Tolin & Maltby, 2005; Meyer, 2010; Simpson et al., 2008), it was integrated to explore Nina's ambivalence. To promote engagement, the intervention was separated into two stages:

- (1) Promotion of engagement via collaborative formulation
- (2) CBT-ERP.

Assessment (3 sessions)

File Review – Records highlighted previous non-engagement with services, suggesting ambivalence towards support. Therefore, a collaborative approach would be central in maintaining engagement.

Clinical interview (CI) – In keeping with the centrality of maintenance processes in CBT, open questions identified specific patterns of thoughts, emotions and behaviours and physiological changes associated with Nina’s current problem (e.g. “What triggers the ‘anxieties’?”, “What has ‘anxiety’ stopped you doing?” “How does that feel in the body?”).

Nina had not attempted to exit the house independently for over 3 years. This pattern of avoidance via safety behaviours (neighbours locking the door) prevented habituation and maintained the “A&R”. Imagery was used to enhance recall (Westbrook et al, 2011). Nina reported thoughts of locking the door triggered an overwhelming sense of fear and thoughts that something “bad” would happen to Evan. Nina assessed the strength of the belief ‘Evan was in danger’ at 9/10 on Subjective Units of Distress Scale [SUDS] i.e. ‘extremely likely to be true’ (Wolpe, 1969). These thoughts triggered checking of taps, windows and power sockets, exacerbated by her doubts (e.g. to Nina, “I didn’t check the tap” meant she had not checked). She repeated checks until it “felt right”. Nina described cognitions, such as “I might lose Evan”, and “If I stop (checking), these feelings will continue”, which made her feel overwhelmed. She rated this as 10/10 SUDs. She reported avoidance was the ‘only way’ she could manage anxiety. Nina stated her thought and behaviours seemed illogical, but the assessment demonstrated a link between loss, losing control and “A&Rs”. An activity diary demonstrated that “A&Rs” had restricted social interactions and activities. Through Socratic questioning, she also identified links between “A&R”, low mood and reduced motivation.

The CI highlighted Nina feared being controlled, causing difficulties in engaging with professionals. These disclosures indicated a good therapeutic relationship. Nina’s need for control was observed as less engagement with certain topics and therapy-interfering behaviours (e.g. not completing tasks). Nina stated “she knew she needed to change” but this caused extreme anxiety. She reported “just” wanting to understand her behaviour. This guided both formulation and intervention.

Psychometric Assessments - The Obsessive-Compulsive Inventory [OCI⁵] demonstrates good reliability (.77-.97) and validity (.61 -.88) for measuring distress caused by obsessions and compulsions (Foa, Kozak, Salkovskis, Coles & Amir, 1998). Overall, she scored 107/168 which is indicative of OCD. It indicated difficulties with checking, doubting, and obsessing, supporting the information gathered within the CI, and highlighted Nina’s use of mental neutralising behaviour which she struggled to disclose.

⁵ The OCI is a 42 item self-report measure. Distress is rated on a scale from 0 (not at all) to 4 (extremely). It is generally accepted that a score of 40 or more is suggestive of OCD.

Formulation

The idiosyncratic comorbid formulation was informed by Waller et al (2007) and Westbrook et al (2011) and incorporates developmental factors, cognitive and behavioural aspects and maintenance cycles as Nina understood them (Figure 1).

Nina experienced her parents as controlling, was unable to meet their expectations and felt rejected by them. She described core beliefs of being “unlovable”, “unacceptable”, and “weak”. Becoming pregnant at 17, Nina was sent to a convent “in disgrace” and coerced into placing her son for adoption. This reinforced the belief she is “weak”, and generated negative automatic thoughts (NATs), and dysfunctional assumptions (DAs) including “Do not trust people”, “Never say ‘yes’” and “If I don’t have control, bad things happen” and began her “A&R”. When arrowing down (Westbrook et al, 2011), Nina stated she viewed herself as “weak” and “a complete failure”; however, seeking help risks others taking advantage (10/10 SUDs).

Nina reported that the only time her “A&R” were manageable was in her early twenties when she was married. Unfortunately, after several years, her husband died, and she lost contact with his children causing further loss of control and support. Later, she had a second son (Evan) from a short-term relationship.

At 37, she entered an emotionally and physically abusive relationship, reinforcing her core beliefs. When she was able to leave this relationship, her son also moved out which triggered a sense of failure and loss.

Trauma

Nina’s experience of traumas caused her to be hypervigilant and feel threat more intensely (cognitive and physiological changes). Although Nina was eventually able to leave the abusive relationship, the traumas impacted on her “A&R” (e.g. she kept the door unlocked so she could escape), and she continues to have nightmares and intrusive memories. Consequently, Nina has many safety behaviours to avoid triggers.

Nina reported the trauma of losing her son made her see risk in every conversation, particularly with professionals, confirming she was a “failure” and “weak”. These, and similar, beliefs created a preoccupation with maintaining control to prevent further negative experiences. Nina rated the intensity of thoughts of “losing control”, “others taking advantage” and “being a failure” at 9/10 SUDs (very intense).

A&R

Several triggers pre-empted Nina’s “A&R” with the most common being touching or locking the door or needing to go out. These triggered thoughts about something bad happening to Evan with Nina being responsible. Nina interpreted these intrusive thoughts as “If I think or feel something bad will happen, it will. Therefore, I am responsible in stopping it”. Nina’s rituals (safety behaviours) create a false sense of

control by reducing her anxiety - "If I check the door, appliances and taps, then it will be ok". Consequently, she employed checking behaviours, and covert safety behaviours (e.g. repeating "it will be ok"). The short-term reduction in anxiety reinforced Nina's appraisal that the rituals "keep Evan safe" rather than there not being a risk. However, the rituals prevent habituation to the anxiety and the disconfirmation of beliefs – thus maintaining the "A&R". Furthermore, Nina is not in control of her rituals which reconfirms her belief – "I am not in control", and "I am weak".

Social Anxiety

Situations requiring social interactions would trigger NATs like "People will control me", and DAs such as "I need to avoid this so that I do not get taken advantage of". Consequently, Nina has complex strategies to avoid people including: only walking her dog within a certain area and avoiding phone calls and the doorbell (safety behaviours). When contact was unavoidable, she would immediately reject any suggestion due to her DAs (e.g. "I won't go to appointments because the letter told me to"). Nina attributed successful interactions to her safety behaviours or to others being 'nice' rather than her ability to manage anxiety. These factors maintained the anxiety by preventing habituation and the disconfirmation of beliefs. When Nina's strategies were unsuccessful, this anxiety could also trigger her "A&R".

Protective Factors

Nina reported the following protective factors: (1) Evan, (2) her dog, (3) her neighbours (who also enable safety behaviours), and (4) memories of times she did not use rituals.

Intervention

Nina's goal for therapy was to understand her A&R and challenge thoughts and behaviours which prevented independent exiting from her home. The trainee presented a rationale for a CBT-based intervention focusing on collaborative development of a detailed formulation focusing on beliefs and subsequent behaviours and the identification and challenge of unhelpful beliefs, behaviours, and maintenance loops. It would also provide skills to increase toleration of physical symptoms of anxiety and support her progress to CBT-ERP.

The intervention was guided by Westbrook et al (2011) and the session plan is presented in Table 1.

Table 1: Session Plan

Topic	Sessions	Skill
Rationale, and Therapeutic Relationship	1	Exposure
Background	2	Identifying NATs, DAs, core beliefs
Trauma	1	Behavioural coaching (BC), exposure via imagery (Evi)
Loss of Control, Others' Control	1	Thought challenging (TC) and behavioural testing (BT)
Anxieties and Rituals	1	BC, rehearsal practice training (RPT), Evi
Social Anxiety	1	BC, RPT, Evi, TC, BT
Safety Behaviours/ Feedback Loops	1	Identifying NATs, DAs, core beliefs, TC
Review Formulation	1	n/a

Note: all sessions included psychoeducation, MI techniques, exposure to professional relationship, identification of protective factors and collaboration in formulation development.

Engagement (MI) and Therapeutic Relationship (Sessional)

Nina was socialised to the CBT model, and her expectations of therapy and the therapeutic relationship were explored to establish a good relationship (BPS, 2017). This exposed her to working with professionals and her fear of being controlled. By engaging in each session, she challenged her belief that she “couldn’t” work with a professional. Nina felt the power imbalance of CBT placing the trainee in the expert role (Westbrook et al, 2011). Therefore, it was agreed her anxieties around this would be reflected upon in each session and she would be encouraged to take responsibility through joint decisions and between-session tasks. To further support ownership of therapy, MI techniques (e.g. cost and benefit of change) (Miller & Rollnick, 2008) were used at session commencement to reduce Nina’s ambivalence. Nina was supported to practise disagreeing and agreeing with the trainee. It was hoped these techniques would provide evidence against the NATs that ‘others want to control [her]’, improve her confidence and increase therapy engagement. Nina reported finding the “friend or foe” tasks useful in understanding her ambivalence to change (Serpell & Treasure, 2002).

Psychoeducation

Psychoeducation was used to socialise Nina to the model, concept or technique (Appendix 1) to provide a rationale for the CBT interventions and promote engagement with ERP.

Identifying and Challenging Unhelpful Beliefs

During formulation, Nina identified and challenged unhelpful beliefs via several techniques (Appendix 2), including: identification of patterns of cognitive bias, evidence for and against beliefs, ‘fact-versus-feeling’, continuums of beliefs (Westbrook et al, 2011), and compassionate person (Gilbert, 2015).

Reduction and Toleration of Physical Symptoms of Anxiety

While Nina was able to identify cognitions and challenge them logically, the behavioural aspects were more problematic, finding it difficult to tolerate physical symptoms of anxiety. Therefore, using a body map, Nina explored how and where she experienced anxiety, recognising signs of increased heart rate and breathing, muscle tension and unpleasant skin sensations. These triggered her NAT, “I cannot cope”, creating a feedback loop which escalated anxiety. The techniques Nina found useful in breaking this cycle were:

Breathing: using breathing techniques to reduce heart rate and breathing, thus, feelings of anxiety.

Cognitive Refocusing or Distraction: using grounding techniques for cognitive refocusing i.e. Nina would refocus on safe thoughts. Nina developed both overt and covert techniques to use when others were present.

For each skill, Nina was provided psychoeducation and practice and had to instruct the trainee how the technique was completed correctly. Techniques would be practised in sessions when necessary, and time taken for consolidation to effectively to challenge the belief: “I cannot do it.”

Evaluations

Nina’s OCI score increased from 107 to 112/168. The Reliable Change Index (RCI) and Clinically Significant Change (CSC) computations (Jacobson & Truax, 1991) determined that this was not a statistically or clinically significant change. Given the intervention had not directly addressed OCD symptoms, the lack of change was expected. Nina, however, felt the scores reflected increased insight and attempts to reduce ‘avoidance’ behaviours.

Nina reported feeling more confident and able to express herself. She stated “[she] would have never thought [she] would attend sessions or be able to talk about [her] difficulties with someone” demonstrating habituation to working with professionals. Observations suggested the frequency of some unhelpful thoughts reduced (e.g. “I am a bad mother”, “I am a failure”), but others still appeared powerful (e.g. “I can’t say yes”, “I am weak”). This suggests this intervention was partially successful in challenging her beliefs. Nina’s behaviour was noticeably calmer (e.g. she remained

seated more frequently), and was she observed to apply CBT techniques (e.g. breathing techniques, thought-challenging) independently. Most importantly, she reported her therapy goal had been met. Nina reported being motivated to continue therapy; however, her belief in her ability to change appeared lower than her stated belief (e.g. frequent NATs of “I can’t do anything”).

Disengagement

During the 12th session, Nina was consulted over continuing to ERP or being discharged to consolidate learning. She chose to continue. She attended one preparation session for ERP then disengaged suggesting that the integration of MI did not enable her to engage. Given high dropout rates (Simpson et al., 2008), Nina’s disengagement was a possibility but may indicate a breakdown in the therapeutic relationship. Ruptures in therapeutic alliance are common in therapy, and, frequently, clients are reluctant to raise concerns or negatives (Safran et al, 2001). It is hypothesized that a rupture may have occurred when it was suggested Nina could continue therapy having already met her goal. Nina’s formulation indicates saying “yes” to anything was difficult for her. Therefore, saying “yes” to ERP was significant. The trainee did not explore whether Nina’s decision to continue was a considered decision, or due to perceived pressure from the service preventing validation and the exploration of concerns. This may have further impacted on the therapeutic relationship, and/or triggered habitual avoidance. While Nina voiced concerns about ERP, she felt these had been addressed. However, she also expressed that her “A&Rs” facilitated relationships with her son and neighbours (protective factors). It is possible she feared they would reject her if she became independent. Therefore, Nina would book an appointment with the trainee (A), which would trigger her thoughts that “therapy might work”, and “if I don’t need support, my neighbours and son will have no reason to talk to me”. These thoughts created anxiety (B) thus triggering avoidance strategies to manage the anxiety (C). Exploring this and alternative strategies to enable Nina to maintain interactions with Evan and her neighbours may have addressed these concerns, or a period of consolidation may have permitted reflection on her apprehension towards further intervention.

Reflection

The CBT model facilitated exploration and understanding of Nina’s experiences and consequently met Nina’s therapeutic goal. On reflection, I knew Nina’s goal had been met, but I hoped that Nina would continue onto CBT-ERP. My concerns about being perceived as “controlling” hindered me from asserting the clinical need for a period for consolidation. Nina may have felt unable to end therapy. This created a

rupture in what had been a good therapeutic relationship and led to similar disengagement observed with other professionals. Consequently, I felt guilty and thought “It is my fault”. On reflection, it was likely she would disengage given that literature predicts high levels of drop-out for CBT-ERP (Simpson et al., 2008). Furthermore, her goal had been met and she may have benefited from a break from therapy to process her experience of therapy. As I have knowledge of the impact of processing such information, in future, I will take responsibility in promoting a therapeutic break and developing formulations of possible endings of relationships to pre-empt difficulties and reduce future ruptures in TRs. I am hopeful that Nina’s engagement for 13 sessions, and personal goal achievement was significant for her, and may prepare her for future relationships with other professionals. For me, this relationship and inability to repair the rupture provided a tough learning curve but has increased my resilience. In the future, I will focus on exploring expectations on endings, therapy-interfering behaviours, and concerns about engaging thoroughly. My personal action plan is summarised in Table 2.

Table 2: Personal Action Plan

Area	Factors to consider
ERP	The adverse nature of ERP with client Imagined exposure within hierarchies Integrating metacognitive models to increase engagement with ERP e.g. detached mindfulness
Therapeutic Relationship	Expectation of therapeutic relationships (considering narratives) Formulation of potential barriers to therapy or disengagement The impact of myself as therapist i.e. my expectation (actual or perceived)
MI	Techniques to develop my MI skills
Consolidation	The importance of promoting learning consolidation

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Appendices

Appendix 1: Summary of psychoeducation used with Nina

1. Therapeutic Relationships: Nina was socialized to the concept of therapeutic relationships, power dynamics (expert role) and collaboration within therapy.
2. ABC model/ CBT Model: Nina was socialized to the fundamental principles of CBT model and introduced to the ABC model.
3. Unhelpful Thinking, Cognitive Bias and Thought Challenging.
4. Anxiety: Nina was socialized to anxiety as a natural response to threat, and the role of avoidance in preventing habituation and the challenging of unhelpful cognitions thereby maintaining or increasing anxiety long-term (e.g. anxiety around people leading to anxiety around leaving the house).
5. Intrusive Thoughts: Nina was socialised to intrusive thoughts to normalise the frequency of intrusive thoughts.
6. Anxiety and Rituals/OCD.
7. Trauma: The potential impacts of trauma discussed, particularly physiological changes, hypervigilance, flashbacks and nightmares.
8. Social Anxiety:
9. Safety Behaviours/Feedback Loops: Maintenance loops were explored – considering the cognitive and behavioural factors which can maintain unhelpful behaviours via short-term reduction of anxiety or confirmation on unhelpful beliefs

Appendix 2: Summary of CBT Techniques used with Nina

1. Identification of patterns of cognitive bias (Westbrook et al, 2011) – For example, Nina could identify catastrophising, over-generalising, and mind-reading and creating a ‘balanced thought.’
2. Exploration of evidence for and against the belief.
3. Consideration of ‘fact-versus-feeling’ – Nina frequently confused thoughts or feelings with reality, assuming her perception was correct (e.g. ‘They are trying to control me.’). Nina was supported to adhere to known facts (e.g. a doctor is likely to want to help her).
4. Consideration of ‘What would your friend (compassionate person) say?’ – With support, Nina could draw on opinions of friends to help challenge beliefs via compassion.
5. Use of continuums of beliefs - For example, Nina explored her belief that she was a ‘bad’ mother using a continuum to discover her belief that she was a bad mother fell from a rating of 10/10 to 6/10 on consideration of all the things she had achieved which fitted within her ‘perfect’ mother category. Additionally, she identified methods by which she could improve communication with her son.

SYP A Case Study

Overview and Referral

Lincoln⁶, a 30-year-old man, was referred to the Specialist Intellectual Disability Clinical Psychology Service by the consultant psychiatrist within the Community Learning Difficulties Team (CLDT). The referral stated that Lincoln had been experiencing depressive episodes and difficulty in expressing his emotions.

Within the assessment with the trainee psychologist, it was identified that Lincoln was experiencing high levels of anger and anxiety, which were significantly impacting on social functioning, self-image and mood, particularly causing non-epileptic seizures. A cognitive behavioural therapy (CBT) formulation and intervention plan were developed and utilised based on Lincoln's goals of managing his emotions more effectively (particularly in relation to anxiety), incorporating adjustments for intellectual difficulty (ID).

Lincoln responded positively to treatment due to a strong therapeutic relationship, collaborative formulation and well-paced intervention plan. Results from psychometric assessments completed in the final session showed reductions in clinical symptoms of anxiety and aggression, but no change in ratings of depression and overall well-being. Informal observations by Lincoln, the trainee and community nurse indicated increased confidence and overall mood. It was agreed that the intervention presented here was an initial stage of a longer-term intervention and, following a period of consolidation post-intervention, further trauma-based interventions would be facilitated.

Diagnosis

Lincoln was diagnosed with ID during childhood. However, his medical records suggest he was initially transferred to the ID service due to difficulties in managing his physical illnesses (including Steven-Johnson Syndrome⁷) and there are no records of any assessments of cognitive or adaptive/social skills. Without these assessments, his level of ability could be misrepresented (BPS, 2000). From Lincoln's assessments with the trainee psychologist and a speech and language therapist (SALT), it was apparent that Lincoln was more cognitively-able than others with a similar diagnosis and perhaps his difficulties might be better understood as a consequence of physical illness and childhood trauma. However, his diagnosis has defined his experiences, though at times

⁶ pseudonyms have been used to protect confidentiality

⁷ an immune-complex-mediated hypersensitivity complex that typically involves the skin and the mucous membranes

has caused him to underestimate his ability and dismiss opportunities. Furthermore, there were benefits for Lincoln to remain within the CLDT due to pace of therapy, the emphasis placed on the necessity for adapted communication, and Lincoln's self-identification with ID. Therefore, for this report, the diagnosis of ID was accepted.

Lincoln's assessment with the trainee, detailed later, evidenced symptoms of generalised anxiety disorder (GAD; The Diagnostic and Statistical Manual of Mental Disorders, 5th edition; [DSM-V] (APA, 2013), with Lincoln reporting that he was constantly anxious, and scoring highly on the Glasgow Anxiety Scale (GAS-LD). However, if an ID diagnosis is assumed, it could be argued that, as diagnostic criteria are rooted in language-based phenomenology and, as such, validated on individuals with average intellectual functioning, there is reduced utility of DSM-V in diagnosing comorbid anxiety disorders ([Cooray & Bakala, 2005](#); [Ruedrich & Hurley, 2001](#)). This highlights the difficulties of diagnosis in relation to Lincoln's experience. On consultation, Lincoln agreed that, while his primary goal was to express his emotions more effectively, the assessment had highlighted that anxiety was a significant barrier to this. Lincoln identifies with diagnostic labels, has long-standing need for medical input via diagnoses since childhood, and, therefore, relies on diagnoses to understand and manage his experiences via medication and medical treatments. However, medication has only been partially successful in managing his anxiety. As such, diagnoses were considered but the focus of this case study was a formulation-based understanding of Lincoln's anxiety.

Prevalence and aetiology of ID and anxiety disorders

The prevalence of ID is reported to be approximately 1% of the general population (APA, 2013) with this group suggested to be vulnerable to mental health issues (Borthwick-Duffy, 1994) although information on prevalence rates is limited. Evidence suggests that anxiety disorders, particularly generalised anxiety disorder, are as common, if not more frequent, within the ID population than within the general population (Bailey & Andrews, 2003; Deb, Thomas & Bright, 2001; Coray et al., 2005). However, lack of data on prevalence may reflect difficulties in diagnosing psychiatric illnesses within the ID population (Fryers, 1997; Kerker, Owens, Zigler & Horwitz, 2004) and reflect both under-reporting (Reiss Levitan & Szyszko, 1982) and under-diagnosis (Veerhoven & Tuinier 1997). Four reasons are postulated for this situation. Firstly, psychiatric classification systems are based on studies that excluded people with learning disabilities ([Cooray et al., 2005](#)). Deficits in language and/or abstract thinking make emotional symptoms difficult to elicit (Sovner, 1986). Limited social experience can influence the content and interpretation of psychiatric symptoms (Sovner, 1986)

Finally, it is suggested clinicians tend to overlook psychiatric symptoms, attributing them to learning disability (Reiss et al, 1982).

Treatment approaches

Within the literature, two relational approaches are documented as proving effective with the ID population: Cognitive Analytical Therapy (CAT) and systemic approaches. CAT has been suggested as a suitable treatment approach for individuals with moderate ID (King, 2005) if appropriate modifications are implemented. The CAT approach hypothesises that the client's difficulties arise from patterns in the way they relate to others and themselves and how they experience others relating to them. Systemic approaches seek to explore the individual's network of significant relationships and the wider system (e.g. cultural factors), considering the beliefs that give meaning to people's actions and existing communication patterns (Dallos & Draper, 2010).

The assessment with the trainee highlighted difficulties in Lincoln's interactions and communication, particularly within his family unit. These could be understood from either a CAT or systemic perspective. The advantage of both approaches would be reduced risk of reinforcement of stigma and/or negative self-perceptions by locating the problems within interactions and communications rather than within Lincoln himself (Dallos & Draper, 2010). However, the assessment indicated that an intrapersonal-focused intervention would be more appropriate as it allows for the emotive nature of relationships to be contained and explored within cognitions and experiences. This was crucial as Lincoln was experiencing intense dissociations when discussing emotionally-laden topics, particularly links between family and historical sexual abuse. It was hypothesised that discussions relating to his interactions or wider system would increase anxiety and, thereby, the risk of dissociation, reducing his ability to engage in and gain from therapy. Therefore, it was concluded that a more exploratory model would not be beneficial until Lincoln could tolerate emotion without the risk of dissociation. On consultation, the decision was made that a formulation which focused on his experiences would create a more meaningful explanation and intervention for him. Thus, a CBT-based approach was utilised.

The CBT approach would conceptualise Lincoln's difficulties in terms of the cognitive and behavioural elements of CBT in that beliefs mediate an individual's reaction (behaviour) to the event. Therefore, beliefs and thinking styles can contribute to significant emotional problems, such as anxiety. Subsequently, the maladaptive patterns of behaviour (e.g. avoidance) reinforce the 'faulty' beliefs and thinking style.

Currently, the evidence-base relating to treatment of anxiety disorders in people with ID is limited and compounded by difficulties in carrying out robust research given most research uses some form of modified criteria reducing consistency (Oliver et al, 2002). However, CBT has been promoted and suggested to be effective for individuals with ID by the BPS (2017) and NICE (2016), and evidence-based research on case studies demonstrates its effectiveness with those with mild or borderline learning disability and anxiety disorders (Lindsay, Neilson & Lawrenson, 1997). However, evidence relating to the long-term outcome of these interventions is unavailable, although assumed to be beneficial (NICE, 2016).

Assessment

File review

Lincoln's medical file indicates he suffers from diabetes, epilepsy and Steven-Johnson Syndrome, and has a significant history of medical problems. Consequently, it was hypothesised that he would hold several core beliefs about himself, his health, capabilities and how others will view him. Little information was available on the impact of ID on his functioning but it was clearly evidenced that health issues had impacted on his education. Once confirmed during the 1:1 assessment, efforts were made to adapt the sessions for these difficulties by, for example, the use of simple diaries, relevant apps and reading materials with high readability.

One-to-One Assessment (3 sessions)

Background

Using generic therapeutic skills (e.g. Socratic questioning), the following relevant information was gathered:

During his childhood, Lincoln witnessed and experienced domestic violence and was a victim of sexual abuse. The use of violence to resolve threats from others outside the family has been, and currently still is, modelled by his family. He expressed conflicting beliefs about anger – “if someone threatens your family you hurt them” but also “violence is bad”. He believes himself to be a dangerous person and is unsure if this is a ‘good’ or a ‘bad thing’. These beliefs are reinforced by his mother who fluctuates between pride in her son's ability to fight and stating he is dangerous and will ‘end up’ in hospital or prison if he does not change. However, ultimately, he reported that he did not want to feel angry or have angry thoughts as this made him a violent person. Through carefully paced and scaffolded arrowing down, Lincoln's underlying beliefs/fears were identified as centring around being “unlovable”, inherently “useless” and “needing support”. Core beliefs were not discussed due to the potential for

dissociation within the session; however, it is likely that Lincoln believes that no-one, including his parents, would want him; he could not look after himself and so is vulnerable to abuse, illness and death (due to his ongoing physical health problems). Consequently, Lincoln reported that he must try to be what people want and do as people say to prevent rejection.

Anxiety

Lincoln's emotional vocabulary and understanding of, for example, anger and sadness were explored. He demonstrated a clear understanding of many emotional states, triggers, beliefs, physical reactions and consequences, and was able to understand the links between them. This supported the hypothesis that his difficulties are more than an inability to express emotions, but related to anxiety. Lincoln reported being anxious about many aspects including social situations, his own and his families' health, the future, and memories of previous trauma. Specifically, he reported that his own emotions and how he "needs" to manage them make him anxious. Currently, he states attempting to avoid or "bottle them up" to prevent rejection, thereby maintaining his anxieties. This frequently leads to violence against himself or property as a form of release. However, if he does talk about his emotions, he is unable to contain his thoughts and feelings. This results in him being flooded with anxieties and dissociating (non-epileptic seizures). This highlighted the difficulty Lincoln has in managing his emotional state; his tolerance to emotions may be low and/or discussions of emotion may be triggering other experiences (e.g. flashbacks) creating a heightened emotional state that he cannot tolerate. Further details are presented within his formulation.

Psychometric Assessment (one session)

The CORE-LD is a measure of general wellbeing based on the well-established and evidenced Core OM (Evans et al., 2002) which has been adapted to be more accessible to the ID population. While little research has been completed on the validity or reliability of this measure, there has been positive anecdotal support from clinicians and is used as part of standard practice within Lincoln's service.

The Dundee Provocation Scale (DPI; Alder & Lindsay, 2007) aims to measure anger-provoking emotions in adults with intellectual disabilities. The measure was utilised due to its accessibility and acceptable measures for validity and reliability (Alder & Lindsay, 2007). However, following supervision, adaptations were made to reflect the use of modern technology (i.e. mobile phones) to improve meaningfulness and thus validity.

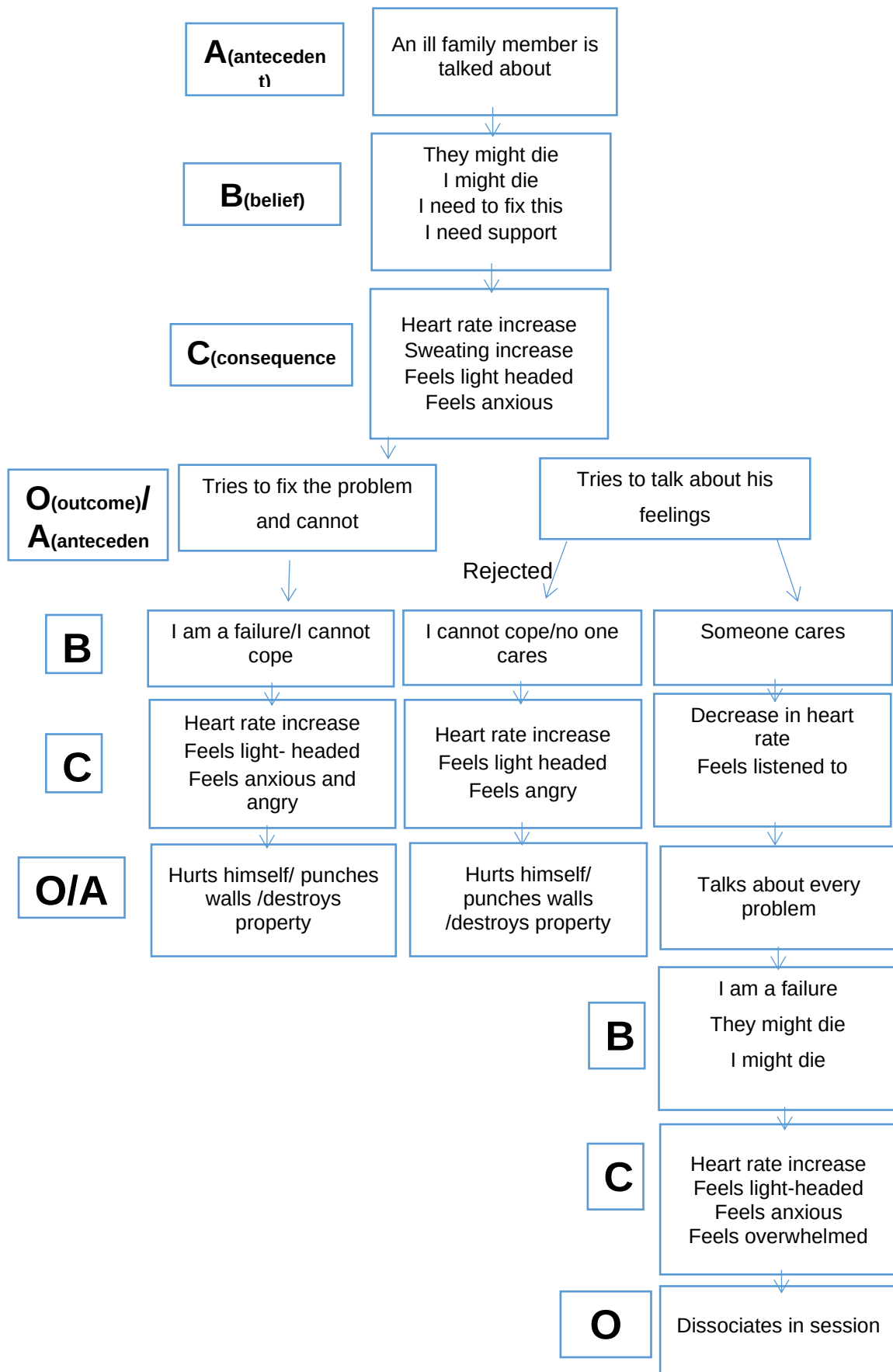
The Glasgow Depression Scale (GDS-LD; Cuthill, Espie & Cooper, 2003) and Glasgow Anxiety Scale (GAS-LD; Mindham & Espie, 2003) aim to measure depression and anxiety over the timeframe of the previous week. These measures are accessible and the literature suggests good validity and reliability within the ID population (Cuthill et al., 2003; Mindham & Espie, 2003).

Formulation (two sessions)

Problem-specific formulations were created collaboratively (e.g. Lincoln identified the antecedent and the model was followed together), demonstrating the links and escalating nature of the difficulties he described. The CBT-based formulation was problem-specific and utilised the structure: A (Antecedent), B (Belief), C (Feelings), O (Outcome) (Dawson, & Moghaddam, 2015) due to Lincoln's preference, and its simplicity. Additionally, it separated Lincoln's physical reaction from his cognitions which he reported was more assessable at times of distress.

Lincoln's formulation is presented in Figure 1. When presented with triggers related to anxieties, Lincoln would have several negative thoughts which, in turn, would create a strong physical anxiety reaction, particularly an increase in heart rate. Subsequently, Lincoln attempts to 'fix' or talk about the problem. However, this usually maintains a cycle of anxiety. Specifically, when attempting to talk about the problem, Lincoln has core beliefs around rejection; he expressed negative beliefs about voicing emotions, as this made him "weak" and undesirable (his mother and her new partner do not "like" him expressing emotions, particularly anger and sadness). Consequently, he attempts to avoid emotions or "bottle them up" to prevent rejection from those who do not want him to talk emotively, which maintain his anxieties, and frequently leads to violence against himself or property or aggression (as a release) creating further 'problems'. However, Lincoln continues to feel overwhelmed by his emotions and wants to express them, linking to his core belief that he "needs support". As a result, when presented with someone who will listen ("who cares"), he is unable to contain his thoughts and feelings, which results in him being flooded with anxieties and negative beliefs. The overwhelming nature of these cognitions, the physical sensations, and inability to use aggression as an outlet lead to dissociation to the point of blacking out, even within a therapeutic session.

Figure 2: Lincoln's Formulation



Intervention (9 sessions)

The overall aim of therapy was for Lincoln to be able to express his emotions more effectively. Following creation of the formulation (Figure 2), the trainee presented a rationale for an intervention focusing on reduction and tolerance to physical symptoms of anxiety as a step towards this goal. Lincoln identified this as essential prior to further psychological input in order to meet his long-term goal. Subsequently, the intervention was grounded within CBT for an anxiety-based approach. This aims to focus primarily on behavioural techniques such as behavioural coaching on anxiety management, rehearsal practice training, exposure and behavioural testing. The use of these techniques aim to improve Lincoln's ability to manage anxiety and improve confidence. The intervention plan is presented in Table 3:

Table 1: Overview of Therapy

	Session Plan	No. sessions
Assessment	Assessment and Engagement	3
	Psychometrics	1
Formulation	Introduce, Create and Revise Formulation	2
Psychoeducation	Anxiety	
	Physical/Body Reaction	1
	Identifying Emotions/ Body Reaction	1
Intervention	Reducing /Tolerating Physical Symptoms	
	Rehearsal Practice: Breathing Techniques	2
	Behavioural Coaching, Cognitive Refocusing,	2
	Exposure and Behavioural Testing	
	Challenging Unhelpful Beliefs	2
Ending	Recap and Psychometrics	1

Engagement

Prior to the formulation and intervention, a 'pre-formulation' intervention was utilised to ensure a good relationship was established (BPS, 2017). The aim was to increase Lincoln's confidence and trust in working with professionals by socialising him to the model and emotions and by clarifying his expectations of therapy and the therapeutic relationship. Particularly, the trainee acknowledged that Lincoln did not wish to discuss the sexual abuse within sessions. However, given the nature of therapy, it may be triggered via other conversations; therefore, it was agreed were this to occur the trainee would prompt Lincoln that this had occurred, monitor his anxiety, and allow him the choice of changing the topic or taking a break, if needed. Additionally, the trainee contracted with Lincoln to manage any further dissociation in sessions, creating an action plan to support him.

Psycho-education (two sessions)

Psychoeducation on anxiety, focusing on its physical presentation, was discussed and the focus of each session was narrowed to one concept to reduce content and increase understanding. Visual representations of physical symptoms were discussed e.g. using a body map to highlight where Lincoln experienced anxiety. Lincoln recognised that increased heart rate indicated his anger and anxiety, and, when angry, he saw different shades of red – with bright red meaning he would be violent. Lincoln completed a mood diary over the two-week period to practise identification of physical symptoms of anxiety and anger.

Reducing /Tolerating Physical Symptoms

From the formulation, an intervention plan was derived to reduce physical symptoms to decrease feelings of anxiety and anxious thoughts and reduce the reinforcement of negative thoughts e.g. “I cannot cope”. Therefore, escalation of panic or aggression would be minimised to improve wellbeing and develop skills needed for further intervention.

Breathing: using breathing techniques (rehearsal practice training) to reduce heart rate and, thus, feelings of anxiety.

- Psychoeducation on breathing techniques and introduction to an app to facilitate correct breathing (Session 1)
- Practise breathing technique (Session 1)
- Lincoln to instruct the trainee how to ensure correct breathing (Session 2)
- Consolidation of the evidence of Lincoln using the technique effectively to challenge belief: “I cannot cope” (Session 2)

Cognitive Refocusing: using grounding techniques (rehearsal practice, exposure and behavioural testing) for cognitive refocusing i.e. refocusing Lincoln from anxiety-related to safety thoughts.

- Psychoeducation on grounding techniques (Session 1)
- Practise breathing technique in vitro (Sessions 1)
- Lincoln to recap the technique to trainee (Session 2)
- Consolidation of evidence of Lincoln using the technique effectively to challenge belief: “I cannot cope” (Session 2)

Finding Evidence for Positive Thoughts: using physical memory aids to challenge negative thoughts by finding evidence against them.

- Psychoeducation on grounding objects and gathering evidence for positive beliefs (Session 1)

- Lincoln brought in and discussed his grounding objects (Session 2)
- Consolidation of the evidence of Lincoln using the objects effectively to challenge belief: “No one cares” (Session 2)

Outcomes

During each session, Lincoln completed an adapted rating scale evaluating the therapy session on a 5 point Likert scale; however, Lincoln systematically rated each session as 5 on each question. This limited the information which could be drawn from this measure. It is likely that Lincoln’s experience of “not feeling listened to” meant that, in comparison, any feeling of being heard felt significant. Additionally, Lincoln’s fear of rejection might have reduced his ability to provide feedback that might be perceived as negative.

Information for the evaluation of the effectiveness of therapy was drawn from psychometrics, observations and self-reports.

Psychometrics

Lincoln showed no change in score on either the Core LD, or the GDS-LD. However, he showed a reduction on the GAS-LD from 36 to 28 and a reduction on the DPI from 43 to 25. The Reliable Change Index (RCI) and Clinically Significant Change (CSC) computations (Jacobson & Truax, 1990) were used to determine that these scores indicated statistically and clinically significant change. Therefore, his scores show a reduction in anxiety and aggression, but no change was demonstrated in depression or general wellbeing. It is important to note that, prior to this session, Lincoln had a verbal altercation with his mother related to the sexual abuse he had suffered. It is likely that this incident affected the results of the psychometric assessment due to its significant emotional impact; this highlights an issue affecting validity when utilising self-report measures to evidence outcome. However, given Lincoln’s history of trauma and the focus of the intervention centring on management of anxiety, these scores are not unexpected and highlight the need for further psychological input.

Observed Improvements within the Intervention Period

Within sessions, and from reports from Lincoln’s community nurse, it was indicated that Lincoln appeared to have more frequent periods of improved mood (e.g. increased use of jokes, improved posture and reduced conversations about suicidal thoughts), increased confidence in his abilities (e.g. discussing his techniques and how they had worked) and more motivation to complete tasks (e.g. Lincoln applied for voluntary work).

Self-Reported Improvements

Lincoln reported that the therapy had been “helpful” and that he felt “supported” for the “first time in years”. This had made him feel more confident about working with other professionals in the future. He reported that he and his mother had noted that both his anxiety and aggression had reduced and he stated this was due to the techniques he had learnt.

Reflections

It has been useful to reflect on this case from a CBT perspective.

The Model

Given that I was on my ID placement, I was aware I was to complete a systemic case study, which made it difficult for me to remain as congruent to the theory without input from supervision. However, working with Lincoln increased my appreciation of the benefits of CBT in containing trauma and preparing individuals for further work. From my experience, CBT allowed Lincoln to develop self-understanding and to increase his confidence to utilise specific skills he found helpful. However, CBT had limitations, which at times became frustrating and upsetting for me and led me to utilise supervision to manage transference and countertransference. Upon reflection, I considered the benefit of systemic work with Lincoln. Although I maintain that the decision to utilise an intrapersonal approach was appropriate for Lincoln, future systemic work would improve his and his family’s understanding of openness of their boundaries and some of the unhelpful/inappropriate family rules that are prevalent e.g. violence is used to solve problems.

Personal learning

At the start of this placement, several beliefs were triggered: “I will not be able to understand anyone”, “I cannot do therapy if I cannot understand” and “I won’t be able to do this”. These beliefs are exacerbated by difficulties ensuing from auditory processing disorder (APD) and dyslexia. These beliefs led me to feel anxious and apprehensive and experience a negative automatic thought: “you can’t do this”. However, it is also possible that my experience evidences my faulty thinking and the expectation I would find this population more difficult.

Developing good therapeutic relationship utilising skills, such as slower pacing, simplifying language and visual prompts, facilitated the communication I feared would be problematic. In addition, exposure to new forms of communication and techniques and the experience of success and some failure within these modifications have reduced my anxiety to “get it right” all the time. Additionally, discussion with my

supervisor enabled me to use the space to challenge my thoughts, create solutions and increase my exposure to clients with difficulties in communication. I remained uncertain of my ability throughout the placement, perhaps compounded by the increase in required independence. However, through feedback and supervision, I completed the placement with increased confidence in my ability and feeling proud of the achievements I made. However, perhaps I found working with Lincoln easier as he was more able than I was predicting given his diagnosis. Therefore, it is important for me to continue to maintain and develop my skills. Table 4 highlights my action plan from these reflections.

Table 4: Action Plan

<u>Action</u>	
<u>Personal</u>	For each placement and client: Explore negative beliefs about my ability • Use supervision to discuss and explore concerns Ensure reflection to consider strengths and weaknesses of work
<u>Work</u>	Within job role: Continue to develop skills on communication and pacing • Request verbal and written feedback from clients and supervisor • Use qualitative and quantitative evaluation where possible and appropriate Within job role: Continue to allocate specific and adequate time to compare theories and models for intervention, particularly for those adopted by the service and others that may also be suitable: • Use supervision for a period of reflection post-assessment • Consider the advantages and disadvantages of approaches to ascertain when and how they can integrate and when they cannot For each client: Question diagnoses applied: • Consider whether diagnoses are substantiated by reliable and valid evidence and their helpfulness to the client and other professionals

Word count: 3997

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SYP A APE

Overview

‘Communication and teaching’ are key proficiencies for qualified and trainee psychologists. This report considers the proficiency and effectiveness of the trainee psychologist’s ‘communication and teaching’ through evaluation of two training sessions on the “Role of the Psychologist in ID” delivered to support workers within the ‘Shared Lives’ Team who work within the Community Learning Difficulties Team (CLDT).

Background

Currently, psychologists are governed by the Health and Care Professions Council (HCPC, 2015) which requires maintenance of several professional proficiencies to ensure effective practice (BPS, 2014; HCPC, 2015). A core proficiency states that psychologists must ‘be able to communicate effectively’ (HCPC, 2015) in order to:

- a) ‘understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions’;
- b) ‘be able to communicate ideas and conclusions clearly and effectively to specialist and non-specialist audiences’; and
- c) ‘be able to explain the nature and purpose of specific psychological techniques to service users’.

Correspondingly, the British Psychology Society (BPS) lays out standards for doctoral programmes in clinical psychology, one of which is: ‘Communication and Teaching’ (BPS, 2014). This integral requirement focuses on effective communication of both clinical and non-clinical information by means of preparation and delivery of teaching and training which consider the needs and goals of the participants, and where communication style is adapted to participants’ level of knowledge and ability. Therefore, ensuring proficiency of these skills is crucial for trainee psychologists.

One role which requires teaching and communication is provision of training to colleagues. Within the service, a referral was made to the clinical psychology team to provide training on the “Role of the Psychologist in ID” to support workers within the ‘Shared Lives’ Team. This team organises support workers for individuals with intellectual disabilities (ID) within the community. Following discussions with the team manager, the agreed overall objective of training was to increase support workers’ knowledge of the role of clinical psychologist, specifically focusing on:

- a) the role of psychologist (particularly to highlight differences between psychologists and psychiatrists)
- b) the different theoretical models used by psychologists
- c) assessment, formulation and intervention (particularly the support workers' role in supporting these processes).
- d) increasing support workers' knowledge to enable them to make informed decisions when supporting clients (HCPC, 2015).

The training was delegated to the trainee psychologist as this was within her professional remit. Consequently, in order to assess proficiency in teaching and communication, the following research questions were investigated:

- (1) Does the training improve participants' perceived knowledge of the role of the clinical psychologist?
- (2) Is the communication effective?
- (3) Is the training presentation adapted effectively for the participants?
- (4) Is the training relevant to (i.e. meets the needs of) the participants?

Methods

Participants were support workers who attended one training session on the 'Role of the Clinical Psychologist in ID'; two separate sessions were held (Session One: n=10 and Session Two: n=8).

18 participants (demographics not recorded to preserve anonymity) completed pre- and post-treatment questionnaires. The pre-training questionnaire obtained a score of perceived knowledge of the 'Role of the Clinical Psychologist in ID'. Each participant rated their knowledge of this role, scored on a 5 point Likert scale (0=no knowledge of the role of clinical psychologist in ID services, 5=complete knowledge).

The post-training questionnaire repeated this question and participants re-rated their perceived knowledge. Additionally, they were asked to rate on a 5 point Likert scale presentation (0=extremely poor presentation, 5=extremely good presentation), communication (0=extremely poor communication, 5=extremely good communication), and relevance of the training (0=not relevant, 5=extremely relevant). Finally, participants were also presented with three free text sections for additional comments.

A *t*-test analysis was considered appropriate as it has been shown to remain robust to Type I errors with sample sizes as low as $n=2$ (de Winter, 2013)⁸. The mean and range of the communication, presentation and relevance scores were calculated. Qualitative information was utilised to support the quantitative results. All results were triangulated via feedback from both the trainee's clinical supervisor and the manager of the Shared Lives Team who observed the training to increase reliability and validity.

Results

The results of the analyses of the data is presented in Table 5:

Table 1: Results of the analyses of pre- and post-questionnaire

Measure (IV)	Pre-training	Post-training	Interpretation	t-Test Result
Perceived Knowledge	2.56	3.67		
Mean (SD)	(1.65)	(1.18)	Increase in knowledge	$t(17) = 5.66$; $p < 0.001$.
N=18				
Communication				
Mean (range)		4.4 (4-5)	Very good communication	
N=18				
Presentation/adaption for audience				
Mean (range)		4.4 (4-5)	Very good presentation	
N=18				
Relevance/meets need of participant				
Mean (range)		4.8 (3-5)	Very relevant	
N=18				

Perceived Knowledge

A dependant t-Test was conducted to compare participants' knowledge of the role of the clinical psychologist pre-and post-training. There was a significant difference in the scores for knowledge pre-training ($M=2.56$, $SD=1.65$) and post-training ($M=3.67$, $SD=1.18$) conditions; $t(17) = 5.66$, $p < 0.001$. These results suggest that that participants' perceived knowledge of the role of the clinical psychologist increased post-training. Data from the free response section also demonstrated increased knowledge and highlighted perceptions of the most useful element of the training: six participants reported that it was "understanding the difference between psychology and psychiatry" (P2); three participants reported it was "recording all the information" in relation to positive and negative behaviours; and three participants reported the value of exploration of the "different models [of psychology] available" (P6).

⁸ A Wilcoxon Ranked Sum calculation was also computed. Results also indicated a statistically significant rise in perceived knowledge ($p = 0.04$)

Communication

The mean rated score of effectiveness of communication was 4.4 (range 4-5) which falls within the 'very good communication' range. This indicates that participants felt the communication was very good. The qualitative data also supports the conclusion that the information was communicated effectively: "description of the role was explained fully" (P10).

Adapting style of communication

The mean rated score for effectiveness of the presentation style was 4.4 (range 4-5) which falls within the 'very good presentation' range. This indicates that participants felt the information was presented to a very good standard, and therefore, was adapted to suit their current level of understanding. Again, the qualitative data also supports the conclusion that the information was communicated effectively: "very helpful and interesting presentation" (P11).

Meeting the training needs of participants

The mean rated score of relevance/effectiveness in meeting participants' needs was 4.8 (range 3-5) which falls within the 'very relevant' range. This indicates that participants felt that the training was meeting their needs. Data from the free response questions also highlights participants felt the training met their training needs: "all very informative and will help in role [as a] shared lives carers" (P10) and, when asked what was least useful, one participant commented 'all content was relevant' (P14). Additionally, the qualitative data also highlights the achievement of specific learning needs for the training: understanding the differences between the roles of psychologists and psychiatrists, the use of different models and the support workers' role in supporting psychologists with the provision of relevant information.

Discussion

Overall, the results suggest that the trainee has demonstrated proficiencies in 'communication and teaching', indicated by the rise in perceived knowledge, and ratings in communication, presentation and relevance all fell within the 'very good', or 'very relevant' ranges. This was demonstrated over two separate training sessions, suggesting consistency and was supported by qualitative feedback from participants, the clinical supervisor and the manager of the 'Shared Lives' Team. Therefore, it can be postulated that the trainee is likely to show proficiencies in communication and teaching across other settings and in other training. However, the sample is small and context-specific. Therefore, results may not be generalizable beyond this training and

further evaluation of the proficiencies should be made at regular intervals. Additionally, as with any proficiency, effort must be made to maintain skills and a single evaluation should not be assumed to represent required achievement of proficiency.

Additionally, knowledge was measured through perceived knowledge rather than a measure of actual knowledge. Therefore, results may have been biased by the perceptions of the participants, and may not represent participants' concrete knowledge. Actual knowledge could have been evaluated via a more detailed measure but this would have placed increased burden on support workers and, potentially, decreased engagement with future training. Equally, there was potential for demand bias in the method and, thus, in the results: while questionnaires were anonymised, participants may have felt less able to provide feedback perceived as negative. Therefore, to improve further evaluations, a long-term consideration of increased knowledge and effectiveness of training would be sought, via observations of and discussions with staff, and monitoring of the quality and relevance of referrals made to the team.

Finally, there were two participants who rated their perceived knowledge at the maximum score (5/5) prior to training, meaning that the quantitative information gathered could not measure any change or difference caused by the training. The qualitative information provided indicated these participants found the session useful; however, their experience of the training was, in practical terms, unassessed. This feedback could have offered diverse information and, as such, should be considered in future evaluations.

Summary

Overall, there was evidence to support that the trainee's effectiveness in 'communication and teaching'. However, perceived knowledge was measured post-training and, therefore, actual knowledge and the longevity of knowledge was not measured. These issues will be considered in future assessments of personal effectiveness.

Word Count: 1500

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SYP B Case Study

Overview

Ella⁹, a 76-year-old lady residing on Harvard Ward – a ward for patients with an organic mental illness¹⁰, was referred to clinical psychology by the consultant psychiatrist following episodes of “anxiety”. These were understood by the nursing staff (NS) as a secondary behavioural or psychological symptom of dementia (BPSD), and frequently described as “histrionic” and “manipulative”. Psychological assessment identified these periods of “anxiety” occurred most frequently at night, on waking, and in relation to poor working memory (related to dyslexia and dementia) and were causing conflict with NS. The anxiety was further exacerbated by Ella’s attachment difficulties/developmental trauma during early childhood. A team formulation meeting was planned; however, the NS did not engage with this. Therefore, the case was reformulated by the trainee psychologist (TP) and alternative interventions were utilised to improve communication, interactions and ‘gate-keep’ long-term placement. Records suggested that NS struggled to implement/maintain changes generated during intervention. Consequently, although the use of terms ‘histrionic’ and ‘manipulative’ reduced, NS’s description of the ‘anxiety’ and their interaction with it remained largely unchanged. However, records from Ella’s long-term placement document fewer, and more manageable, episodes of ‘the anxiety’.

Capacity and Consent

The MDT assessed Ella as not having capacity to understand the complexities of giving consent to psychological input or her experience being utilised as a case study. To remain person-centred, evidence was collected via file review, observation and discussions to corroborate Ella’s consent. She openly discussed her ‘anxiety’ and life experiences with the TP, spoke of a desire to help people and was historically reported by friends to “go out of her way for people”. Therefore, the MDT agreed that Ella would have consented to both.

⁹ Pseudonyms have been used to protect confidentiality.

¹⁰ Harvard Ward is a ward (pseudonym to protect confidentiality) for patients with an organic mental illness, most frequently accommodating those with dementia. It employs a multidisciplinary team comprising psychology, medical and nursing staff (For this report, healthcare assistants are included within nursing staff), occupational therapists and activity co-ordinators.

Diagnosis

Ella has a diagnosis of dementia. An estimated 850,000 people live with dementia in the UK (Alzheimer's Society, 2014). In 2013, this diagnosis was re-categorised by the Diagnostic and Statistical Manual of Mental Disorder (5th edition; DSM-5) as a Major Cognitive Disorder (APA, 2013). However, the term 'dementia' is still utilised within the ICD-10 (WHO, 2009) and within UK Trusts and will be used within this report.

The assessment/formulation with the TP evidenced symptoms of generalised anxiety disorder (GAD), and reactive attachment disorder (RAD) as defined by DSM 5 (APA, 2013). The literature suggests the prevalence of GAD and RAD are not significantly different from that of the non-demented population (Magai & Cohen, 1198; Wolitzky-Taylor, 2010). However, NS understood her presentation as either Ella's personality or as a direct result of dementia. Consequently, her symptoms were documented as BPSD. The difficulty in classifying 'secondary symptoms' (those exacerbated by dementia, those present prior to dementia, and natural reactions to a life-changing diagnosis) highlights the significant overlap of symptoms between diagnoses and the difficulties in applying discrete diagnostic categories to the complexities of psychological distress (Boyle, 2007). This overlap can lead to inconsistent or inaccurate diagnosis and, subsequently, misunderstanding of the client's difficulties, poorer outcomes and inappropriate, and possibly harmful, interventions (Bentall, 2003; Freeman, Stone & Martin, 2007; BPS 2000).

The MDT's conceptualization of Ella's behaviour/symptoms as BPSD appeared to create a reliance on medication, obstructing consideration of other interventions, even when increasingly higher doses were unsuccessful. Furthermore, Ella's medical records indicated the medication may have caused both physical and psychological side-effects: frequently, Ella appeared to present with rebound anxiety (Herman et al, 1987), and reported increasing confusion and agitation following medication. Consequently, she would receive further pharmacological treatment until sedated – potentially reducing her quality of life and reducing future effectiveness of the medication (tachyphylaxis). These reflect published concerns about the use of high-dose prescribing and polypharmacy within dementia populations (Holmes et al., 2008; Margallo-Lana, 2001), and demonstrates the difficulties of focusing solely on diagnoses when understanding/managing the complexity of Ella's presentation/experience. Therefore, due to the complexities/overlap of dementia and 'secondary symptoms' and

the relational/systemic difficulties identified in the assessment, it was considered beneficial to utilise a systemic formulation.

Treatment Approach

CBT is frequently utilised with OAs (Arean & Cook, 2002) and recommended by NICE guidelines (NICE, 2006). However, the assessment with the TP indicated that her cognitive decline would limit her ability to engage in and benefit from individual therapy. Her presentation indicated that, while she would be able to engage, she would struggle to retain information within/between sessions or generalise skills learnt to different settings, although adaptations to CBT might have addressed some of these difficulties (Kraus et al., 2008). 'Anxiety' was linked to interactions between her and the NS/wider system. Given that CBT aims to change the 'faulty' to 'rational' thinking, if Ella's beliefs are largely a fair reflection of her situation (e.g. cognitive decline and restrictive accommodation) and her conflict with NS, then CBT would be ineffective.

Although difficulties with Ella's attachment style were identified, attachment-based therapies are most frequently intended for children (Hughes, 2007, Howe & Fearnley, 1999). Given Ella's age (76) and cognitive decline, it was agreed that attempting 'cognitive restructuring' was unrealistic, particularly during this short-term admission, and 'therapeutic holding' might raise concerns due to lack of capacity.

Systemic approaches 'externalise' the problem and understand difficulties as stemming from system dynamics rather than from the individual or diagnosis. By allowing/creating curiosity, reflection of alternative conceptualisations, and potential interventions, the system may develop a clearer understanding of itself and particularly the feedback loops between NS and Ella. Systemic approaches with OAs have limited evidence base. However, the literature suggests benefits for adults (Von Sydow, Behr, Schweitzer & Retzladd, 2010) and individuals with intellectual difficulties (ID) (Baum, 2006). As within ID, a systemic approach addresses the complex and salient familial, social and professional relationships around an OA with dementia. Ella stated she wanted the NS to understand why she was distressed, how the Harvey Ward reminded her of being in care and thereby improve the relationship. However, it was felt that, due to the power dynamics, it was not appropriate for Ella and NS to have traditional systemic sessions which could reduce effectiveness. Also, a systemic approach within a ward setting relies on the engagement of staff and the assessment process had indicated that psychological interventions were not a high priority for NS. Nonetheless, it was felt NS were crucial in implementing change. Therefore, a systemic approach was deemed most suitable, given Ella's requests, and that her presentation

was affected by the current healthcare system (and other contextual factors), the inter-relational problems observed/reported by staff and cognitive decline limiting the scope for individual work. Subsequently, Vetter and Dallos' (2003) formulation scheme was chosen due to its integrative approach and particularly its detailed consideration of attachment.

Analysis

Due to the fluidity/curiosity of systemic approaches, assessment, formulation, and intervention are not distinct phases (Table 1). Assessment and formulation were undertaken as the interconnected processes of analysis (exploring the system and its problems) and synthesis (integrating information into initial hypotheses of the problem) (Dallos and Draper, 2010; Dallos & Steadman, 2006).

Ella's System:

Figure 1 provides an overview of relationships between system members at the time of TP's entry to the system¹¹:

¹¹ The distance on the sculpt indicates how 'close/influential' members of the system appear e.g. Ella and OT are close together as they have many hours of contact and a good relationship and the psychology team is closer to OT than NS due to similarities in therapeutic approach.

The larger box represents Ella's wider System: The healthcare provision for those with Dementia

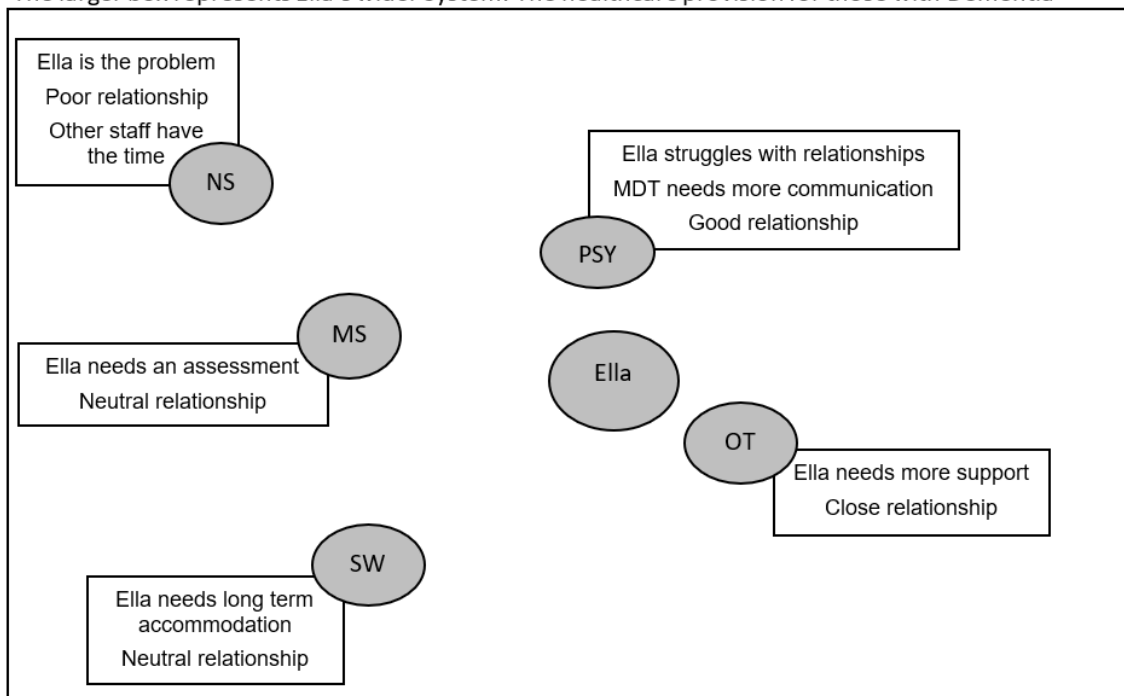


Figure 1: Sculpt of Ella's System at the time of psychological referral

MS= Medical staff; NS = Nursing staff; OT = Occupational therapy; PSY = Psychology team; SW = social worker

Deconstruction of the problem

The initial stage in systemic therapy is to deconstruct the problem (Dallos & Draper, 2010) utilising curiosity to form formulations and hypotheses. Ella's records were reviewed alongside interviews with her and members of the MDT (Table 1). The Hospital Anxiety and Depression Score (HADS; Zigmond, & Snaith, 1983) was considered as a method to help ground the inter-relational information within a measure of wellbeing, which has been shown to be valid and reliable (Bjelland, Dahl, Haug & Neckelmann, 2002). However, when Ella completed this, the scores did not reflect observed and reported experiences. Instead, it appeared to reflect how 'safe' Ella felt within the therapeutic relationship. Consequently, analysis of observations records was utilised to explore frequency and context of the 'anxiety', which was more in keeping with the systemic approach (Dallos & Steadman, 2006). This revealed NS understood the problem as being within Ella, frequently reporting within records and observations "Ella is demanding", "manipulative" and/or "attention seeking". The anxiety was rarely discussed or recorded. It was apparent Ella was ambivalent, sometimes feeling the problem was attributable to herself and, at other times, to NS.

Contrary to this, discussions and direct observations indicated that the problem occurred when Ella became worried, confused or scared, usually occurring prior to going to bed, on waking, or in relation to her experience of dyslexia (i.e. poor working

memory, difficulties following conversations and being asked to read or write) or dementia. Ella attempted to regulate emotions via learnt coping strategies (e.g. going to her room or outside). When these strategies could not be utilised, 'the anxiety' would drive her to repeatedly seek help from different staff members to 'fix' the problem (e.g. allow her into her room). NS would become frustrated by the 'anxiety', their inability to reduce it and thus her request, leading NS to reject support-seeking behaviours. This triggered Ella's relational difficulties/ insecure attachment style. She would become angry and rejecting while still attempting to meet her unmet need (Hughes, 2007). This was viewed by NS as further 'anxiety' or Ella being 'demanding', 'histrionic' and 'manipulative'. Furthermore, with no consistent strategy to support Ella with her distress, staff managed the 'anxiety' in different ways creating a split within the team (Figure 1).

When Ella did not disengage with staff (e.g. return to the lounge), her behaviour was reported as 'unmanageable'. However, NS frequently could not identify her needs or were unable to meet them due to staffing issues. When Ella sought support from other staff (e.g. psychology or occupational therapy), NS reported feeling inadequate and became disparaging towards other MDT members. Consequently, they reasserted the need for medication. However, observations and discussions suggested that when NS were able to facilitate Ella's coping strategies and remain supportive, they were able to work together to reduce distress within a shorter period and without medication. However, inconsistency in approach created increased distress due to Ella's attachment difficulties (Hughes, 2007). Ella appeared to present with a disorganised attachment style (Bowlby, 1989): with OT staff, she would frequently seek them out and become acutely distressed on separation; however, she would experience NS as rejecting creating an increased need for attachment/safety from other staff (Hughes, 2007). Consequently, 'anxiety' escalated further with NS increasing the split between staff.

Problem-maintaining Patterns

A cycle was observed between Ella and NS (Figure 4): Ella would become distressed (pacing, shaking, reacting fearfully to men [e.g. flinching], crying and, when exacerbated, banging her head) and attempt to utilise her coping strategies (e.g. seek solitude by going outside or to her room), but usually failed and felt "useless". Consequently, she would feel scared and seek support from staff, but struggled with a feeling of being a burden. Initially, NS were supportive of Ella's requests, but became confused, overstretched and frustrated, and on failing to meet her needs, became angry/rejecting. Ella then felt rejected by the NS, but also her needs were not met.

Subsequently, she became increasingly scared/angry, but continued to seek support. Further requests of support then led staff members to develop a sense of resentment for creating extra work; Ella became the cause of problem, causing them to disengage from providing additional support, thereby maintaining the 'problem'. This pattern may be reflective of Ella's early relationships when in care.

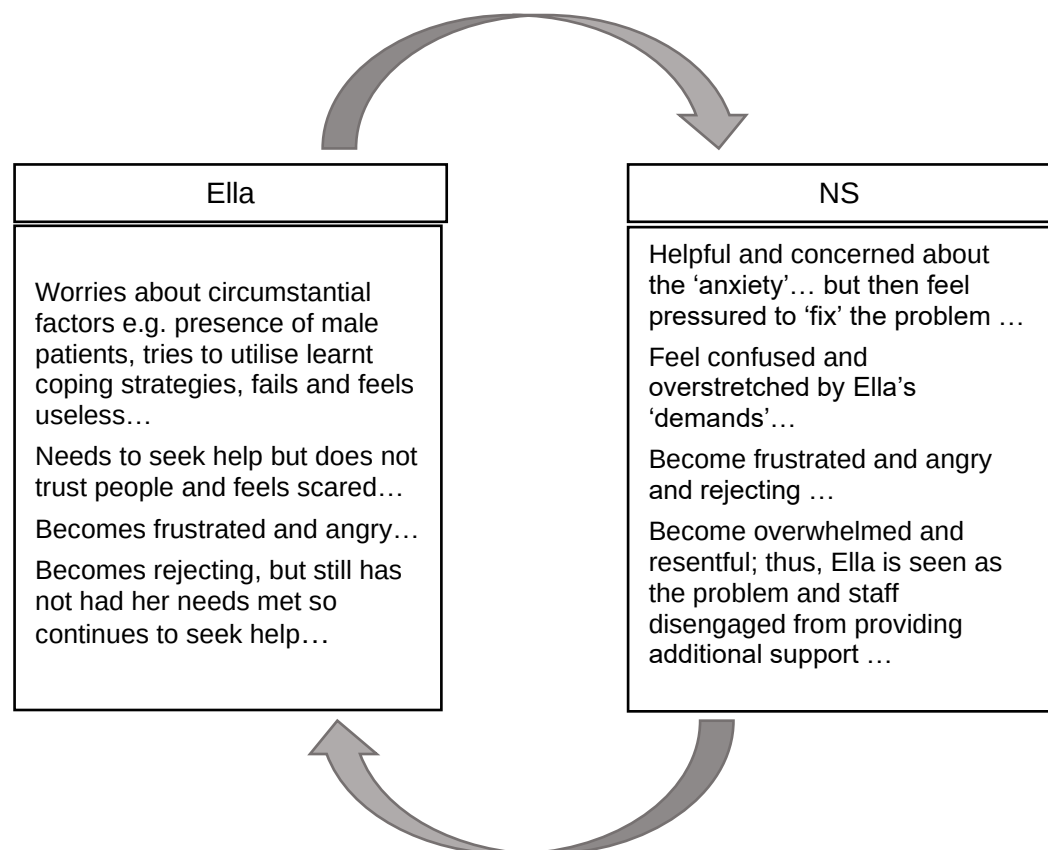


Figure 4: Circularity indicating core patterns maintaining the problems

Attachments

Ella reported she was “dumped” into the care system at a young age following several years of neglect from her birth mother. It is therefore likely she will have experienced developmental trauma and difficulties with her attachments (Hughes, 2007; Van de Kolk, 2017). She also remained in a care home for many years before finally being adopted, and it is unlikely, given her age, appropriate interventions were provided to reduce the impact of developmental trauma (Van de Kolk, 2017). These experiences are likely to have led to formation of insecure attachment – a sense that she was not loved, wanted or worthy of affection. This might explain why Ella was described as ‘fiercely independent’ but also very ‘demanding’. It is likely that the above

interactions continue the pattern of both rejecting others while constantly seeking approval and support.

Belief and Expectations

Given early attachment experiences, Ella is likely to view herself as unlovable and a burden (Howe & Fearnley, 1999), further exacerbated by prolonged periods in care where she reports experiencing abuse. She has lived alone for 19 years which may have been due to beliefs that others, particularly men, are untrustworthy. It is possible the hospital setting triggered memories of abuse or neglect, and at referral, there were no other female residents on the ward most likely exacerbating Ella's fears and anxieties. Additionally, she perhaps expected health professionals to go "above and beyond" as she had during her employment as a support worker.

NS expect patients to behave 'appropriately' and remain calm and co-operative, alongside assuming a certain presentation of cognitive decline. Contrastingly, Ella was deemed difficult and unmanageable, and her reaction 'histrionic'. NS perceived the apparent cognitive ability to mean she should appreciate their perspective and not seek support at 'inappropriate' times. The NS were a closed system and viewed themselves as separate from other professionals. Consequently, it was hypothesised that they did not always value the input from the MDT and would not engage. The nonattendance of staff at the case formulation meeting confirmed this hypothesis. This prevented more directive therapeutic approaches. Subsequently, shorter and more frequent input from the TP was utilised.

Contextual issues

Ella faced many disadvantages: she lived in a socially deprived area with limited financial resources; dyslexia impacted on literacy; she recently suffered from bowel cancer; and had no family support for 19 years. Being hospitalised via a deprivation of liberty safeguards (DoLS; Mental Health Act, 2005) may have eroded the personal independence on which she relied to manage these life events, leaving her increasingly anxious and hopeless.

Synthesis

Numerous complex factors have shaped and maintained the 'anxiety': Ella's insecure attachment style is likely to have developed from experiences prior to and within the care system. This attachment style was replicated with NS. While attempting to manage her cognitive decline (e.g. disorientation), Ella had to cohabit with numerous strangers on Harvard Ward and rely on health professionals to facilitate her activities. Her environment further triggered her insecure attachment style, and fears around

abuse/neglect, particularly fear of male patients whom she could not avoid. When Ella was prohibited from using her own coping strategies, distress increased, and she became increasingly reliant on support from staff. However, staff members' expectations that Ella should behave in a certain manner (i.e. not become overly anxious or ask multiple people for support) created conflict between Ella and NS.

Intervention

The intervention aimed to change the system towards more humanistic care strategies, by drawing upon systemic ideas of hypothesising, circularity and neutrality (Dallos and Draper, 2010). Given this circularity, the intervention cannot be distinctly separated from other aspects of the approach. Therefore, an overview of the main contacts with the system is presented in Table 6, followed by a more detailed account of the processes of intervention over a two-month period.

Table 6: Ella's intervention					
Week	Contact Type	Analysis	Synthesis	Intervention	Present
1	Referral	Deconstruction			
	MDT, Handover(X3)	Deconstruction Beliefs			MDTX8; NSX3
	Meeting	Deconstruction Beliefs		NC, EP	Ella
	Observation	PP Attachments		NC, EP	Ella MDT
2	MDT, Handover(X3)	PP, Attachments	Synthesis	NC, EP	MDTX8 NSX3
	Meeting	PP, Attachments	Synthesis	NC, EP	OTX2
	Observation	PP, EP, Attachments			Ella MDT
3	MDT, Handover(X3)	Beliefs, CI	Synthesis	NC, EP	MDTX8; NSX3
	Report	Systemic Formulation	Synthesis	Report	
4	MDT, Handover (x3)	Beliefs, EP, CI	Synthesis	Referral to AC	MDTX8; NSX3
	Formulation Meeting	Systemic Formulation	Synthesis	GH CQ	DNA

	Report	Deconstruction, Beliefs, PP	Synthesis	Recommendations	
5 - 8	MDT, Handover			Education, CQ, GH Gatekeeping	MDTX8; NSX3
7	Meeting for Carehome			Formulation, Education	OTX2
8	Meeting			Evaluation	MDTX8
	Meeting			Evaluation	OTX2
3 month	Records review			Evaluation	

AC—activities co-ordinator; CI—contextual issues, CQ—circular questioning; EP—exception to the problem; GH—generating hypothesis; MDT—multidisciplinary team; NC—neutrality and curiosity; NS—nursing staff; OT—Occupational therapy; PP—problem patterns

Neutrality and the invitation to curiosity (Hedges, 2005; Dallos & Steadman, 2006)

Given the closed nature of the NS and concerns that being overly directive would hinder integration with the NS system, a neutral position was aspired to prevent the TP from siding with or blaming either Ella or NS. However, to remain neutral might have limited change or inadvertently promoted a non-person-centred approach to care; therefore, the trainee also encouraged the system to be curious, and question all understanding and possible solutions (Cecchin, 1987). Additionally, this allowed TP to also remain questioning of her reactions to Ella, NS, and other team members.

Circularity and questioning (Tomm, 1988, Hedges, 2005)

In systemic practice, questioning methods are part of the intervention. During the contact with Ella's system, questioning type was determined by the intended outcome. Initially, linear questions were exploited to orientate TP to the concept of the system and its problems (e.g. "Who is involved in supporting Ella?" "How would they describe the problem?"). This also allowed TP to join staff in the traditional linear view of presenting difficulties. Once orientated, circular questions were used to identify, explore, and identify 'patterns that connect' different perspectives, feelings and events within the system (e.g. "How would Ella describe the problem?" "How would OT react to that situation? Who is most effected by the anxiety?"). Strategic (directive) and reflexive (non-directive) questions were used in later contacts to influence NS in specific ways to prevent them from continuing in the same problematic manner (e.g. "What would happen if for the next week you spent the time to understand Ella's needs?" "If you were to spend more time with Ella what do you think she would do?" "If next time Ella seemed anxious you thought about her developmental trauma, how do

you think you would react?”). Due to the closed nature of the system, reflective questions were utilised to facilitate change via exploring alternative views/explanations, whereas strategic questions aim to question behaviours to ‘correct’ them and may have led to further disengagement between the NS and TP.

Hypothesising and exception to the problem (Hedges, 2005; Dallos & Steadman, 2006)

During contacts with the system, attention was paid to times when the system deviated from problem-maintaining patterns. This occurred at times when NS supported Ella in creative ways that reduced distress in Ella and NS, and when they externalised the problem during discussions. Curiosity was used to explore these exceptions to the problem with NS to widen and develop their descriptions. This was to increase NS belief this could be replicated (e.g. “Why was that situation different”, “What helped you act differently? “How did that feel”? “What would using that strategy in the future look like?”). The aim of identifying these exceptions was to allow NS to consider alternative solutions and alter thinking about the problem.

Hypothesising was used in all contacts for several reasons. It engaged NS in exploration of their own ideas and “hunches” by viewing NS as working in the optimal way given the circumstances. It connected NS more closely with the client’s unique story and encouraged further curiosity and self-other reflexivity. This prevented any member of the system from ‘falling in love’ with their hypotheses and made explicit when members were imposing their world view onto the system or Ella. However, hypothesising was utilised more frequently later in the intervention following the limited engagement of NS. Example of curious hypothesising included: I wonder if Ella’s early neglect makes her really struggle to feel safe; I wonder if experiencing abuse means Ella worries this might happen again, and I wonder if NS’s frustrations might appear rejecting and scary.

Evaluation

Due to limited NS engagement, a content analysis (Graneheim & Lundman, 2004) of Ella’s daily observations was used in the absence of systematic behavioural records. As predicted, there was no reduction in NS reporting ‘anxiety’ and similar themes following psychological input. It was unlikely that Ella would adapt to different relationship styles within two months, and many aspects of the hospital context continued to trigger her anxiety. However, the initial theme/narrative reported - ‘Ella is a problem’ (‘Ella is demanding’ - 10 pre-input, 3 post-input, ‘Ella is being her normal self’ - 2 pre-input, 0 post-input) was shown to be replaced by a theme/narrative of NS

externalising the problem (e.g. Ella was anxious). This change in the NS's understanding of Ella's difficulties was also observed in handover meetings, by both the trainee and supervisor; the use of these words within recorded notes was less frequent.

However, results indicated increased use of anxiety medication, in line with the externalisation of the problem. This initial step of externalising the problem may have led to pharmacological treatments for anxiety (medical model). This was not the desired outcome. While this broke the problem-maintaining cycle, NS appeared to gain more benefits (e.g. reduction in the pressure to manage her behaviour) than Ella, as she was often left increasingly sedated, and still reported feeling anxious around staff. Due to the limited period to continue psychological input, it was unclear if this change did improve Ella's experience with NS. With greater time, input would have continued, using the same skills to explore and encourage curiosity about other methods to understand and relate to the "anxiety" and Ella's experience.

Gatekeeping placement

Ella's systemic formulation hypothesised that attachment disorder/difficulties would prevent her from returning home with live-in carers due to increased anxiety from "strangers" entering her home. Therefore, it was in Ella's best interest to be placed within supported care. The formulation and feedback loop were explored with the care home via OT. Three months into the placement, reports indicated Ella still experienced episodes of 'anxiety', but these were infrequent and "manageable". This indicated that the problem-maintaining feedback loop had not arisen within the supported care placement, and, arguably, the systemic intervention supported a successful placement transition. However, due to discharge, exploration of the new system was not possible. Consequently, further systemic work was recommended to ensure continuation of support.

Reflections

I have chosen to reflect upon the difficulties encountered in engagement with NS. I was struck by the closed nature of the NS system: frequently they appeared reluctant to allow other professionals into their system regardless of the difficulties faced. I found it hard to appreciate how, even when clear benefits had been presented and acknowledged by NS, they remained fundamentally closed to others' input. I felt uncomfortable with much of the language used to describe Ella, and the tendency to rely on medication to 'treat' clients. Specifically, I was concerned that questioning the status-quo may have further separated subsystems (Figure 4).

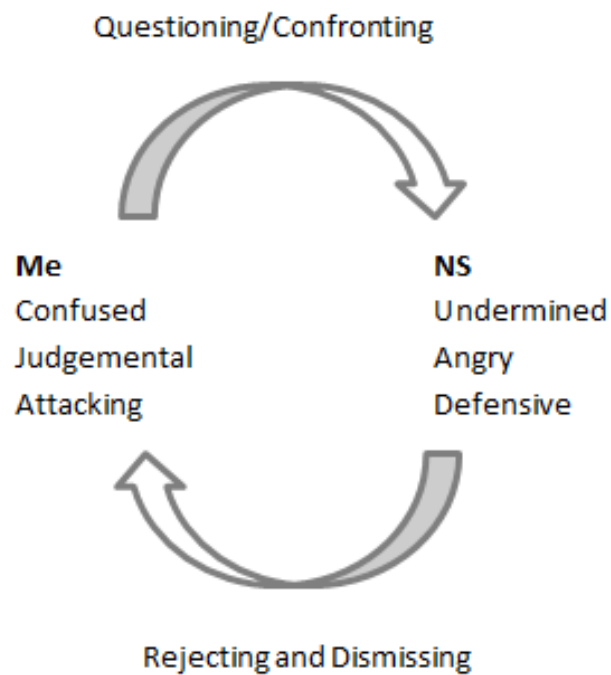


Figure 4: Possible feedback loop of questioning NS

This led me to a state of homeostatic inertia (Jackson, 1957) and impacted on my ability to engage with the NS (Figure 5).

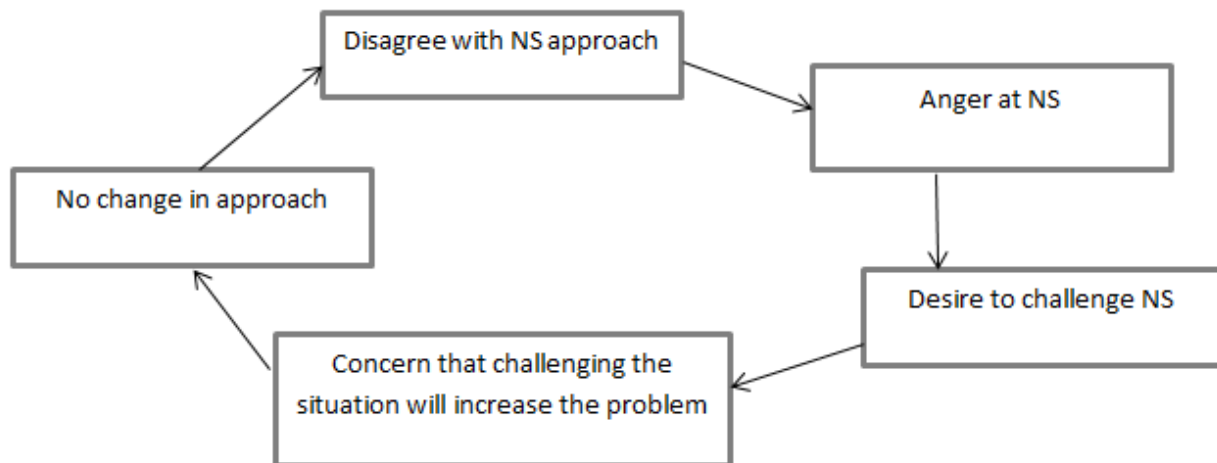


Figure 5: Homeostatic Inertia

The mapping out of these loops helped me understand important aspects of the system and then use supervision to explore this from a narrative approach i.e. how frequently psychology subsystems maintain scripts around working with different teams. NS are historically the main providers of care and, due to the many competing expectations

placed upon them (Gordon, 2005), are likely to have scripts about 'not needing/be able to integrate with other professions', 'that other professions do not understand their difficulties' and 'other professionals have it easy'. Reflection allowed me to appreciate the level of complexities any system has, and the historical (cultural and social) influences. Subsequently, I was able to consider ways to effectively engage NS, by focusing on difficulties voiced in relation to the system and by remaining neutral when discussing the advantages and disadvantages of all potential solutions. However, even at the end of my placement, it was evident I had not made much progress in becoming integrated with the NS (e.g. NS not attending case formulations). In future roles, I will need to develop closer relationships prior to difficult interventions.

Working with Ella's system has helped develop skills in the management of situations with strong historical dominant narratives and closed systems which are hard to integrate and change. These issues will likely occur within many psychology roles and, therefore, I will inevitably continue to develop essential skills.

Word Count: 4000

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SYB B APE

Overview/Background

The Health and Care Professions Council states that psychologists must 'be able to communicate effectively' 'adapting to the service user's needs/requirement (HCPC, 2015) and, similarly, reflected in British Psychological Society (BPS, 2014) standards for trainees: both clinical and non-clinical information must be communicated effectively through preparation and delivery of teaching and training which consider the needs and goals of participants.

These professional standards suggest the therapist's abilities directly relate to effectiveness of therapy and, thereby, abilities and skills must be monitored across varying roles and settings using individualised measures of efficiency combined, where possible, with traditional standardised outcome measures.

The trainee psychologist's (TP) communication and teaching skills were evaluated by direct qualitative and quantitative feedback corroborated by the standardised outcome measures of the Looked After Children (LAC) services specific 'Attachment Group'. This group aims to increase Foster Carer's (FC) psychological knowledge and provide specific skills to address the difficulties LAC experience to reduce their child's overall stress and increase parental confidence.

Methods

Participants were FCs who completed the 'Attachment Group' (n=11). The course comprised seven, weekly three-hour sessions, followed by face-to-face reviews three weeks later. During the first session, participants¹² completed the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) and the Brief Parental Self-Efficacy Scale (BPSES; <https://www.corc.uk.net/media/1279/brief-parental-self-efficacy-scale.pdf>). Participants also generated one personalised goal (Appendix 3).

During each session, participants completed:

(1) feedback on 'relationship' with facilitators, 'goal and topic' of session, and 'approach or method of facilitator'. Each area was measured on a 100-point Likert scale and four free-text sections were available for additional comments (Appendix 3)¹³;

¹² Demographics not recorded to preserve anonymity

¹³ The service agreed participants should not complete feedback separately due to increased participant burden, but should be encouraged to provide feedback for both facilitators

(2) a goal progression scale, rating how the session had helped them progress towards their goal.

In the final session, the SDQ and BPSES were repeated.

Three weeks later, the follow-up review was completed to discuss long-term effects of the group.

Analysis

A dependant *t*-test analysis was appropriate for the pre- and post-outcome measures as it remains robust to Type I errors with sample sizes as low as $n=2$ (de Winter, 2013). The Likert scales were also analysed for the most clinically informative information (e.g. mean/mode/range) using Excel, and content analysis of qualitative information (Hsieh & Shannon, 2005) was utilised to support these results¹⁴. Results were triangulated (Morse, 1991) via ‘check-ins’ with the group to monitor confounding variables, feedback from the trainee’s clinical supervisor, the co-facilitator and during reviews to increase reliability and validity.

Results

The results of data analyses are presented in Table 7.

Table 7: Results of data analyses

	First Session Mean (SD)	Final Session Mean(SD)	t-Test result
SDQ *	21.5 (7.2)	19.4 (6.9)	$t(11) = 2.43, p < 0.03.$
Brief Parental *	17.6 (2.9)	19.3 (3.3)	$t(11) = -2.25, p < 0.046.$
Relationship *	93.9 (6.77)	97.8 (3.09)	$t(11) = 2.17, p < 0.03.$
Goal Topic *	87 (11.12)	97.27 (5.18)	$t(11) = 3.75, p < 0.002.$
Method and Approach *	96.6 (5.84)	98.9 (2.02)	$t(11) = 1.30, p = 0.11.$
Goal Progress (change in score) *		+4.4 [1-7]	

Note: * $n=11$;

The data from the key domains demonstrated the TP’s skills in teaching and communication:

¹⁴ The service agreed a structured examination of parental skills/knowledge would potentially risk disengagement from the service

- (1) 'Relationship with facilitator' (RF) - The t-Test analyses showed increased scores for RF between first session (M=93.9, SD=6.8) and final session (M=97.8, SD=3.1) conditions; $t(11) = 2.17$, $p = < 0.03$. This indicates participants felt understood, respected and accepted by the TP within the first session. This was supported by qualitative data: "facilitators really listened to the group" (P5), "group felt really supportive and safe" (P8).
- (2) 'Goal and Topic' (GT) - The t-Test analyses showed increased scores for GT between first session (M=87, SD=11.1) and final session (M=97.3, SD=5.2) conditions; $t(11) = 3.75$, $p = < 0.002$. This indicates participants felt the TP worked on/talked about what they wanted to discuss. Qualitative data also implies the TP's ability to adapt to the participants' needs/requirements: "[the group was] really useful and helped me understand my child's difficulties" (P1), "session was really good, wish I had been told about PACE before" (P6).
- (3) 'Method and Approach' (MA) - The t-Test analyses showed increased scores for MA between first session (M=93.9, SD=6.8) and final session (M=97.8, SD=3.1) conditions; $t(11) = 2.17$, $p = < 0.03$. This indicates participants felt the TP's approach was a 'good fit'. Qualitative data suggests the TP's ability to adapt style and approach led to effective communication of psychological concepts and skills: "enjoyed the discussions, very helpful" (P4), "I found the exercises thought provoking" (P6).

The mean change in progress towards personalised goal (M = 4.4) indicates that participants felt the group helped them move towards achievement of personalised goals and further evidenced the TP's ability to consider individuals' goals. Additionally, the overall improvements following the group reflect the TP's effectiveness in communication and teaching. The t-Test analyses show reduction in overall stress scores between pre-group (M=21.5, SD=7.2) and post-training (M=19.4, SD=6.9) conditions; $t(11) = 2.43$, $p = < 0.03$, and an increase in the participants' belief (self-efficacy) to manage children's difficulties between pre- (M=17.6, SD=2.9) and post-group (M=19.3, SD=3.3); $t(11) = -2.25$, $p = < 0.046$. Both changes were small, but statistically significant.

Finally, qualitative data from reviews indicated longer-term effectiveness of the TP's communication and teaching skills – participants statements illustrate themes:

- (1) Increased knowledge and understanding: All participants reported increased understanding of their child's attachment and its impact on their behaviours: "I now understand why my child lies even when he is so obviously lying" (P1). Most participants could explain different areas discussed and their implementation of

these: "... it was interesting to think about how [child]'s brain is different This helped me be more empathic and curious with him" (P5). Two participants provided fewer examples, but still reported increased understanding and implementation of skills.

- (2) Helpfulness of group: All participants highlighted how the group was helpful and provided relevant information: "really helpful group – it has given me lots of techniques to use" (P1).
- (3) Approachability of therapist: Most participants discussed the supportive role of the therapist and creation of an environment in which they could openly discuss difficulties: "[the facilitator/s] were open and not judgmental, [pause] it made me feel safe to approach them and talk about my difficulties with the group" (P10).

Discussion

Data from key domains, 'RF', 'GT' and 'AM', demonstrate consistently high ratings for the TP's skills in teaching and communication. Furthermore, results show that, between the first and last sessions, 'RF' and 'GT' ratings improved further, and 'AM' was maintained. This evidences the TP's ability to form and develop a strong therapeutic relationship with participants (Horvath, 2015), to combine the goals and topics of the service with participants' goals and needs, and to facilitate small groups with an approach that meets the needs of participants (HCPC, 2015). These skills are further corroborated by ratings of overall effectiveness of the group in reduction of overall stress, increase in parental self-efficacy, progression towards individual goals, and demonstration of longer-term increase in knowledge and skills within follow-up reviews.

Although sample size is small and context-specific, there is evidence of consistency in TP's skills between sessions. However, likelihood of demand bias (Grimm, 2010) must be considered, as, inevitably, there will have been areas in which the TP could improve which were not reported. Therefore, the TP should continue to reflect and seek supervision to improve skills. Also, it would be beneficial for the TP to evaluate these skills in larger group settings (e.g. lectures).

Although qualitative data demonstrates the recall and application of long-term knowledge and skills, it is possible that these might not fairly reflect the totality of participants' knowledge, and, therefore, the long-term effectiveness of the TP's communication skills. Actual knowledge could be evaluated through structured examinations of knowledge. However, as foster carers, participants may feel their

parenting skills or ability to do their job are being questioned. This may cause undue stress (Folkman & Lazarus, 1985) or negatively impact on working alliances thereby potentially decreasing effectiveness of therapy (Horvath & Symonds, 1991) or even preventing individuals, and thus the foster child, from continuing therapy. Therefore, further long-term evaluation of knowledge should be obtained via interviews with social workers, via observations in therapy and from clinical records.

Word Count: 1387

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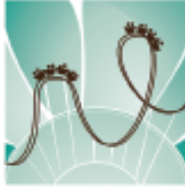
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Appendices

Appendix 3: Goal Progression Chart



Goal progression chart

Goal N°



This is one of up-to-three goals to track.

You can turn this chart on its side for a quick look at progress over the sessions.

GOAL:

Session	Date	Today I would rate my progress to this goal? (please circle the appropriate number below)										
Remember a score of zero means no progress has been made towards a goal , a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two												
1		0	1	2	3	4	5	6	7	8	9	10
2		0	1	2	3	4	5	6	7	8	9	10
3		0	1	2	3	4	5	6	7	8	9	10
4		0	1	2	3	4	5	6	7	8	9	10
5		0	1	2	3	4	5	6	7	8	9	10
6		0	1	2	3	4	5	6	7	8	9	10
7		0	1	2	3	4	5	6	7	8	9	10
8		0	1	2	3	4	5	6	7	8	9	10
9		0	1	2	3	4	5	6	7	8	9	10
10		0	1	2	3	4	5	6	7	8	9	10
11		0	1	2	3	4	5	6	7	8	9	10
12		0	1	2	3	4	5	6	7	8	9	10

Copy of Completed SSRI Form

