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the Degree of Doctorate in Clinical Psychology (ClinPsyD) at
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Volume II

Clinical Practice Component

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This Volume is dedicated to the memory of the late ‘Sister Grace’

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My thanks first and foremost is to God for guiding my every step. Thank you for being ‘my’ refuge, ‘my’ strength and ‘my ever’ present help. For Your grace, Your mercy, Your love – I thank You.

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Overview

This thesis is submitted in partial fulfilment of the requirements for registration for the degree of Doctorate in Clinical Psychology (D.Clin.Psy.) at the school of Psychology, University of Birmingham, UK. This thesis is presented in two volumes. Volume I consists of the research component of the thesis and Volume II contains the written clinical component or work undertaken during training. .

Volume I is comprised of two papers; the literature review and a research paper. The literature review presents a narrative account, exploring the literature related to understanding the experience of ethnic minority therapists. The research paper follows on from this review and is therefore a qualitative exploration of the experience of identity in Black British psychologists.

Volume II contains five Clinical Practice Reports (CPR's) that were completed during the course of training. They are a representation of the clinical work carried out whilst on placement within Child and Adolescent Mental Health, Older Adult, Learning Disability and Adult Mental Health specialities. CPR1 presents both psychodynamic and systemic formulations of a young boy and his family referred to the service for help to cope with the behavioural and associated learning difficulties associated with his diagnosis of Autistic Spectrum Disorder. CPR2 reports a small-scale, service related, research report. It was designed to explore attitudes, beliefs and experiences of the practitioners tasked with delivering a parenting programme, in order to examine the implementation and dissemination of the group. CPR 3 details the use of the Model of Consequences of Need-Driven, Dementia-Compromised Behaviour, which guided the assessment of an older adult and her care environment. A single-case experimental design was used in to evaluate a psycho-social intervention. CPR4 is a case study which outlines an adapted approach to cognitive-behavioural treatment for a 12-year old Autistic boy experiencing generalised anxiety. CPR5 presents a narrative cognitive-behavioural approach to working with the impact of psychosis. It details the assessment, formulation and intervention conducted with a 63-year old man with a diagnosis of Schizophrenia. As CPR5 was presented orally, the abstract and slides are presented here for reference.

VOLUME II

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CLINICAL PRACTICE REPORT (CPR1)

Psychological Models

Systemic and Psychodynamic formulations of 8-year old Sukwinder and his family.

*** All names and identifying features have been changed to maintain confidentiality**

ABSTRACT

The report considers the case of Sukwinder, age 8. Sukwinder has a diagnosis of Autistic Spectrum Disorder and associated learning and behavioural difficulties and attends a specialist educational placement.

Sukwinder's family were referred to Child Psychology for help in managing his behaviour. In addition to this, Mrs S's added that she required help to manage his "restricted" diet, his sensitivity to loud noises, demanding behaviour and the competitive, conflictual relationship that exists between Satwinder and Sukwinder. However the assessment presented Sukwinder's difficulties from a different perspective and reflected Mrs S's difficulties in accepting her son's diagnosis in the context of her cultural and personal expectations.

Formulations from a systemic and psychodynamic perspective are outlined.

CASE HISTORY

Referral

Sukwinder, age 8, was referred to Child Psychology by a Consultant Community Paediatrician. Sukwinder has a diagnosis of Autistic Spectrum Disorder and associated learning and behavioural difficulties and attends a specialist educational placement. The family have previously been seen by another Child and Family team who worked with them since his diagnosis at three years old. His mother (Mrs S) has also previously completed the 'NAS Early Bird Plus' programme, a psycho-educational group aimed at increasing awareness and confidence in parents with autistic children. The referral was made requesting additional help for the family in managing his behaviour. Mrs S added that her main reasons for seeking help were to manage his "restricted" diet, sensitivity to loud noises, demanding behaviour and the conflictual relationship between Sukwinder and his twin, Satwinder.

Assessment

A range of methods were used to assess the needs of the S family. The assessment took place over three sessions and consisted of two interviews a home observation and a battery of questionnaires from the Triple P – Positive Parenting Programme.

Interviews. Clinical interviews were used in order to gather descriptive information from differing perspectives. They also provided an opportunity to observe patterns of communication between family members.

The initial assessment interview was attended by Sukwinder, Mrs S, his twin sister Satwinder and his 16-year old sister, Jagvir. During this assessment, Sukwinder busied himself drawing and playing with the building blocks in the room. He did not engage with the psychologist and initiated contact with his family members only when he needed their help, for example to draw something specific. Satwinder appeared acutely aware that the focus of the session was on Sukwinder's difficulties and she was keen to give her account of her experience of living with him., stating that "got away with things". She also appeared keen to engage the psychologist attention and thus early on in the session she drew a picture of the psychologist and presented it to her.

Throughout the assessment it was clear that in an attempt to avoid tantrums, Sukwinder's demands were met immediately. However this often had an adverse effect on Satwinder, whose wishes were ignored or compromised in order to placate Sukwinder. This resulted in both children becoming tearful. Mrs S was notably anxious at this point and it was her 16-year old daughter, Jagvir who intervened. She became the mother-like figure in the room, negotiating between the twins and eventually resorting to taking both children outside of the room to console them. Both Mrs S and Jagvir later reflected that Jagvir often took this role as a parental figure. Mrs S added that she felt Jagvir often did so more effectively that she did.

The second was attended by Mrs S alone to follow up on issues raised in the initial session that she may not have been comfortable raising in the company of her children. It also allowed her the space to speak freely without having to keep a watchful eye on her children. She was visibly less agitated in this session.

Questionnaires. Questionnaires were used alongside this method in order to access further information on Sukwinder's strengths and difficulties, the family's parenting style, and the impact of the problem on the family as a whole. As Sukwinder's autism was diagnosed at three years, no diagnostic assessment was deemed necessary. The questionnaires were therefore used as a means of identifying key difficulties and to follow up on the relational themes raised during the initial interviews. As mentioned above these questionnaires form part of the pre-group assessment for the Triple-P programme. Questionnaires included the Strengths and Difficulties Questionnaire (Goodman, 2000), the Relationship Quality Index (Norton, 1983), the Parent Problem Checklist (Sanders & Dadds, 1993), the Parenting Scale (Arnold, O'Leary, Wolff & Acker, 1993), the Depression Anxiety Stress Scales (2nd Edition) (Lovibond & Lovibond, 1995) and the Being a Parent Scale (Johnston & Mash, 1989). Mrs S was also required to complete a Parent Daily Report Checklist (Chamberlain & Reid, 1987). The full breakdown of scores is included in the appendix. Due to the sheer number of questionnaires and to aid therapeutic rapport, Mrs S was not required to complete these during the session.

As expected, the scores on the Strengths and Difficulties questionnaires were in the abnormal range, with Sukwinder scoring particularly highly on the Hyperactivity factor. Scores on the Parenting Scale were not within the clinic group mean, however it is worth noting that her score on the 'laxness' factor was above the clinical group mean. Also, a number of her answers were inconsistent with that reported during interview and that which was observed. On this particular questionnaire Mrs S may have felt her parenting was under scrutiny and may have felt unwilling to give an impression she feared would be viewed unfavourably.

On the Being a Parent Scale, Mrs S's total score was within the mean for mothers in the community. However it is worth noting that her score on the 'satisfaction' scale was below the mean, highlighting her frustrations with her inability to "do a good job".

In addition scores on the Relationship Quality Index and the Parent Problem Checklist were both within the clinical range, highlighting relational difficulties and differences in managing Sukwinder's behaviour.

Her scores on the Depression Anxiety Stress scales were all within the normal range. However the level of distress reported on the questionnaire is again inconsistent with the level of distress reported during interview. She is currently on medication to manage her high blood pressure and reports that she has approached her doctor on several occasions stating that she feels she is depressed. The euro-centricity of these measures is noted and the fact that psychological distress if often reported and expressed differently in different cultures is acknowledged. This is a factor that these questionnaires may be unable to account for.

Observation. As such questionnaires ask questions about parenting style, it is acknowledged that parents, particularly early on in the therapeutic relationship, may wish to give desirable answers in order to prove themselves to be “good parents”. Direct observation of the child in the home environment was therefore used alongside the questionnaires and clinical interviews. The observation took place during the school holidays to allow for an observation of a ‘typical’ home routine and included observation of a meal time routine which had been reported at interview to be problem area.

The observation also allowed for relationships to be observed as they naturally occurred, outside of the environmental influence of the clinic. However it is acknowledged that having a stranger in the family home, observing another family member, naturally creates a false environment. Nevertheless, the observation was particularly useful in Sukwinder’s case as he was more communicative and engaged than he had been during the initial interview. It was noted that he is capable of feeding himself, showing and receiving affection, and carrying out tasks such as hanging the clothes on the washing-line. Tantrums and sibling rivalry and the way in which Mrs S managed these behaviours were also observed. As well as observing Sukwinder, this assessment allowed for observation of patterns of relating to family members who had not attended the initial interview.

PRESENTING PROBLEM AND BACKGROUND INFORMATION

Mrs S initially described Sukwinder's difficulties in the context of a family holiday that was being planned to India. She was primarily concerned with Sukwinder's limited diet, which she felt would be a particular problem in India. She was also reluctant for extended family members to notice these difficulties and therefore wanted to avoid where ever possible having "special" food put aside for him. However, given his diagnosis, Sukwinder eats a surprisingly large variety of food of different textures and flavours.

Mrs S also further explained Sukwinder's difficulties with loud noises in the context of familial obligations to attend family gatherings and special occasions. She explained that Sukwinder was unable to tolerate the loud music and fireworks that were often present at these parties. Someone was therefore always required to miss the gatherings altogether or sit in the car with him.

Mrs S also spoke of her difficulties in managing Sukwinder's tantrums and demanding behaviour. She noted that certain behaviours were exhibited with her only, such as his refusal to feed himself or follow instructions. She added that she was often too anxious to take him out for leisure activities as she has on numerous occasions been forced to leave, embarrassed by his behaviour. However Mrs S admits that his misbehaviour is behaviour is often met with an immediate response to his demands in order to placate him.

It became clear that Mrs S had chosen not to share Sukwinder's diagnosis or difficulties with the extended family or community. As a consequence, she worked hard to conceal his difficulties, for example, taking him to a different temple. Mrs S stated that she had done so to protect Sukwinder as she felt that very few people would understand his diagnosis. She also felt the need to protect his future and spoke of the impact his diagnosis might have on his ability to marry and continue the family name.

An additional presenting problem, inextricably linked to that above is managing Satwinder's behaviour and meeting her demands to be treated equally. Satwinder made reference to the reward charts that had been set up by Mrs S and stated that Sukwinder had more stars that she did despite his bad behaviour. She also expressed that Sukwinder was rewarded for minor things and the good things she did appeared to go unnoticed. Mrs S admitted that she often felt overwhelmed by Sukwinder's special needs to the point where Satwinder's needs for attention could not be met.

Family Background Information

The family structure is summarised in the genogram in figure 1. The S family are of Indian origin and are practicing Sikhs. Mr S is self-employed and Mrs S is a house-wife, although she works voluntarily at Sukwinder's school for a few hours a week.

Mrs and Mrs S married in 1983. Mrs S was 17-years old at the time and living in England with her family. The marriage was arranged by her parents to Mr S who was, at that time, living in India with his family.

Sukwinder lives with his mother (Mrs S), Father (Mr S), his twin sister, Satwinder, and three older sisters, Narinder (23), Harwinder (20) and Jagvir (16). The paternal grandparents also live in the family home.

His maternal grandparents also live in the Midlands. Mrs S takes the main responsibility of caring for her parents. Mrs S has a distant relationship with all her siblings. She has very little contact with her brothers and states that the values shared by her sisters, which differ from her own, have distanced them. She speaks of being the remaining “good Indian daughter” and of being the only one who has followed the cultural and religious traditions. Notably her sisters have all changed their first names, via deed poll, to Western names and have partners of White British origin. Mrs S speaks of this with some contempt, adding that her sisters were always allowed to “get away with things she could never do”. She added that one of her sisters ran away from home with a Chinese boyfriend and spoke of her fury that her sister had been accepted back home without question.

Mr S did not attend assessment sessions. However Mrs S describes him as taking a very traditional male role in the household. He is described as a strong disciplinarian but the childcare and responsibilities of the household remain that of Mrs S.

Birth and Development.

Mrs G described the historical context surrounding Sukwinder’s birth. She spoke of the disappointment of her mother-in-law when she gave birth to her first daughter and that she had become determined to have a son to continue the family name. Following the birth of her second daughter, Mrs S was instructed to travel to India to seek spiritual advice and it was there she was informed, by a member of her husbands’ family, that she had been cursed at her wedding to have only female children. She stayed in India to pray for several months and returned pregnant with her third child. She described the rage of her mother-in-law who tore up pictures of their Guru’s and Gods at the birth of her third daughter, Jagvir. Mrs S recalls feeling that she was in some way to blame.

She had decided at this point that she would not have anymore children, but states that increasing pressure from her mother-in-law led her to try once more for a boy. She spoke of her sense of relief when told that one of the twins she was carrying was a boy. However this was quickly tempered by a difficult pregnancy. She was taken into hospital due to an increase on her blood pressure and induced early. Her mother-in-laws recollection of a superstition of bad luck for a male child born after three girls added to her woes. Sukwinder was indeed born just before Satwinder, however Mrs S states that she has kept this secret, even from the children themselves. Sukwinder’s subsequent diagnosis of ASD further compounded Mrs S’s feelings around having a son and his diagnosis also remains a secret from the extended family.

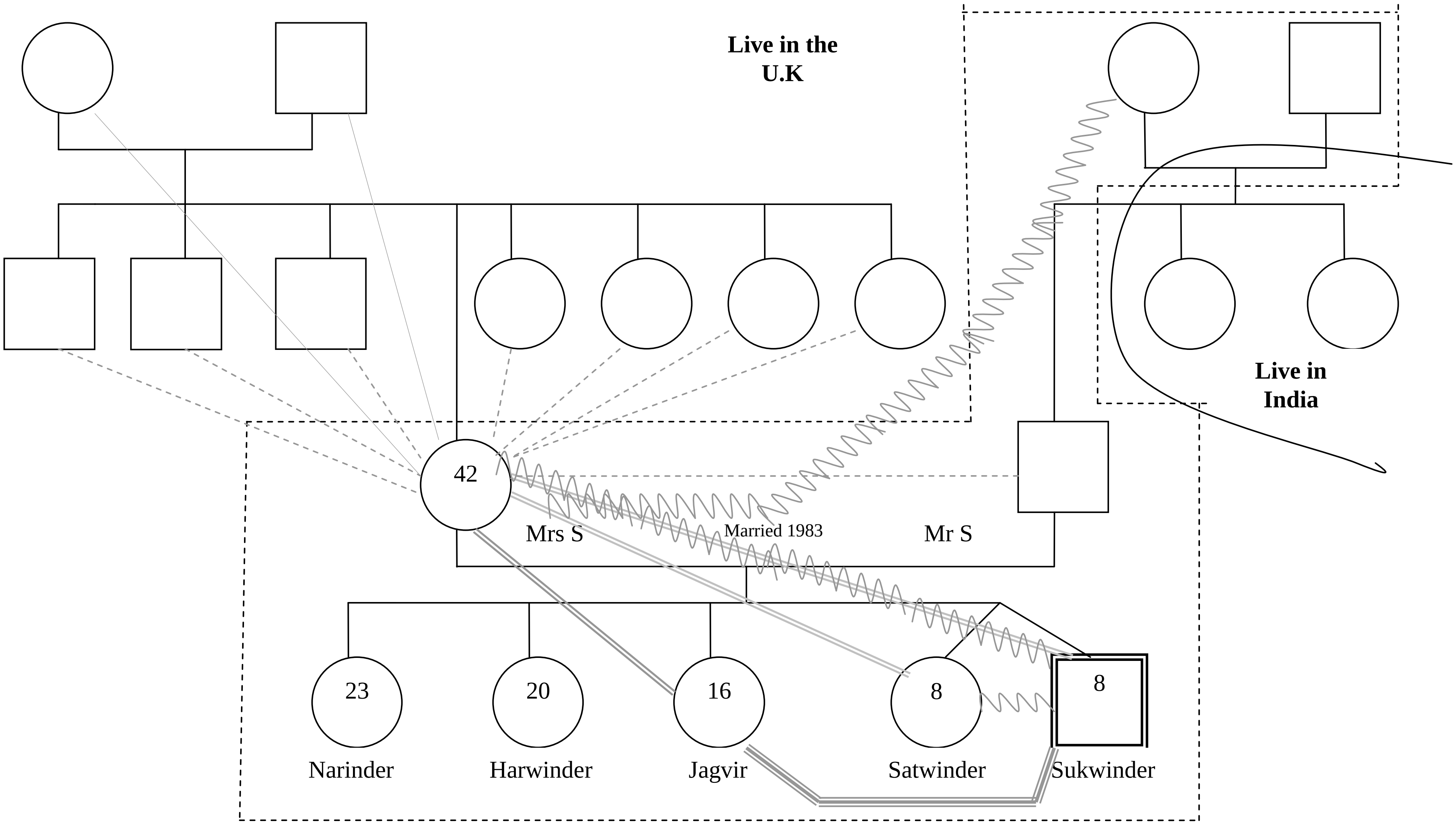

Figure 1: Genogram *illustrating the S family.*

A SYSTEMIC FORMULATION

Introduction.

During the assessment process, Mrs S presented Sukwinder and his difficulties in the context of his significant relationships, thereby offering an interpersonal perspective of his difficulties. Relationships are said to be shaped by beliefs and rules defined by the wider culture and modified through personal experience, such as exposure to White British culture (Maitra & Miller, 1996). Dallos and Draper (2000) add that the ideologies and discourses within society and culture have a massive impact on the way in which a family views itself and judges how families "should be". This was a prominent theme throughout the assessment, where for example Mrs S spoke of impact of Sukwinder's diagnosis on their ability to perform cultural duties as well as the impact of her son's birth order and his subsequent diagnosis. The Eco-map (Figure 2) further illustrates the influences of the wider context of the S family.

The Multiple Levels of Context framework (Burnham, 1986), adapted from Cronen and Pearce's (1985) Co-ordinated Management of Meaning (CMM) approach, provides a framework with which to explore the Sukwinder's diagnosis and difficulties within the context of culture and family script of the S family (Vetere & Dallos 2003).

CMM is a social constructionist theory of communication which is based on the notion that society provides a context onto which we create stories influenced by our experience of family, gender and culture. These stories are said to influence our actions (Oliver, 1992). CMM and the Multiple Levels of Context further suggests that by using the idea of levels of context we can explore the influence each story might have on the other, for example the story of Sukwinder's autism being seen in the context of the story of the meaning given to gender and this has on Mrs S (Burnham, 1986). Every level of context therefore impacts on the level below but it is also acknowledged that lower levels can also have implications for higher contextual levels (Burnham, 1986). The framework therefore allows for an exploration of the family's belief systems.

It is also acknowledged that "problems" often arise when demands are place on the family to change and adjust, for example, births and deaths. Within systemic theory these are referred to as transitions (Burham 1986). The implications of such a transition, namely the wedding of the eldest daughter, are also hypothesised.

The formulation also addresses the issue of family homeostasis (Jackson, 1957 cited in Dallos & Draper, 2000). It acknowledges that although the family presented to the service requesting change, in some way Sukwinder's difficulties have been incorporated into the dynamics of the family, the way in which they relate to each other and the roles each of them have within it. Thus the family may actually act in ways that maintain his difficulties rather than help to change them.

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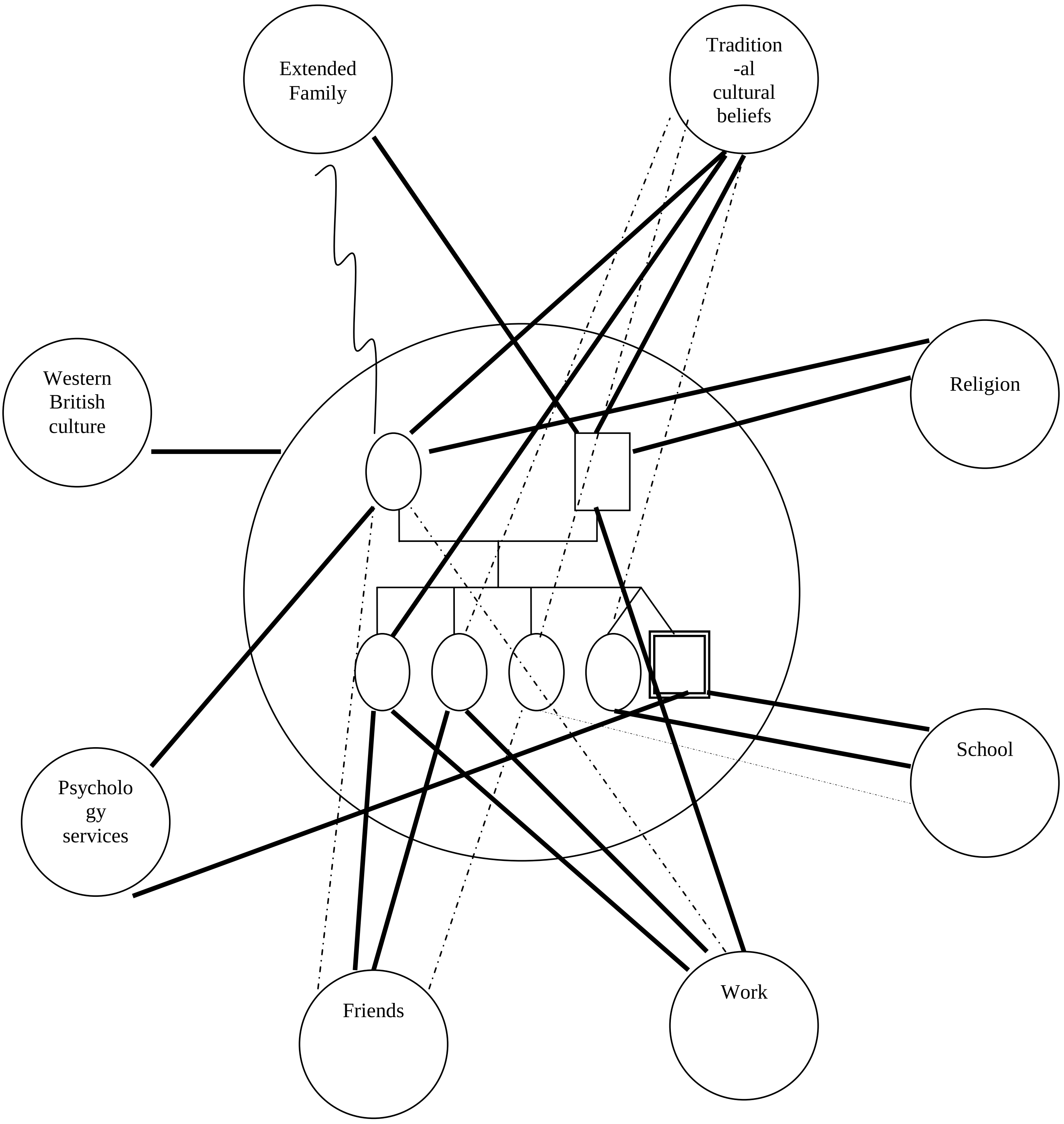


Figure 2: Ecomap of the S family

CULTURE/SOCIETY

Importance of cultural and religious heritage
Traditional parental roles
Men/boys are important members of the family
It is important for the whole family to attend community/family functions
Negotiation of bi-cultural identity

FAMILY SCRIPT

Girls leave home and marry into the family of their husbands.
As a woman the family's needs come before your own.
Women are expected to have sons to continue the family name.
Superstitions and curses

PERSONAL SCRIPT

It is important to be a "good Indian" daughter – look after your in-laws
It is important to be a good Indian wife and mother – provide a son
"Good Indian" mothers are judged on the basis of their "good Indian" children.
Good Indian children are children who do as they are instructed and expected to do

RELATIONSHIPS

Poor communication between Mr and Mrs S
No parental support or support from in-laws for Mrs S
No support from siblings for Mrs S
Mrs S jealous and resentful of sisters' rebellion
Sukwinder's older sister, Jagvir viewed as mother figure
Jealous conflict between Sukwinder and his twin Satwinder
Mrs S's poor social network.

EVENTS/EPISODES

Mrs S's marriage at 17.
"Rebellion" and neglect of cultural traditions of Mrs S's sisters
Birth of her first three daughters
Birth order of Sukwinder and Satwinder
Sukwinder's diagnosis of ASD
Oldest daughters wedding later this year

BEHAVIOURS

Sukwinder's diagnosis kept secret
Sukwinder is taken to a different temple
Mrs S expresses a wish to have a "normal" boy.
Seeks psychology services to "normalise him"
People respond quickly to Sukwinder's demands to "keep him quiet".
Incidentally reward misbehaviour behaviour

Figure 3: Multiple Levels of Context – A systemic formulation of Sukwinder's difficulties in the context of Mrs S's experience.

Formulation.

This formulation frames Sukwinder's difficulties firmly within the context of S family script which is largely influenced by Mrs S's family and personal script. Mrs S grew up in a family where she had consistently been viewed as the "good daughter" choosing to obey her parents' wishes for her to marry a man of their choice and not to rebel against cultural traditions as did her sisters. When she married, it is hypothesised that she began to create a new family script of the "good wife and daughter-in-law", within the traditions and superstitious culture of family she married into. Her new script meant that to fulfil these roles she would have to produce a son in order to continue the family name. Although she eventually did so, Sukwinder's diagnosis is viewed with a degree of shame and disappointment as it believed that it will prevent him from marrying and thus the family line will not be continued. Hence Mrs S presents to psychology services primarily with the desire for Sukwinder's behaviour to be "normalised".

It is further hypothesised that the transition, the approaching wedding of her oldest daughter has further amplified Mrs S's struggle. Within this formulation, the family holiday to India is placed within the context of this wedding and the main area of concern moves away from what Sukwinder might eat, but more to whether Mrs S will be able to conceal his difficulties from her extended family as well as the family her daughter is marrying into. The wedding also brings with it cultural expectations of the male sibling in the family and again highlights Mrs S's concern that his difficulties may be exposed in front of the community, leaving her exposed to be judged a "bad Indian mother". As a result what is presented is a hypothesis of a mother who is struggling to cope with the emotional consequences of her son's diagnosis and its meaning for her as a "good Indian mother".

Systemic thinking would state that Sukwinder’s diagnosis of ASD might serve some function here. Thus despite Mrs S’s wish to “normalise” Sukwinder’s behaviour, it can be hypothesised that at some level his diagnosis maintains the status quo of the family unit, enabling her to feel needed and validated in her role as mother. Sukwinder’s diagnosis and difficulties can also be seen be meeting the needs of other family members, such as Jagvir (the third daughter). It is worth recalling that her birth was met with anger at the Gods, grief that she had not been a boy. Nevertheless Jagvir’s role as ‘second mother’ to Sukwinder has meant that she has been able to carve out a new role for herself as “the good daughter” rather than the ‘disappointment’.

Conclusion.

It is acknowledged that the formulation is itself just one set of hypotheses on the nature of Sukwinder’s difficulties and the impact it has on the family as there can be no objective truth or concrete formulation (Dallos and Draper, 2000). Dallos and Stedman (2006) add that the process of hypothesising in systemic formulation is a fluid one, guiding the search for additional information from family members rather than definitive answers. However the Multiple Layers of Context allow Sukwinder’s difficulties to be viewed as part of a larger system. In light of past involvement of psychology services and the focus on psycho-education on ASD, this approach could be argued to enrich the therapists’ choice of intervention with the family.

A PSYCHODYNAMIC FORMULATION

Introduction

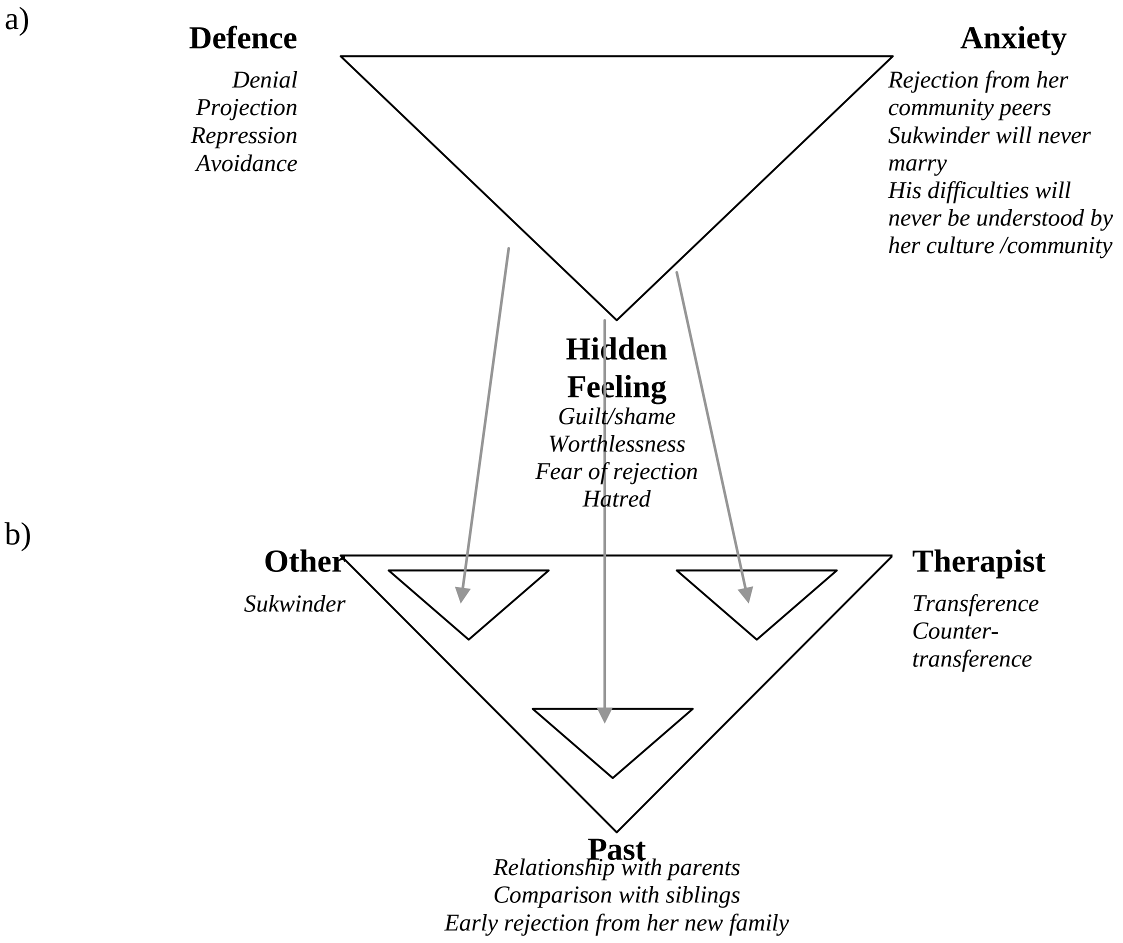
The psychodynamic perspective is based on a series of developing ideas, rather than one singular overarching theory (Leiper and Maltby, 2004). However, a common focus runs through all of the theories in this approach, that of internal conflict/psychological pain. Life is conceptualised as a series of struggles and social pressures and the psyche is said to develop an unconscious response, defences to these conflicts in order to manage them (Leiper, 2006 in Johnstone and Dallos, 2006). However these are often ineffective and can merely add to the struggles of daily living. The premise is that internal emotional conflict underpins and motivates the way we think, feel, behave and view the world underpins all psychodynamic theory (Wallerstein, 1988).

This is conceptualised in what is known as the Triangle of Conflict (Figure 4a) (Malan, 1995).The conflict is said to arise from 'hidden feelings' which are feared to have dire consequences if expressed. Action is taken to defend against this anxiety and to avoid acknowledging the conflict in the conscious (Leiper and Maltby, 2004).

Menninger (1958 in Malan 1995) outlined the second triangle which is the Triangle of Person (Figure 4b). It allows for the dynamic exploration of relationship/behaviour patterns in past relationships with parents or siblings, current relationships with others and the relationship with the therapist.

Molnos (1984) combined the two triangles illustrating that the conflict and defence response is re-enacted in each of the relationships. These triangles form the basis of the formulation. Rather than use any specific psychodynamic theories, this dynamic perspective allows for an exploration of Sukwinder's diagnosis and difficulties in the context of the internal conflicts and defence strategies that are in place for Mrs S.

Figure 4a & b: A formulation of Mrs S's experience using the Triangle of Conflict and the Triangle of Person (Malan 1995)



Formulation

As the family have been referred to the service due to difficulties in managing Sukwinder’s behaviour, the formulation starts in the Triangle of Person, in the ‘Other’ corner of the triangle and explores the defences, anxiety and hidden feelings in this relationship.

It is hypothesised that one of Mrs S's defences in this relationship is to deny Sukwinder’s difficulties. She appears unable to fully accept the limitations of his communication, social skill and behaviour associated with his diagnosis and “hopes he will grow out of it”. She also avoids situations where Sukwinder’s difficulties might be exposed. Hence her choice to attend a smaller temple and avoid large family gatherings fearing rejection from her community peers who she believes will not fully understand Sukwinder’s difficulties and will consequently deem her to be a bad mother, unable to control her child. As Mrs S’s sense of worth and fulfilment is entwined with her role as a wife and mother, her anxieties expose her to feelings of worthlessness.

Projection is also viewed as a significant defence within her internal conflict (Jacobs, 2004). The genogram in Figure 1 illustrates the confrontational relationship she has with her mother-in-law, which reminds of her inability to conceive a boy as a first child. However it hypothesised that much of the projected anger directed at her mother-in law may be a defence against the anxiety that his autism may be in some way her fault or that she may indeed be cursed. It may also defend against self-condemnation that she was not able to conceive a “perfect” son.

A common reason for a defence is ensure that conflicting feelings about the same person, such as love and hate, are kept apart. It is therefore also hypothesised that hidden feelings of anger and resentment or even hatred she might feel towards her son for being autistic are repressed. Any expression of this anger towards her son is feared as this may prohibit her from feeling any empathy towards him and his difficulties and further prohibit her from fulfilling her role as a “good mother”. As a result we see a mother who is anxious to please and who is unable to put in or make explicit boundaries and rules for his behaviour.

The present conflict resembles that enacted in the past, thus the formulation turns to the triangle of conflict in this area. Mrs S grew up in a family where sons were revered and daughters were viewed as less important. During the assessment she spoke of her experience of being the first daughter born into a family of sons. She spoke of her need to please them to manage her anxiety that she was less loved and accepted. She did so by ensuring that she was a “good” daughter abiding the cultural and religious traditions and ignoring western culture influencing her siblings. In this triangle we see clearly her anxieties around her being loved and accepted, her fear of rejection and feelings of worthlessness.

However, in the context of her younger sisters’ rebellion against the family traditions, we also see the defences against being exposed to her anger towards her parents. This anger is repressed in order for her to continue to fulfil her role as “good” daughter. Mrs S speaks openly about her envy of younger sisters, especially that of the “prodigal” sister who ran away from home but was welcomed back home by her parents. It is therefore hypothesised Mrs S projects much of the anger she might feel towards her parents onto her sisters in order to preserve the relationship and protect her from the anger she feels towards them.

In the final corner we can explore Mrs S’s internal conflict as it manifests itself within the therapeutic relationship during assessment. Mrs S is never misses appointments, arrives early, completes homework task and is keen to accept any intervention offered. In conversations with the psychologist previously involved with this family, she was even described as a “good” person to work with. It is hypothesised that what is being replicated in this relationship and demonstrated in her ‘pleasing behaviour’ is her need for acceptance.

It is hypothesised that she fears that if she is not a “good” client, she will be rejected by services and she will not receive the support she feels she is in need of and Sukwinder will remain “abnormal”. However it is also hypothesised that what Mrs S might primarily defend against is her anger towards the therapist for not “fixing” Sukwinder. She defends against her anger and anxiety that no amount of input from Child Psychology will change his diagnosis. However, coming from a culture wherein professional/doctors opinions are revered and unquestioned, this anger is repressed and was interestingly projected onto the trainees’ supervisor (who observed the assessment interview).

Throughout the assessment period the trainees’ countertransference reaction to Mrs S has mirrored that hypothesised in the transferential relationship. It was initially filled with some dread as the status of trainee exposed fears of rejection by Mrs S, a experienced recipient of psychology services. There was a fear of not being good enough coupled with an eagerness to please her. Sessions, have also been met with some frustration and to some extent, anger what felt like the setting of an impossible task of curing Sukwinder of his autism.

Conclusion

The Triangles of Conflict and Person allow for hypotheses to be drawn about Mrs S’s internal conflict and the unconscious means by which she avoids it. They also provide some insight into how past patterns of relating may be being replicated in her current significant relationships. However, central to the model is the insight provided by the therapeutic relationship which would enable Mrs S to bring that internal conflict into the room with each session and allow the therapist direct access to that internal, unconscious world (Leiper and Maltby, 2004).

REFLECTIONS

There is a wealth of literature that acknowledges the social, communication and behavioural challenges faced by people with autism. Services have made good use of such in devising evidenced-based intervention programmes that provide psycho-education on autism and support parents in helping their children to develop skills in these challenging areas (Carr, 2006). As mentioned above, Mrs S had already attended such a programme and had benefited from the insight and support it provided.

However the literature pays very little attention to the impact of culture in this area. Culture in itself presents a challenge to both the families trying to adapt to raising a child with autism and service providers in providing an appropriate intervention (Dyches, Wilder, Sudweeks, Obiakor and Algozzine, 2004).

Both formulations took account of such within the assessment and consequently formulated Sukwinder’s difficulties as they sat within the family system and Mrs S’s internal conflict between acceptable and unacceptable parts of herself. Both drew heavily from what was brought into the assessment by Mrs S, focussing primarily on the families and/or Mrs S’s response to Sukwinder’s autism rather than the autism and associated difficulties. It is felt that this allowed for a greater understanding of the overall needs of the family.

However, in an NHS culture of waiting list targets, short interventions and outcome data, simply managing the behaviour problem could pose an all too tempting offer to the service provider who has no way of predicting the length of time it would take for Mrs S to, for example, rewrite her personal script.

The history of both models, developed around western cultural norms, is also acknowledged. It is therefore the duty of the psychologist to remain mindful of the risk of pathologising cultural differences, for example, judging an arranged marriage as something negative. As difference values are placed on, for example, independence and expression and psychologists can too easily fit information formulation based on our own cultural norms (Burnham, 1996; Maitra & Miller, 1996).

The absence of cross-cultural literature discussing the issues that arise when both the therapist and client are of ethnic origin is also an issue for consideration. Questions remain of the transferential relationship and the neutrality of the therapist. However it further reflects the need for formulations to reflect context, colour and culture of both the client and the therapist.

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CLINICAL PRACTICE REPORT (CPR2)
SERVICE EVALUATION

Keeping the Faith: A Qualitative exploration of the experience of practitioners in the delivery of the Triple P programme in the North and East of Birmingham.

***Names and identifying features have been changed or omitted to maintain confidentiality**

ABSTRACT

The government has outlined a ten-year plan that is designed to meet the needs of parents, children and their families and promote high quality child-centred services. In line with this, Birmingham City Council has developed its own strategy to address higher than national scores for conduct disorders, hyperactivity and poor pro-social behaviour in 7-18 year olds. Part of this strategy includes heavy investment in implementing evidence-based programmes such as the Triple P (Positive Parenting Programme). However, research has shown that the attitudes, beliefs and experiences of practitioners tasked with delivering the programme can affect the implementation and dissemination of such initiatives. Services are therefore encouraged to identify gaps between evidence base and real-life practice and bridge those gaps wherever possible.

This project uses focus groups to capture the experiences of Triple P practitioners in the North and East of Birmingham (BEN) in an attempt to identify such gaps. An inductive thematic approach is used to analyse transcripts and explore the emerging themes of beliefs and concerns regarding the programme and its delivery in the context within which they work. Three main themes emerged from the data; Belief that Triple P meets the needs of their families, The “Road to Conversion” - the belief that Triple P meets their needs as practitioners, and Hope and Aspirations for the Triple P programme. These themes and their associated sub-themes are discussed, along with the implication of these for future planning and development of programme delivery within BEN. The use of metaphors, in the process of organisational change and design, in particular the religious metaphors running that run throughout the data, are also discussed.

INTRODUCTION

"... this white middle class way of thinking, way of doing things. So I actually think there is a selection bias going on and it's kind of quite systematic. So I think, erm, the evidence is produced by people who think in these types of ways..."

In 2003 the government published a green paper, Every Child Matters, setting out its proposals for improving the delivery of services for children, young people and families. In addition to this, the National Service Framework for Children and Young people and Maternity Services (2004), published by the Department for Education and Skills (DfES) and the Department of Health (DH), set out, for the first time, national standards for children's health and social care, promoting high quality child-centred services. These services were outlined as part of a ten-year care programme, designed to meet the needs of parents, children and their families. Both documents were viewed as national policy drivers for local authorities and changed the culture of services working with children and young people.

In July 2006 the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) published guidelines for local authorities in their delivery of parent programmes in the management of children with conduct disorders. Recommendations stated that such programmes should be structured and informed by principles of social-learning, include relationship enhancing strategies, offer sufficient number of sessions (optimum 8-12) and enable parents to identify their own parenting objectives. It stated that such programmes should be delivered by trained facilitators who would adhere to the programmes' manual to ensure delivery remained consistent (DfES, 2006). Informed by these documents, Birmingham City Council went on to develop its own strategy, 'Brighter Futures', to transform children's services throughout the city. The developers of the strategy found that children in Birmingham, aged 7-18 had higher than national scores for conduct disorders, hyperactivity and poor pro-social behaviour. As a consequence, investment in early years support and prevention and implementing proven programmes was central to planning.

The government identified three such programmes, Strengthening Families Strengthening Communities, Triple P (Positive Parenting Programme) and Webster-Stratton's Incredible Years, as part of a national initiative to provide parenting support and evaluate effectiveness. Of the three highlighted by the government, Triple P is said to have the strongest evidence base, having been evaluated in over 25 years of research that include randomised control trials showing clinically significant benefits for children and their families (Sanders, Markie-Dadds and Turner, 2003; Sanders, Turner and Markie- Dadds, 2002). However Triple P is costly to implement at a cost of £1400 per practitioner as well as the additional costs involved in purchasing copyrighted materials. Although, it is also worth noting that NICE, in a statement on cost effectiveness, stated that Triple P would in fact pay for itself by averting the cost of managing cases of conduct disorder (NICE&SCIE, 2006). Thus, evidence-base and cost-effectiveness informed the selection of Triple P as appropriate for the Birmingham parent population.

Triple P, developed in Australia by Professor Matthew Sanders and colleagues, was designed as a multilevel of parenting and family support strategy. It incorporates five levels of intervention on a continuum of increasing strength of intervention (from a Level 1 media-based campaign to intensive family intervention work) for parents of children and adolescents. Much of the work within the Birmingham East and North (BEN) locality targets intervention on Level 4, delivering group interventions to parents and as such, adheres to the recommendations outlined by the NICE and the DfES.

Research literature states that there is often a gap between the adoption of such evidence based programmes by government bodies, local authorities and local services and the adoption of the programmes by the practitioners themselves (Addis Wade & Hatgis, 1999; Sanders & Turner, 2005). Dissemination is crucial to the continued growth of the evidence base as is information pertaining to the way in which this is conducted. For example, research has shown that practitioners often adapt evidence-based programmes, which arguably weakens the treatment effects of the programme (Addis, 1997). Hence information on the experience of practitioners delivering the Triple P, in the context of their communities, is essential to the way in which evidence is collated, validated and evaluated (Turner, Nicholson and Sanders, in press).

Turner et al. (in press) also highlight the need for services to address gaps between evidence and real-life practice by identifying barriers that might exist to the practitioner in adopting an evidence based programme in their everyday practice. They identified a number of key factors that contribute to the adoption of the programme by the individual practitioners including practitioners' opinions on the resources he/she has been provided with and their views on the quality of the training provided. Individual factors, such as self-efficacy and attitudes about the programme were also identified as influential. They went onto develop a conceptual model of these factors (Figure 1) and used structural equation modelling to test the model against the survey responses. Self-efficacy and support within the workplace were found to be predictors of practitioners' implementation of the programme.

Addis et al. (1999) state that the reluctance of services to listen to the experience and concerns of practitioners can seriously impede the implementation of evidenced based programmes. Hence the aims of this service evaluation were to:

1) Explore the attitudes, beliefs, concerns and experiences of practitioners delivering the Triple P programme across BEN.
2) Use these to highlight issues pertinent to the standard of delivery and dissemination of the Triple P.

METHOD

Participants

A total of 14 practitioners participated in the project. Practitioners were based within CAMHS services and Children's Centres. Most of the practitioners were of White British origin (n=10), however the sample also included practitioners of Asian origin (n=3) and African-Caribbean origin (n=1). The professional groups within the project included Clinical Psychologists, Early Years Workers, Family Support Workers, Outreach Workers, Senior Parent Support Workers and a Midwife Assistant. Qualitative data revealed that participants had many years of professional experience within children's services, however the mean number of years experience working with Triple P was 1.7 years (SD =1.25). The number of groups delivered by professionals involved in the project, since training, ranged from 1 to10 groups (M=3.93, SD=3.09).

Procedure

Recruitment. The project was qualitative in design, thus participants were invited to take part in focus groups to explore their experiences. Practitioners from a range of services within the BEN locality were invited to take part in the project by poster, email and direct contact. They were invited to share their experience of delivering the Triple P programme and were therefore recruited to the programme on the basis of having facilitated a group. Efforts were made to ensure that the focus groups took place at a time and location that was convenient to them. Participants received the information sheet outlining the purpose of the project. They were also informed that groups would be audio-taped and transcribed, thus assurances of anonymity and confidentiality were given and consent was obtained to use the data. Demographic information was also collected from participants.

Focus Group implementation. The focus groups were facilitated by the researcher, with an average of 3 people per group. As recommended by Millward (1995) questions and topical guides were developed to facilitate the process of the group, allowing the relevant issues to be covered whilst enabling the group to control the content of the discussions. The aforementioned model of factors (Figure 1) influencing implementation of Triple P was used to develop topics and questions (see Appendix 3).

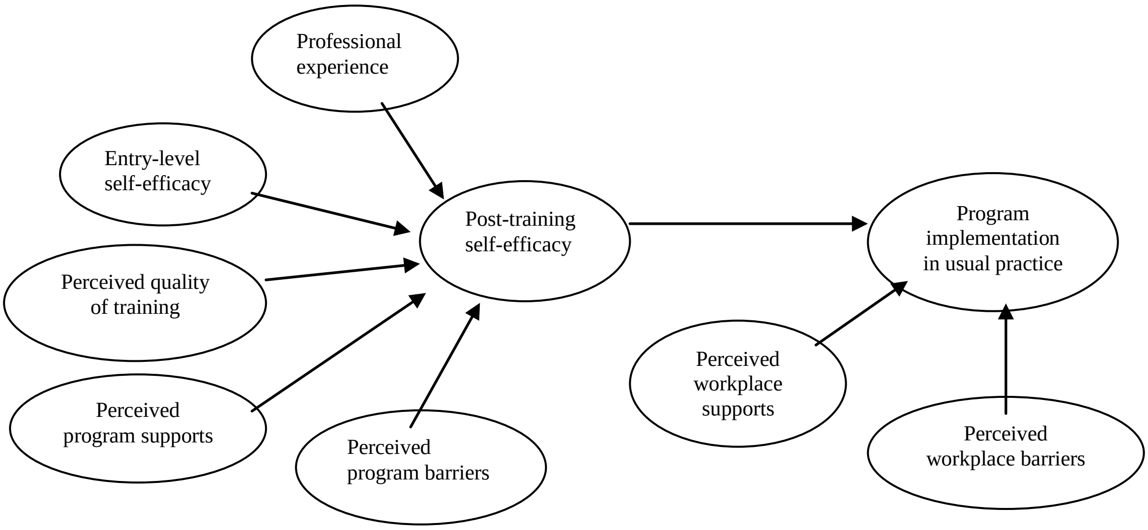

Figure 1. Model of Conceptual factors theorised to influence the implementation of the Triple P programme (Taken from Turner, Nicholson and Sanders, in press).

The topic guides/questions were designed to illicit practitioners' experiences on each of these factors. The final question was not drawn from this model as it was designed to allow them to step outside of the professional boundaries and expectations of their roles and elicit their views from that perspective. Although groups were encouraged to tell their stories starting with their experience prior to Triple P training through to their experience as group facilitators, groups were not held to a strict order of questioning.

Analysis

Four focus groups were conducted in total, each lasting between 30 and 90 minutes. The data from each of the groups were transcribed. Having already become familiar with the research literature, a theoretical thematic analysis, driven by the model outlined in the development of the questions, may have been adopted to coding the data (Braun & Clarke, 2006). However, it was felt that the study and analysis itself would benefit from allowing the data to speak for itself. As a consequence, an inductive thematic procedure was used to analyse responses. Nevertheless as an active participant in the research, the author acknowledges that analysis of the data is not entirely free from the influence of theory and recognises the influence the process of coding and theming the data.

The phases of thematic analysis outlined in Braun and Clarke (2006) were used to guide the process of analysis. Consequently, the transcripts were read and re-read familiarise the author with the data. Secondly, the codes were manually identified in the data grouping together interesting and meaningful features in the transcripts (see Table 1 for data extract). The frequency of appearance for each code was noted and measured as the number of times a code was articulated within the data. Although useful, frequency was not crucial to the analysis, which was predominantly led by the research question and overarching themes that grouped the data. Codes were sorted into overarching themes, overlapping themes and sub-themes using thematic mapping, with some codes becoming themes themselves.

Table 1.

An extract from the data with applied initial codes

Data	**Codes**
You know in that 3rd session.. because it is such a lot to fit in and we are limited on time, so... erm our crèche is only a two hour slot, erm and the parents don't always turn up on time and then by the time they have got in, it can be late starting and the 3rd session is so full of stuff we feel exhausted at the end of it. I can't believe for one minute that the parents have taken in all in...	1. Time constraints 2. Programme structure 3. Feelings whilst delivering the group 4. Doubts about ability of parents in the group.

RESULTS

"...I would love to have...", "Faith?", " Yeah!"

Analysis of the data revealed three predominant themes: Engaging Families, Engaging Practitioners and Hopes/Aspirations for Triple P. These are discussed in further detail below. Care has been taken to use the language expressed by practitioners in conceptualising names for each of the themes (see Appendix 5: Tables 1, 2 and 3 with sample extracts from the data).

Theme 1: Engaging Families

> *"And they say... 'I've been told this is the only way I'm gonna get my children back..' Beside that, 'I've got to be here but really I've got an eviction notice that I should be sorting out, or the bailiffs coming tomorrow' and you think, my God, you've got no chance of succeeding on this, so that bugs me..."*

Practitioners spoke with a sense of ownership when discussing the families they worked with stating that they wanted the best for "their" families. However, they expressed varying degrees of belief as to whether Triple P was best placed to serve their communities. Hence a number of sub-themes emerged from the data.

Resources. Practitioners spoke of Triple P as a tool they were generally satisfied with in terms of the theory and resources. "I think the advice is sensible and I feel that I am giving them tools they can actually use". However, practitioners also spoke of their frustrations with the resources such as the DVD, which they explained they often apologised for.

> *"It's quite middle class.. you know what I mean?"*

"Yeah"

"It's not reality"

"Some of the women just think it's a joke!"

Time and money were resources that practitioners felt negatively impacted on their ability to deliver the programme effectively.

"...it's just a whistle stop, and we are just going, and if they start to ask questions we are very, thinking, you are very aware of the time, thinking we haven't got time for this, we need to move on". "..the expense of the resources which you only really realise and truly understand when you have to reorder stuff and when you are not allowed to photocopy any of the resources which I don't like the sound of at all".

Making adjustments to suit the needs of the families. Class, culture and language were of great concern and led practitioners to disclose adjustments made to the programme to facilitate engagement and increase parents' ability to connect with the programme. There were also concerns about the general ability of the parents to understand the material presented in the programme due to levels of literacy with some practitioners having to translate material into Urdu. Practitioners also expressed the pace and intensity of the programme as additional factors for concern.

> *" ..it took me three days to realise that was called an escalation trap, but I'm expecting you to do it for possibly 10 minutes of the two hours of the 8 weeks!"*

However, within this subtheme, practitioners also expressed some surprise at what the parents had been able to achieve in spite of their difficulties and practitioners own anxieties.

> *"We came out thinking that it's never going to work with our parents, I mean, and I think we did the parents down 'cause actually it has worked..."*

Staying true and "faithful" to the principles. Whilst all practitioners reported having made some adjustment to the programme, every group expressed the need to be mindful of the "principles" of the programme whilst doing so. Religious metaphors ran throughout the groups as practitioners described their wish to stay "true" and "faithful" and steer clear of any infidelity. Reference was made to the dangers of changing the programme in some groups *"we don't wanna be changing the programme, you gotta be careful."* However, it was notable very little reference was made to the issue of adjustments in relation to evaluating the programme and the evidence base of Triple (mentioned just twice in only one of the groups) as practitioners spoke more of adherence to the principles of the programme.

Factors increasing their belief in the effectiveness of the programme for families. More so than the existing evidence base, practitioners emphasised the importance for them of evidence from both the quantitative and qualitative feedback from the parents they worked with in their judgements on whether the programme had been effective.

> *"I suppose I was quite pessimistic...but we found obviously, from experience of this group that it does work and that it, it's brilliant, it's really good there are some really good outcomes for both families and practitioners".*

Theme 2: Engaging Practitioners.

> *"You have to believe wholeheartedly in what you are doing and what you are presenting entirely, in order to be convincing in your presentation".*

The religious metaphors continued to be used by practitioners to illustrate their own needs in delivering the group and in many ways expressed the importance that they connected with the programme in the same way they hoped the parents would. Sub-themes are outlined below.

The Powers That Be. A number of practitioners expressed some disillusionment with why Triple P had been chosen for Birmingham over other programmes they felt may have been less costly and better suited to the families in their localities and better suited to them as practitioners

> *"..it just seems like Birmingham City Council thought, 'Oh, this brilliant parenting programme..' unaware of the intensity it involves to actually deliver it successfully...".*

They also expressed frustrations with direct management in, at times, not understanding the time investment required by the practitioner to train and deliver the programme effectively.

> *"..and I guess the managers have got huge responsibility, I mean you were talking about barriers before, if someone is going to stump up the money to go on that course they they have got to facilitate that training and then they have got to allow you to use it.."*

Experience of Training. Although practitioners expressed a general satisfaction with the quality of the training

> *"I was very impressed with the trainers, I thought they really knew their stuff, they were walking manuals.."*.

Practitioners also expressed feeling unprepared for the intensity of the training and the accreditation process. There were also comments about the way in which they felt their questions relating to the adjustments to the programme were dismissed by the trainers whom they felt misunderstood their concerns.

> *"I think that they felt when you were asking certain questions that you wanted to change Triple P and it wasn't about changing it, changing its content, it is about its delivery..."*.

As a result, training left them feeling less confident about delivering the programme and failed to reassure them that it would work.

Some practitioners stated that their previous training contributed to their ability to grasp the concepts at the pace it was being presented. However, concerns were raised over what they felt was the clear inability of others to do the same. Added to this was their concern that these practitioners were able to pass the accreditation process.

> *"There was a couple of ladies on my training...[sigh], I wouldn't be confident if they went on to do, they just hadn't grasped it, the training at all and yet they got through*

> *the final assessments, but it was, you know, a struggle that they were sort of dragged through it."*

Continued Development. Practitioners went onto express what had been effective in their development as practitioners following training with the majority of practitioners stating that support from fellow practitioners is invaluable to their progress

> *" I think having the opportunity to discuss with colleagues, I think having people watch you..." "Or understand".*

Expressed feelings by practitioners. The feelings expressed by practitioners gave some insight into how the practitioners experienced both the training and delivery of the group, *"exhausting"* and the relationship with the programme itself at varying levels of experience.

> *"I'm not completely converted [laughter], erm [pause], at all [pause], but I have only delivered the one, so [pause] I dunno.."* .

It also gave some insight into their feelings of self-efficacy and how, through experience, they manage the burden of responsibility as trained practitioners to deliver it correctly

> *" there was a lot of pressure, you've actually got to do this right and if you didn't do it right you would get penalised in some way". "Experience! It's making mistakes, it's learning from those mistakes, standing back and thinking, how did I do that, now what went well, what didn't go so well, what could I do differently next time....".*

Confidence in the practice of fellow practitioners. There is some overlap with the confidence in the accreditation process in this sub-theme but of concern to many of the practitioners was the level of confidence they had in the ability of other practitioners to deliver Triple P in the way in which they believed it should be delivered.

> *".. you know, I've had a family come to me recently and say, 'I've been invited to a Triple P group', and it starts sooner than the one we can offer them, but I would absolutely, always, 100% always, say to them,' WAIT and have it done properly!', 'cause that's how I feel about it."*

Theme 3: Hope – Aspirations for Triple P

Practitioners expressed a number of ways in which the programme as a whole could be improved. These have been grouped into the sub-themes below.

Improving quality of the programme and evaluation of the programme in Birmingham. Suggestions were made as to how the quality of the programme could be maintained.

> *"maybe we should check each other out to make sure that it's actually still okay. Just because I have run X number of groups, done X number of Triple P courses.... [name] could be better at it than me because of what has happened to me over time".*

Practitioners also expressed a wish to see their outcome data used for evaluation and research into the long-term effects of their delivery of the programme in BEN.

Improving training and resources. Practitioners, unsurprisingly, had suggestions for how these also might be improved, such as an Urdu translation, standardised packages for families with low literacy levels and audiovisual resources that the families could identify with, English and “multicultural”.

> *“…well I think if you are gonna charge all that money for it then make it in English and have a variety of different families”.*

Supporting practitioners. Support was identified as key to their continued professional development, as such practitioners also made suggestions for how this might be achieved, such as an improved use of the peer support network, Triple P supervision groups and opportunities to observe groups prior to delivering their own.

“…this was new, it was a bit scary, but I think that buddying support was tremendously important early on”.

True Multi-level delivery. Practitioners were keen to emphasise that as yet BEN was not using the Triple P package to its full potential and were therefore keen to utilise the 5 levels of intervention, particularly early intervention and prevention work. *“and like you were saying earlier about prevention, it’s not just about saying prevention strategy, it’s a prevention model”.* Practitioners expressed that a multi-level approach would also facilitate their delivery and help parents maintain improvements long-term. Practitioners spoke specifically about improving the promotion of the programme, *“So 12 months down the line and they are back in ‘Shitville’ again, they will be walking down the street and they see a logo or something they will think, ‘Oh yeah, Triple P!’*, and access for the parents such as delivering Triple P in a variety of venues. *“We need to get Triple P out there as accessible to parents as Diet Coke and Mars bars...it just becomes the norm like Calpol.”*

DISCUSSION

The aims of the study were to explore the experiences of Triple P practitioners within BEN in order to bring to light both the positive and negative aspects of their experience and highlight areas for improvement. In so doing it aimed to bring to light barriers that might prevent practitioners from fully committing to the Triple P programme and delivering it effectively.

Thematic analysis of the focus group transcripts, allowed for a rich account of the data containing real experiences and meanings for practitioners. The use of individual interviews may well have captured similar data, with the added advantage of accessing feelings and values held by each individual practitioner. However the use of focus groups allowed these personal opinions, which are arguably socially constructed ideas, to be communicated and explored within the group. Millward (1995) adds that focus groups can also serve to increase an individuals' awareness of their own perspective as, when confronted with differing opinions within a group, individuals may be prompted to consider their own beliefs and values with greater scrutiny than in an individual interview. The use of focus groups was also felt to be an effective way of collecting data from as many practitioners as possible, given the time restraints of the project. However it is acknowledged that eliciting an honest contribution from all participants may well have been affected by the presence of direct line managers within the group. Individuals may well have wished to portray a more favourable opinion of the programme in their presence.

With regards to the analysis of the data, it is also acknowledged that the process of independent analysis of transcripts, by another qualitative researcher, would have improved validity of the analysis.

The inclusion of participants who had facilitated only one group may have, arguably, skewed the data in terms of their lack of confidence and experience in delivering a group and the effect of this on their opinion of the programme as a whole. Nevertheless it was felt that it was important to include these less experienced practitioners in order to draw attention to the early experiences and highlight additional needs in terms of support and training new practitioners. As a result the themes in the data provided an invaluable insight into the factors relevant to BEN practitioners in their delivery of Triple P at varying stages of their development as Triple-P practitioners.

It is also worth noting that the author has also facilitated a Triple P group and, as such, acknowledges the impact this experience may have had on the identification of themes within the data. Nevertheless, the themes identified were in line with previous research that outlined programme and individual factors as variables in the effective dissemination of the group (Turner et al. in press). However, in this case, factors in addition to self-efficacy and satisfaction with the materials were identified, such as practitioners' perceptions of the programme's ability to enrich their practice, prove successful with their families, and develop as a strategy. These were viewed as key to the ability and, in some cases, willingness of these practitioners to participate in the active dissemination of the Triple P programme across BEN.

Hence the first theme illustrated that whilst practitioners valued the theory and principles of the programme, they were concerned about the programmes ability to meet the needs of the types of families that they worked with. They drew particular attention to the disparity in class between the programme and the families. The evidence-base for Triple P, which includes a number of dissemination studies with diverse populations, had no bearing here, as practitioners expressed a need to make it real to parents in their communities. As a consequence, almost all of the practitioners involved reported having made some adjustment to the programme to facilitate engagement.

Practitioners made no apologies for these changes and stated them as necessary for the continued engagement and learning of the families that they work with. The feedback they received from parents served to confirm their belief that these adjustments were necessary and worthwhile. However, what was apparent was the level of suspicion the “adjustment” issue arose between practitioners, who were either mistrustful of “changes” made by others or concerned that no adjustments had been made at all.

The conditions giving rise to the aforementioned theme appear embedded in the second theme, their engagement in and the belief that the programme was able to meet their needs and expectations.

Practitioners also expressed some disillusionment with the decision making process behind choice of programme for their communities. It could be argued that training is best placed to answer the expressed concerns of practitioners that the programme, as it stands, is not accessible to non-white and non-middle class, low-income families. However, practitioners reported that these concerns were dismissed during training, leaving them disillusioned and, in contrast to the findings of Turner et al. (in press), less confident about their ability to deliver the intervention post training.

Practitioners expressed high levels of anxiety about their ability to deliver the programme in the “right” way, irrespective of their previous experience working with parents. Practitioners also expressed feeling “exhausted” by the programme, which they felt placed, often unrecognised, additional demands of them in terms of their existing roles within the service.

The recently drafted proposal for future practice by the Senior Parenting Co-ordinator of Birmingham City Council acknowledges the above and as such has attempted to address the co-ordination of training and delivery of evidence-based programmes across the city. The proposal is yet to be agreed by service leads at this stage, however the plan will include the organisation of peer support groups, clinical consultation, supervision and locality network meetings. The aim of these groups will be to enable practitioners to access much needed support to reduce stress, facilitate collaboration between practitioners and the ongoing development of skills as well as increase quality control and fidelity to the programme. In addition to this Birmingham's' recently drafted Children and Young People's Plan (2008) sets out further actions for service design and the implementation of 'Brighter Futures'. It includes a review of the current use of both Triple P and SFSC to evaluate issues of outcomes and fidelity with the aim of making them more effective or decommissioning. This is a particularly significant move given the results of the Parenting Early Intervention Pathfinder Evaluation (2008) that, having implemented Triple P, SFSC and the Incredible Years programme across 18 local authorities, found that outcomes for all three programmes were equally effective. The report also reports large differences in cost effectiveness and encourages local authorities to consider their findings in their plans for dissemination of parenting interventions.

In the final theme, religious metaphors expressed hope, belief and faith in the programme with practitioners expressing a wish to be supported to stay "faithful" and develop the use of the programmes' multi-level design. Metaphors are said to play an important role in the change processes of services and larger organisations in providing insight into the beliefs of individuals (Mainstone & Schroeder, 1999). As such, the religious metaphors used by practitioners provided some insight into the shared values of practitioners delivering the programme. There was an expressed belief that, if empowered to do so, desired outcomes for families, in their areas, could be achieved. As such, those responsible for change may wish to remain mindful of these metaphors and use them as a vehicle for structuring and assisting services manage the change process.

The Triple P model goes some way to acknowledge the importance of engaging the practitioner by advocating a culture of support. However, the experience voiced by practitioners participating in the project highlights a worrying gap between the support structures that currently exist to address their concerns and the practitioners’ ability to access it and use it effectively. This may well be due to time constraints with practitioners expressing difficulties balancing the time it takes to actually deliver the programme and the additional pressures of their roles. However without support and encouragement to access support structures, practitioners can be seen to become increasingly anxious, less confident and fearful of judgements that may be made of them should the parents “fail” to make change.

RECOMMENDATIONS

With this in mind the following recommendations are made:

- To support the plans drafted by the Senior Parenting co-ordinator for improved support structures for practitioners.
- For practitioners to access this support in order to improve co-ordination between professionals delivering the programme. This would allow newly trained practitioners to gain from the experience of others already delivering groups, and thus improve practice standards.
- For managers to actively encourage their practitioners to access support structures in place as part on their continued professional development and ensure the effectiveness of delivery of the programme in their locality.
- For training to address specific concerns relevant to the delivery of the programme in their communities.
- For practitioners to actively contribute to the quality control of the programme by communicating changes and adjustments made to their programme structures, irrespective of the size of that change, to the Parent Support Quality Group.

- For these changes to be communicated and discussed between practitioners in peer support groups in order to facilitate continued learning, self-regulation and some uniformity of practice across BEN practitioners. This would facilitate relationships and trust between practitioners by providing some assurance of the fidelity of the programme across Birmingham.
- To conduct further research using outcome data for BEN as well as consider collating data to assess long-term effects of the programmes’ delivery.
- For Local Authorities to consider the multi-level strategy of the Triple P programme and to consider the both effectiveness of a community awareness (Level 1) and prevention strategy rather than solely intervention coupled with the expressed wish of practitioners to work in this way.

The service-evaluation outlined above incorporates an action research design in its identification of the problem, collection of data regarding current practices and the feeding back of such data, results and recommendations to the organisation. However time constraints limited the effectiveness of the project itself in being unable to complete the final and essential stages of monitoring and evaluation in the action research cycle. The processes necessary for change are further illustrated by the model outlined by Lewin (1951) which uses the analogy of changing the shape of a block of ice, (unfreeze, change, refreeze) to aid understanding of reshaping organisational practices. Using this analogy it is easy to see that the current service evaluation only goes as far as to “unfreeze” practitioners, identifying why change is necessary.

Diagnosis of the problem is an important phase in the organisational change and development. Nevertheless, interventions as well as the monitoring and evaluation of such interventions play an integral role in the change process in much the same way they would in working with an individual client. Thus the conditions necessary for engaging clients in a service or therapy, such as trust, working collaboratively and feeling heard are also required to engage practitioners (Kahn, 1990; Rogers, 1957; Stern, 1999). Birmingham City Council, in recognising a need in the delivery of Triple P, has sought to develop "an intervention" for addressing the difficulties identified. However, without building the foundations for that change, communicating a shared vision rather that a "top-down" vision of good practice and engendering the trust and cooperation of the Triple-P practitioners, those offering support and quality assurance may struggle to engage the very practitioners they wish to engage in the supervision process. The experiences voiced by practitioners participating in the project, highlight key factors that may affect their engagement. Thus the ability of the programme and the surrounding system to engage the practitioner by facilitating the same trust, setting a collaborative agenda and listening to their concerns is arguably a key factor in the programmes dissemination and the maintenance of effective change.

The stage of actual change, where practitioners behave in ways that support the new direction, are left untouched by this report. However change itself can take more time than the service evaluation allowed. It requires careful management and consideration of people involved, to ensure that they engage fully with the process and embrace a new way of working. Only then can the process of "refreezing" take place. This would then serve to anchor any changes to the delivery of the programme into the culture of Triple P delivery across BEN, ensuring that change is maintained and relapse is prevented. As such, those concerned with organizational planning, implementation and change may also wish to consider the vision communicated by the practitioners who took part in this study.

> *"...knowing that it can be done... it can be done and it really builds up the faith in the whole Triple P system, it's okay, it can be done in Birmingham! (Laughter)*

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CLINICAL PRACTICE REPORT

(CPR3)

SINGLE-CASE EXPERIMENTAL DESIGN

Growing Old with Grace: A Psychosocial approach to challenging behaviour.

Names and identifying features have been changed and/or omitted to maintain confidentiality

ABSTRACT

A Single-case study of Sister Grace, a catholic nun of 99 years, with a diagnosis of dementia is presented. Sister Grace was referred due to behaviour that was experienced by care staff and other Sisters as challenging. A person-centred model was used to guide the assessment which was conducted across four domains. Assessment methods examined the behaviour itself and incorporated the personal history of Sister Grace, characteristics of the carers and the care environment, as well as the physical and sensory environment. Using the Model of Consequences of Need-Driven, Dementia-Compromised Behaviour, the challenging behaviour is viewed in the context of an unmet need. This need is said to be further compromised by her cognitive deficits and the devaluing environment in which she was cared for. The interventions loosely fall into three categories; Individualised interventions for Sister Grace, interventions targeted at the carers and those specific to environmental factors. An A-B design is proposed to evaluate their effectiveness. A significant difference is found between the baseline and intervention phases. However, limitations of the design and findings are discussed.

Ethical issues and considerations for future work in the context of organisational change are also reflected upon.

INTRODUCTION

Referral

Sister Grace was[1] a 99-year old, catholic nun, with a diagnosis of dementia. She was referred by her GP who requested assessment and intervention to assist care staff, working within the convent nursing home, to reduce her challenging behaviour and alleviate her depressed mood. Challenging behaviours reported included frequent shouts for help and some aggression towards care staff.

Assessment

Sister Graces' loud requests for attention are categorised as disruptive vocalisations (DV) (Moniz-Cook, Stokes & Agar, 2003). DV's are one of the commonest forms of challenging behaviour exhibited by individuals with dementia in nursing home care. However, the causes can vary across individuals (Moniz-Cook, Stokes & Agar, 2003). It is therefore widely accepted that it requires intervention targeted at causal factors that are grounded in the individuality of the presented case (Bird, 2003; Moniz-Cook, Stokes & Agar, 2003; Moniz-Cook, Woods & Richards, 2001, NICE-SCIE, 2006). Kitwood (1993) provides a useful framework for doing just that. Within this framework, the challenging behaviour is placed within the context of the interaction of five factors (Kitwood, 1993). These factors include the person's history/biography, personality, physical health, neurological impairment and their social environment. Kitwood (1993) further suggests that the challenging behaviour itself may be a result of being cared for in a "malignant social-psychology"; a devaluing environment that is damaging for individuals with dementia. Stokes (2000) therefore advocates a 'multiple pathway' approach to assessment that incorporates an examination of the above factors to aid understanding of the behaviour.

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[1] Sister Grace suffered a second stroke and died the week following her discharge.

The assessment was conducted within the four domains outlined by Bird and Moniz-Cook (2008). It examined the behaviour itself, the personal history of Sister Grace, characteristics of the carers and the care environment, as well as the physical and sensory environment. The assessment process therefore utilised interviews with care staff and Sisters in charge, direct observation, psychometric assessment and behavioural monitoring forms. Also essential to the assessment process were interviews with Sister Grace herself.

Domain 1: The Behaviour. Assessment interviews enabled further information about the specifics of the challenging behaviour to be gathered. Within these interviews, her aggressive behaviour was somewhat minimised. Staff spoke instead of the distress caused to them and other residents of the convent, by her frequent calls for attention. They described that Sister Grace often became agitated and/or distressed when she was not responded to immediately and that summons for help would often escalate to verbal aggression or throwing items as a result. Staff also added that the behaviour had gradually escalated since her stroke last year, when Sister Grace had begun to experience cognitive difficulties coupled with physical disability.

Behaviour monitoring forms were used to chart the frequency of Sister Graces' challenging behaviour and provide the data for behavioural analysis (see Appendix 1). Staff record sheets were designed in accordance with an ABC approach and as such, care staff were required to provide details of the problem behaviour, its antecedents and the consequences of such behaviour across every shift (Stokes, 2000). They also proved useful in determining any patterns in behaviour in terms of frequency and time of day. Baseline data was collated over a two week period. The behaviour was non-specific to times of day, staff or place. However, the behaviour was seen to escalate during periods when staff reported that they had been exceptionally busy.

Domain 2: The Person. Individualised, person centred treatment care plans that acknowledge personal experiences, interests and general sense of identity, are said to be highly effective in decreasing challenging behaviour (Cohen-Mansfield, Parpura-Gill and Golander, 2006). A biographical investigation was therefore conducted using self-reports from Sister Grace as well as knowledge held by care staff and other Sisters.

Sister Grace was born in 1909 and was the third of four children born to her parents. She was raised on a farm with her older brother and sisters and had a keen interest in animals from an early age, often preferring to work on the farm than attend school. Her father became seriously ill and died when she was young and she developed an interest in nursing as a result. During her nurse training she travelled extensively, working initially in Egypt. However she returned to England when war broke out. She was, by her own accounts a feisty, young woman who ignored the advice and strong criticism of her family and worked in the army as a nurse. After the war she reportedly worked abroad as a senior nurse in countries such as India, France and Tanzania. As a result, she spoke at least three languages. She eventually returned to England to live with her younger sister. She became a nun in her late 40’s, however she refused the offer to live within the convent with the other Sisters, preferring to live with her own sister. However, due to her failing health she was reluctantly moved to the convent. The Sisters recall that she was moved “kicking and screaming” but had lived there with them for over 10 years. Overall accounts indicate that Sister Grace initially lived a highly independent life within the convent and was characterised as a feisty, strong willed woman. Staff stated that, prior to her stroke, a year ago she had maintained her independence, occupying herself throughout the day. She had also enjoyed the company of the other Nuns, attending many social evenings. However, as her stroke had severely limited her mobility, she was now dependent on staff for daily care and stimulation.

Sister Grace scored 16 on the MMSE (Folstein, Folstein and McHugh, 1975). Nevertheless she had retained language skills and some insight. As such the assessment was also able to identify areas of strength that could be utilised later in direct work. In interviews with Sister Grace, she recalled having enjoyed being in a position of power within her role as a senior nurse and added that, at times, she felt the care staff within the convent needed to be "kept on their toes" and would summon them to ensure this was the case.

Domain 3: Carer Characteristics and Environment. Bird & Moniz-Cook's (2008) definition of challenging behaviour suggests that Sister Graces' DV were a manifestation of distress in her and the carers. As much of the work would be done through the enlisting of staff as co-therapists, gaining some understanding of their distress was seen as imperative to the assessment process (Teri, McCurry, Logsdon & Gibbons, 2005).

Care staff completed the Challenging Behaviour Scale (CBS) (Moniz-Cook, Woods & Gardiner, 2001). However, as the authors of the scale acknowledge, staff can vary widely in their experience of the behaviour as challenging as it can depend on, for example, their personal level of tolerance. As such, staff ratings were made collaboratively, as recommended by the authors, in order to achieve inter-rater reliability. The scale itself requires staff to rate the frequency, difficulty and the level of challenge the behaviour poses to staff (see Appendix 2). The incidence score of 13 and the challenge score of 108 both fell into the severe level of challenge.

Observations of staff allowed the assessment to consider whether care practices contributed and/or accentuated the problem. Thus the author was able to observe that when staff were not engaged in caring duties with other residents they were often engaged in administrative duties in the office, whilst patients were left alone in their rooms or in the kitchenette.

Interviews with staff also allowed questions to be asked regarding staffing levels, resources, morale and their motivation to change. Staff expressed their frustrations with low staffing levels and shifts dominated by attending to each resident in turn and the administrative duties that accompanied these tasks, leaving little time for any meaningful engagement with the Sisters.

Multiple interviews with care workers also allowed the author to hear accounts from staff who had reported having fewer problems with Sister Graces' behaviour. These accounts were used to look for exceptions and problem solving with the team. Examples of this included allowing Sister Grace accompany them in the staff office while they completed administrative duties and facilitating time spent with other Sisters.

Following on from this, interviews also revealed that staff were dissatisfied with the inflexibility of the system in which they worked. There appeared to be an invisible hierarchy that governed the practices of the care team. Thus although the care staff were formally employed by a private company, the management structure of the convent, in which the nursing home was based held the most influence over the way in which care staff were able to work. Care staff also expressed frustration with the lack of autonomy and powerlessness to make real change. They gave examples of having tried to include the Sisters requiring care with other, more mobile Sisters. However, their efforts had been criticised and they had been reprimanded for not considering the needs of the able sisters who were said to be reluctant to be exposed to difficulties of the Sisters with dementia.

The general feeling appeared to be that Nuns were expected to 'grow old gracefully'. This, in fact, appeared to be an unwritten rule/condition of stay within the convent. Consequently, Sisters who required extra personal care but had no symptoms of dementia were openly praised for the way in which they “quietly” managed their disabilities. On the other hand, individuals with dementia seemed to be looked down upon as they did not behave in ways that were expected of a ‘good nun’.

Domain 4: The Physical and Sensory Environment. The absence of stimulation is generally felt to be a causal factor in challenging behaviour (Bird & Moniz-Cook, 2008). Sister Grace was often left to sit for long periods of time on her own in her bedroom or in the kitchenette, both of which severely lacked sensory stimuli. Although both rooms had CD players and radios they were not often utilised. Sister Grace also commented on her feelings about her own room, stating that the colour on the walls made her feel she was “being kept in a toilet”.

The design of the physical environment in which individuals with dementia reside is also considered to be a possible precipitating factor (Day, Carreon & Stump, 2000). The design of the convent building was therefore considered a possible contributory factor. The convent itself is split into two halves. The lower floor, being the residence of the able Nuns, has easy access to the dining room, recreational facilities and the chapel for daily mass. The less (physically and cognitively) able Sisters reside in the upstairs living quarters. The windows on the first floor are high and are generally positioned in a way that makes it difficult for wheelchair bound Sisters to look out of them. Physically moving these Sisters downstairs is also a difficult chore for the care staff who have to use the slow chair lift for each resident. Access to the garden is also limited, as the surfaces were unsuitable for wheelchairs. The small kitchenette is the only social area available upstairs but this can only comfortably occupy a maximum of five Sisters. This number rapidly reduces should one of the Sisters need, for example, to be lifted using the hoist as to manoeuvre the hoist into the room it would be necessary for some to leave.

Formulation

In light of the findings of the assessment, the formulation conceptualised Sister Grace's behaviour in the context of unmet needs that were further compromised by her cognitive deficits and the devaluing environment in which she was cared for (Kovach, Noonan, Schlidt & Wells, 2005).

Disruptive vocalisations are themselves said to be examples of an acute state of an unmet need (Beck & Vogelpohl, 1999) and as such, the unmet needs model was used to reconceptualise the behaviour from being viewed as challenging to being need-driven. The formulation adapted the Needs-Driven Behaviour model outlined by Kovach et al (2005). In line with the assessment, it was sensitive to the complex interaction between the individual and contextual variables of the case (see Figure 1).

Antecedents. As illustrated in Figure 1, antecedents to Sister Graces' behaviour included details of her physical and social environment. The long periods of isolation, un-stimulating day schedule and routine care practices that provided responsive rather anticipatory care were viewed as contributory factors. The culture of exclusion of individuals with dementia, as well as the segregated design of the living area was also viewed as significant in Sister Graces' case. A lack of knowledge and understanding of the disease was also believed to be a contributory factor in her social isolation.

The model also considers biographical factors in her extensive history at the age of 99, for example, her position as a senior nurse. It also considers her personality as a fiercely independent, intelligent, feisty and at times rebellious woman. Prior to her dementia then it is likely that Sister Grace would have been the type of person who would "shout" if her needs or wishes were not heard/met.

Primary/Unmet Needs. Sister Grace was therefore viewed as a woman who placed a high value on autonomy, occupation and authority, but was seen to be frustrated by the dependency, social isolation and lack of stimulation put upon her by the physical and cognitive effects of the stroke and the restrictions of the residential care setting. The primary need was therefore thought to be her need for occupation, stimulation and social contact that allows for the expression of her identity.

Consequences. In accordance with the model, the challenging behaviour was conceptualised as a primary need driven, dementia-compromised behaviour (ND-DCB) occurring as a result of her unmet need. The ND-DCB continues and/or worsens as a consequence of Sister Graces' needs remaining unmet. The additional factors that result are split into the categories below.

i. ***Personal factors*.** The unmet need increased her feeling of anxiety, loneliness and depression. Sister Grace also experienced boredom through her lack of stimulating activity.

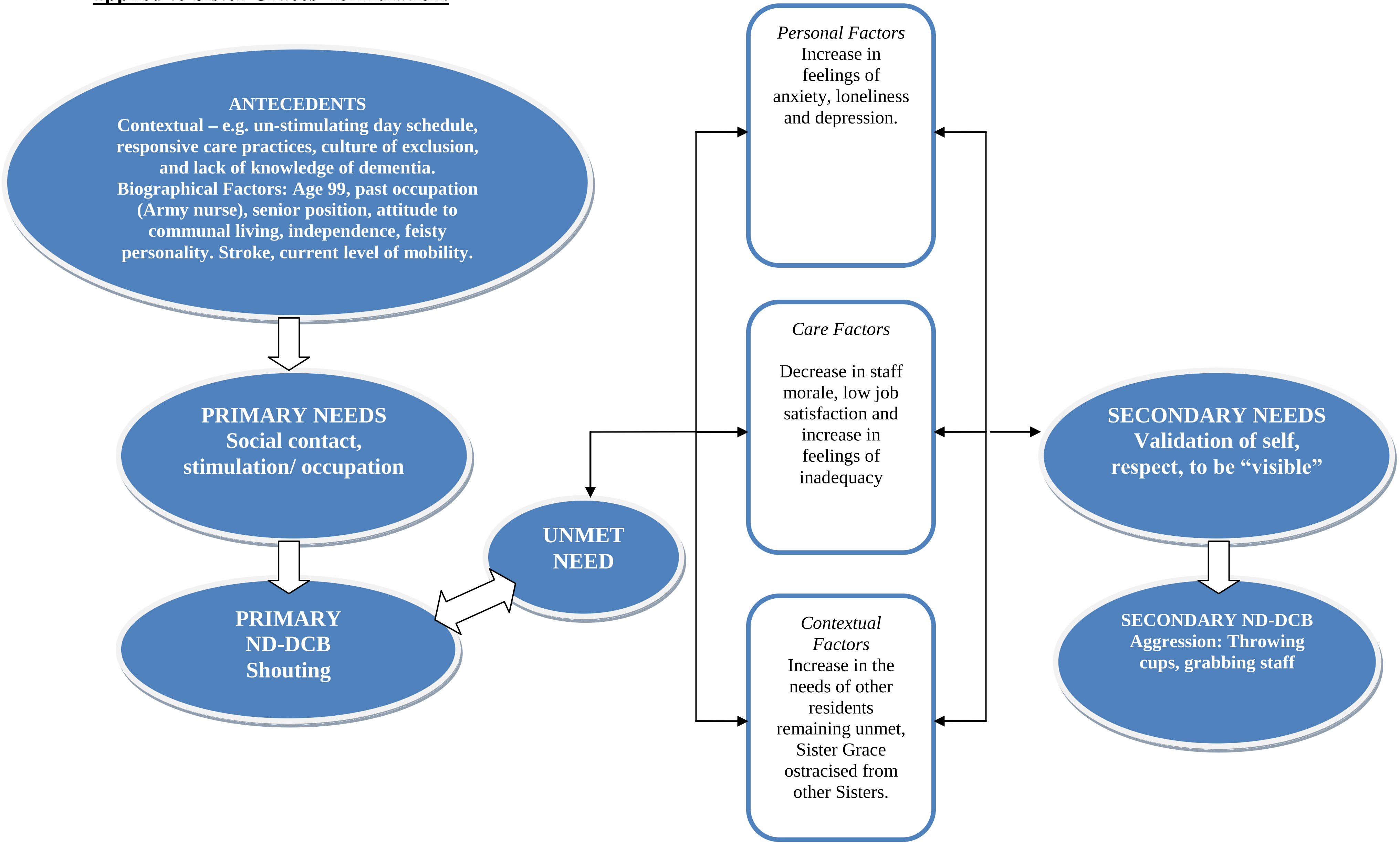
ii. ***Care factors*.** As supported by the literature, the stress caused by the ND-DCB increased the work related stress experienced by carers (Hallberg & Norberg, 1995). This in turn led to a decrease in staff morale and feelings of inadequacy. The ND-DCB also impacted on the care they were able to give other residents.

iii. ***Contextual Consequences.*** The contextual consequences of Sister Graces' ND-DCB were seen in the impact the behaviour had on other residents. As the behaviour

> was experienced as stressful to other Sisters, she is ostracised from social activities.

Secondary Needs and ND-DCB. Kovach et al (2005) draw attention to the effects occurring as a result of the needs remaining unmet. From the consequences outlined above, we can see that Sister Graces' secondary needs come out of her increased loneliness and social isolation. Loneliness and depression are said to lower an individuals' sense of self (Cohen-Mansfield, Golander & Arnheim, 2000). Thus it is likely that resulting secondary need is to maintain a sense of self; be 'visible' and 'respected'. Staying mindful of her past social position of authority within her nursing role, her aggressive behaviour is therefore viewed in this context, and is therefore postulated to be an attempt to resolve this secondary need.

Figure 1. An adapted model of the consequences of need-driven, dementia-compromised behaviour theory (Kovach et al, 2005) as applied to Sister Graces' formulation.



DESIGN & INTERVENTION

By conceptualising the challenging behaviour in this way, the author was able to gain a better understanding of Sister Grace's needs and behaviour. The intervention was then targeted to address the identified need.

An A-B single-case experimental design was proposed to address the identified needs and evaluate the effectiveness of the proposed intervention. Staff continued to record the frequency of the target primary ND-DCB for a further two weeks, in order provide a baseline measure prior to the introduction of any interventions.

The interventions loosely fall into three categories; individualised interventions for Sister Grace, interventions targeted at the carers and those specific to environmental factors.

Care Team Interventions

The literature states that attending to staff needs improves staff morale and coping, thus enabling the process of intervention to be a more collaborative exercise rather than expert led, the latter of which is said to result in poorer outcomes (Berg, Hannson & Hallberg 1994; Moniz-Cook et al, 1998, Sanchez & Ferrari, 2005). Addressing the carer distress was therefore deemed necessary, prior to introducing any interventions that required extra effort on their part. However as the meetings with staff formed part of the intervention they occurred after baseline measures had been collated. The aim of this initial part of the intervention was to build a rapport with the staff team and build an "appetite for change" (Brooker, 2008). Weekly meetings were set up between the author and the care staff in order to provide support for staff. It was also imperative that staff understood the rationale for intervention and change, thus meetings incorporated the sharing, and at times, the co-development of the formulation with the staff team. Weekly meetings were therefore used as a space for individualised case supervision, improving skills and knowledge through education and providing support and guidance. They were also useful in working with resistance to change, monitoring and addressing motivation to change and identifying 'key players' within the team who would be able to facilitate change between sessions (Brooker, 2008). Weekly meetings with staff were continued throughout the intervention phase.

The author was also mindful of the invisible hierarchy identified during the assessment and therefore involved Senior Sisters in the care planning process by building rapport and sharing the formulation. The design recognised them as additional 'key players' within the change process. Thus, although their contribution to the process was not an active one, they were recognised as falling into the "let" category of individuals necessary to achieve change (Brooker, 2008). They were therefore important to the process in as much as they held the power to allow lasting change to occur.

Individualised Interventions

Interventions in this phase of treatment were designed to shift patterns of care from being responsive to the behaviour to being anticipatory of her needs. On an interpersonal level, staff were encouraged to be co-therapists and as such, were guided in their completion of reminiscence work with Sister Grace. This served a dual purpose. It firstly provided further biographical knowledge which helped to inform staff practices, as they were better able to consider what life was like from Sister Graces' perspective (Bird et al 2007, Edberg et al, 1999). It also provided opportunities for one-to-one interaction with Sister Grace which is said to be effective in reducing verbal behaviours associated with specific requests (Cohen-Mansfield & Werner, 1997).

Interventions that consider the dementia patients retained cognitive abilities are said to be effective in raising self-esteem and meeting the need for communication (Beck et al, 2002). Staff were therefore encouraged to work with her retained language ability. They were able to engage her in games and activities on a regular basis, such as speed scrabble, that again, provided the one-to-one contact and regular structured activity that is proven to be effective (Younger & Martin, 2000).

Staffing and financial constraints are also important factors that determine the success of the planned interventions (Camp, Cohen-Mansfield & Capezuti, 2002). The design was therefore considerate of the cost of one-to-one care. Staff were therefore encouraged as far as possible to increase social and recreational contact with the other Sisters within the convent. Having built a rapport and increased understanding for the rationale for the intervention amongst Senior Sisters, the care staff met little resistance in their efforts to reintegrate Sister Grace in games nights and meal times with the more able Sisters on the lower floor. Attending morning mass also reintroduced into her daily routine. Sister Grace was thereby able to re-engage with the spiritual rituals and routines of the convent, thus acknowledging and validating her identity as a Nun and providing the comfort and meaning that can be gained through the maintenance of religious practices (Caron & Goetz, 1998).

Providing contact with pets is also viewed as a cost effective means of improving social contact. In addition, providing tactile stimulation is said to be effective in minimising verbal behaviours (Allen-Burge et al, 1999; Camp et al, 2002). In keeping with this, a voluntary service was recruited to provide weekly contact with her favoured animal, a dog. In practice this also proved effective means of increasing her social contact with the other Sisters as “Sister Grace’s dog became the much anticipated weekly attraction.

Environmental interventions

Finally, as environment is also seen as a contributory factor in ND-DCB’s, specific attention was also paid to Sister Grace’s physical surroundings. Audio stimulation is suggested to be effective in reducing verbal behaviours that stem from sensory and or social isolation (Cohen-Mansfield & Werner, 1997; Opie, Rosewarne, O'Connor, 1999). Thus staff were encouraged to use the CD players identified during observation and also to provide music of her preferred choice. Unprompted, staff also moved her to a different room where the walls were painted in a more favourable colour.

Outcomes

Visual analysis of data.

i. ***Challenging Behaviour Scale.*** Visual inspection of Graph 1, which illustrates staff attitudes prior to the intervention and post, shows an overall improvement over the course of the intervention period.

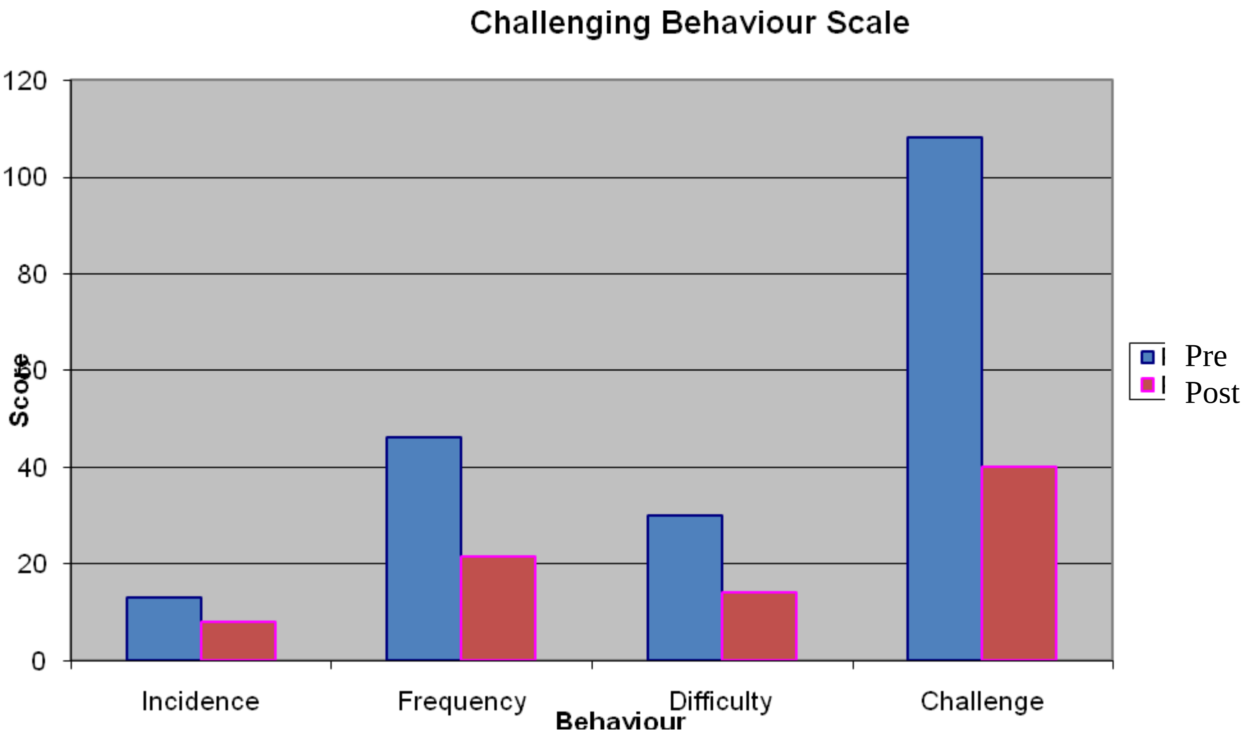


Fig. 2: Experience of Sister Grace's ND-DCB as measured on the four factors of the CBS.

As the measure was conducted as a collaborative exercise between staff, as recommended by the literature, the raw scores are presented below to aid further visual analysis (see Table 1.).

Table 1:

Pre and Post intervention raw scores on the Challenging Behaviour Scale Measures.

	Challenging Behaviour Scale Measures			
	Incidence	Frequency	Difficulty	Challenge
Pre	13	46	30	108
Post	8	21	14	40

Some improvement can be viewed in the staffs' experience of the incidence of the behaviour, as can be viewed in their experience of the behaviour as difficult. Some improvement can also be seen in their reports of behaviour frequency post-intervention. The final measure, of challenge, is calculated as the sum of the products of frequency and difficulty ratings, as although the behaviour may be frequent in its occurrence, it can be experienced by staff with a varying amount of challenge. This appears to be evident in the results shown here where pre intervention, staff experienced the behaviour as more challenging than they did post-intervention, despite the small visual difference in incidence.

ii. ***Frequency of ND-DCB (shouting).*** Visual inspection of Fig. 2, 3 and 4 reveal a difference between the frequency of Sister Graces' ND-DCB at the baseline phase (days 1-16) and the intervention phase (days 17-66). The behaviour in the baseline phase also shows an increasing trend (Fig 2). However the Fig. 3 illustrates a stable trend in the intervention phase that remained lower than that in the baseline phase. Fig. 4 illustrates the overall decreasing trend across both phases. It is worth noting that the collection of data to achieve the ideal of a stable baseline was clinically impractical due to concerns regarding staff engagement and morale. It was also judged to be in Sister Graces' best interests to proceed.

Fig. 3.

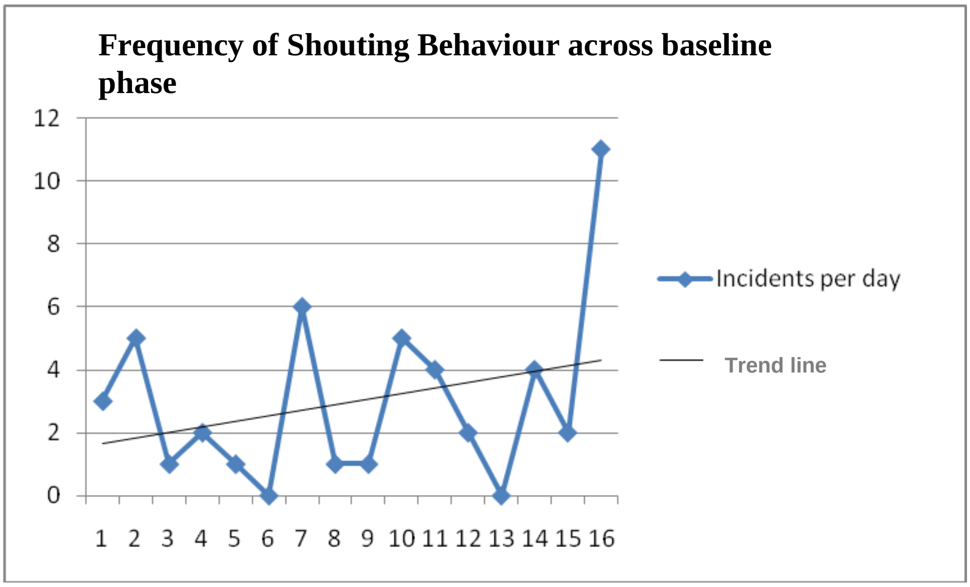


Fig. 4

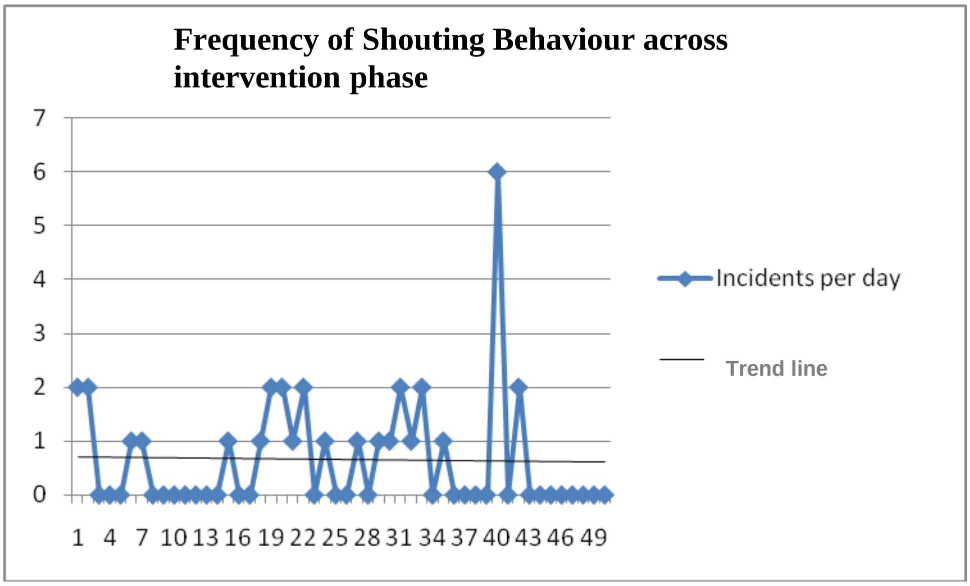
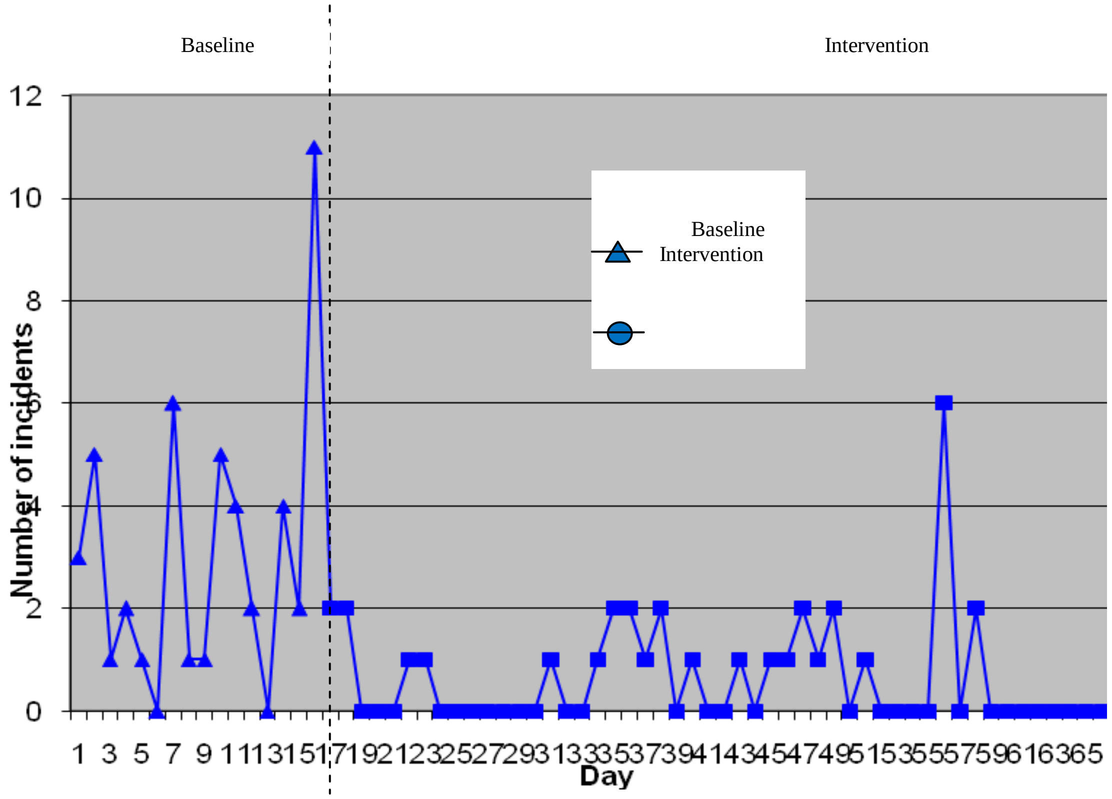


Fig. 5 **Frequency of Shouting Behaviour across baseline and intervention phases**



Statistical analysis of data. Although is it held by some that visual analysis is sufficient to analyse single-case data, many researchers recommend the use of additional statistical analysis to account for any bias that might occur as a result of visual inspection. Single-case data is also typically affected by other confounds, such as unstable baselines and autocorrelations; the serial dependency of the data with each score having some influence on what the next score will be (Brossart, Parker, Olsen and Mahadevan, 2006).

Ideally the data set for the Challenging Behaviour Scales would have been analysed using the Jacobson's Reliable Change Index, to test whether the reductions between the pre and post intervention measures were significant. However the author was unable to do so without access to the norms and reliability data for the measure and was therefore reliant on the visual analysis.

Due to factors mentioned above further statistical analysis was deemed appropriate for the frequency of behaviour. Consequently the autocorrelation was calculated for each phase of the design.

i. Split Middle Analysis. A non-significant autocorrelation was observed at lag=1 in the baseline phase (r=-0.207, p=0.353). However, as tests for the significance of autocorrelations lack power on small samples, in this case, just 15 data points, the size of the autocorrelation is also a factor for consideration at this stage (Brockhard et al, 2008). As Crosbie (1993) suggests that autocorrelations of 0.2 can lead to a doubling of Type I errors, conventional statistics were deemed to be inappropriate. No autocorrelation was found in the intervention phase (r=-0.013, p=0.922).

ii. Double Bootstrap Method Due to the autocorrelation in the baseline phase, the double bootstrap method was used to further analyse the data (McKnight et al, 2000). The programme removes the autocorrelation effect and calculates two regression lines; one for each phase. The results show there was a significant change in the slope (Beta 4; p=0.049). However it is the drop in frequency that is of particular interest to the author, as the data indicates that the change was quick rather than gradual. The data shows that there was a highly significant difference between the regression lines at the point of intervention (Beta 3; p=5.176e-05).

DISCUSSION AND REFLECTIONS

Methodological Reflections and Limitations

The results show a significant decrease in the frequency of Sister Grace’s ND-DCB. However it is important to consider the limitations of the study with regards to the design and the inferences that can or cannot be drawn from the results. Although the A-B design proved useful in the application of the bootstrapping technique, the design itself means that a strong causal influence cannot be drawn between the intervention and the results. Hence it is not possible to say whether another interfering event, occurring simultaneously to the intervention, had an effect. In this case, Sister Grace suffered a stroke a week after the end of the intervention phase was complete. It is therefore equally possible that the results could have been due to a deterioration in her physical health.

An alternative design that may have improved validity may therefore have been an ABAB design. By doing so, the author may have been better able to demonstrate experimental control of the target behaviour (Barker, Pistrang & Elliot, 1994). Nevertheless, with this type of design, it is unlikely that the treatment effects, such as the work carried out to improve the psychological mindedness of the staff team, would have been reversible. Also the immediate, strong effect of the intervention, as suggested by the data in the current study, suggests that effects, such as spontaneous recovery, can be ruled out in this case. It can therefore be inferred that the significant reductions in Sister Graces’ ND-DCB were due to the interventions introduced. In addition, though the Challenging Behaviour Scale lacked statistical analysis, the visual analysis suggests a notable change in the attributions of staff to the behaviour. Thus although the behaviour was not completely eradicated, there was a ‘meaningful’ reduction in the behaviour both in terms of Sister Grace’s well-being and that of the staff group who reported finding the behaviour less challenging to cope with.

The intervention phase of the study, due to the need to address Sister Grace's needs from a bio-psychosocial approach, was varied in its content. However, as highlighted in the literature, as a result, it then becomes difficult to assess the extent to which the client has actually received the intervention. It is equally difficult to assess the extent to which the intervention was delivered as planned, including that delivered by the therapist (Burgio, et al, 2001). Burgio et al. suggest strategies for facilitating and monitoring the level at which interventions are delivered and applied. Using these strategies may have further strengthened the design and provided stronger support for the intervention(s) that actually made a difference.

Ethical reflections

When considering the design, it is also necessary to acknowledge the ethical issues that arise when conducting single-case research (Long & Hollin, 1995). Kazdin (1980 in Long & Hollin, 1995) highlights that the issue of informed consent and it is an issue the author was mindful of whilst working with this client group. The author was mindful of these issues and considered them in relation to the use of the A-B design, in not withdrawing treatment, and not further extending the baseline in order to achieve stability. The author also considered the caution of Long and Hollin's (1995) in that the boundary between good clinical practice and good research may, at times, be difficult to draw.

Clinical Practice and organisational change

Towards the end of the intervention, the convent made an additional referral of another Sister to the Community Mental Health team with similar difficulties to those of Sister Grace. Although a large proportion of the intervention had been directed at staff, the author wondered how much staff had been able to generalise these strategies to be able to work with other Sisters in their care. Although it is acknowledged that staff team interventions are best delivered on a long term basis, future work might do well consider the convent itself as the referred patient to bring about lasting organisational change. However the author is also reminded of the complexity of change processes within organisations and is reminded of the invisible, yet powerful hierarchy that exists within the convent. As such the author wonders how much this second referral might be an indication of the ‘pathology’ of the service itself, as well as than of the individuals referred (Applebaum & Wohl, 2000; Brooker, 2008). As such the ND-DCB of the service could be said to be the repeated referral of their residents. Possible primary needs for the service might include knowledge and understanding of dementia care. However the author is also mindful of the religious context. It is possible that ideals of what it means to be a “good nun”, are entangled with religious ideals and expectations. Thus the struggle for this service and the clinician working with them in the future, may therefore be in the adjustment of these ideals, without compromising religious beliefs, in order to allow a nun with dementia to also be viewed as a “good nun” and thus allow all Sisters the opportunity to grow old ‘gracefully’.

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CLINICAL PRACTICE REPORT

(CPR3)

CASE STUDY

Worried William: A case report of cognitive-behavioural treatment intervention for a 12 year old, autistic boy and his family.

*Names and identifying features have been changed and/or omitted to maintain confidentiality

ABSTRACT

The case presented is that of William, a 12-year old boy, diagnosed with Autistic Spectrum Disorder (ASD). He was referred to psychology, within a Child and Adolescent Mental Health (CAMHS) Learning Disability service, for help in managing his severe symptoms of anxiety. The impact of his co-morbid presentation of ASD and anxiety is formulated within a developmental model of anxiety. It reflects upon the core features of his ASD that increase his vulnerability to anxiety and other contextual influences, such as his parents' anxiety and their role in maintaining his symptoms. An evidence-based, adapted cognitive-behavioural intervention is outlined and evaluated through psychometric measures and qualitative outcomes. The intervention was successful in reducing his anxiety and positive outcomes were also observed for his parents. Reflections are made on the limitations of evidence-based resources specific to this client group and the effectiveness of parent involvement in the intervention. The implications of an ASD diagnosis for Williams' parents and more generally for clinical practice, in the choice and design of the intervention, are also discussed.

REFERRAL

William is a bright and charming 12-year old boy, with a diagnosis of atypical autistic spectrum disorder (ASD). He was diagnosed fairly recently (a year prior to referral), as previously it had been felt that Williams' difficulties did not fit the characteristics of an ASD diagnosis. His difficulties were, at that time, described as 'Developmental delay with complex communication disorder'. Nevertheless, William has a long, documented history of difficulties with anxiety. At the time of referral, there had been a significant deterioration in both his and his parents' ability to cope.

ASSESSMENT

William attended the initial assessment appointment with his mother and father. However the assessment process itself was covered over 4 sessions. Current literature recommends a multimodal assessment (MacNeil, Lopes & Minnes, 2009). As such, it incorporated case note review, self-monitoring forms, interviews with William, his parents and school mentors, informal parent-child observation and psychometric assessment.

Parental Interviews

Interviews with Williams' parents provided an opportunity to hear their perspective and assess the impact on them as a family.

William lives with both his parents and is their only child. He was born after an anxious pregnancy, where his mother had been very ill. He was also described as a "sickly" child, failing to meet many of the developmental milestones. It is also worth noting that Williams' parents also presented as weary from what they described as years "battling" for an appropriate diagnosis for Williams' difficulties. They were frustrated by their inability to access the appropriate level of support and gain some understanding of his behaviour. His recent diagnosis was therefore viewed by them as the end result of increased pressure they had put on professionals to diagnose him.

Williams’ parents added that they had become distant from their extended family. Mom described that, after a recent family holiday where she felt they had been particularly unsympathetic and unsupportive, they had made the decision to have no further contact with them.

However, more recently it has been his anxious behaviour, rather than his autism, that has become difficult for them to manage. When highly anxious, William experiences severe bouts of vomiting and headaches. He responds by crying and talking repetitively about the thing he is worried about. He has also developed a physical tic when anxious. William also bites the inside of his mouth when highly anxious. On one occasion this had become so severe that it had become infected. This added to the worries of both his parents and William who, whenever he would bite the inside of his cheeks, would worry the same might happen again, leading to further biting.

They disclosed that Williams’ anxiety and associated difficulties, such as school refusal, food refusal and difficulties sleeping, were having an adverse affect on their relationship, as they often disagreed in their approach to managing Williams’ distress. They also described existing in a state of constant hypervigilence not that dissimilar to William, in that they felt they needed to be on constant alert for things he may not like.

Williams’ parents reported that their previous attempts to rationalise with William or use techniques such as distraction, reward charts and “calm down” posters, had achieved little success. Pharmacological interventions were also reported to be unsuccessful, making no significant difference in his presentation of anxiety. Williams’ parents therefore presented to the service as desperate for help to managing his difficulties and reduce his and their own distress.

Informal Observation of Family Relationships and Patterns of Behaviour

During session time, William would often spend time hugging and kissing his mother and sitting on her lap. Mom, in turn, would reciprocate this affection. Added to this she often expressed concerns over his ill health. Should he cough briefly in session, for example, she would often state that his asthma “sounded bad” and query whether he should attend school the next day. Dad’s response was often to demonstrate, non-verbally, his disapproval. He also appeared somewhat detached from William and his mother as a unit.

In addition, Williams’ special interest in the Disney adaptation on Beauty and the Beast also revealed much of the family dynamics at home. In the early assessment sessions he referred to his father as “the Master”, referring to the Beast, his mother as Belle and himself as Cogsworth (the one who keeps the house in order).

Other observations of the family included the parental anxiety evident in the initial sessions. Williams’ mother was especially quick to apologise for “not helping William the right way” and worried that she might not be able to remember how to do the homework tasks or that it might be in some way “wrong”.

School Interviews

Meetings were arranged to consult with Williams’ school mentors in order to gain further understanding of his presenting problems. Williams’ anxiety in the school context was viewed as characteristic of his autism and as a result, school mentors did not display high levels of concern as they felt able to reassure him enough for him to continue with his day. However their main concern was that of Williams’ irregular attendance at school, which they believed was often attributed to Williams’ “self-fulfilling prophesies”, for example, “tomorrow I will be too ill to attend school”. They also queried whether Williams’ anxiety was in some way mediated by his parent’s response. School highlighted that William had expressed a wish to go swimming with his peers, however his parents had expressed their reluctance for him to do so, due to a negative experience William had in the past.

Interviews with William

William expressed in the initial session that he would like to “speak with me alone to tell me all about his worries”. However, the assessment with William aimed to assess his difficulties on a number of levels. Firstly, the literature on anxiety disorders among children with ASD recommends careful consideration during assessment to distinguish symptoms of ASD from that of anxiety disorders (Reaven & Hepburn, 2003; Wood, Drahota, Sze, Har Chiu and Langer, 2009). As such, his sensitivity to and dislike of, for example, loud noises (e.g. helicopters) and need for sameness were viewed in this context and differentiated from expressed fears consistent with a diagnosis of anxiety.

Secondly, the assessment aimed to explore his understanding of his anxiety. This was aided by the use of a story called The Huge Bag of Worries (Ironside, 1996). The story tells of a girl who carries a large bag of worries around with her. The girl is assisted by an old woman who helps her by sorting through the bag, making the worries disappear. William readily identified with the themes in the story and it served as a useful backdrop to build rapport and enable him to complete his own bag of worries. He formed an expansive list of worries that centred on his academic performance, what others might think of him, his parents arguing, his health and worries about people dying. He added that these worries were frequent and intense and that he often struggled to “get rid of them” once they were in his head. William was also able to utilise feeling rating scales, designed with visual cues to make the numbers more meaningful, to demonstrate the intensity of his fear.

The assessment sessions with William also provided an opportunity to assess, his level of language/communication impairment and/or ability, alongside his understanding of basic emotions. This was seen as particularly relevant to the development of a treatment plan for him. There is a strong evidence base for the use of Cognitive-Behavioural therapy to treat anxiety in children (Albano & Kendall, 2002; Barrett, Duffy, Dadds & Rapee 2001; Kendall, 1994). However its use with children with ASD is questionable, due to suggestions made in some on the literature that impairments in Theory of Mind (ToM), the inability to infer emotional states in themselves and others, and CBT's reliance of such ability, would make autistic children unsuitable for this type of intervention (Baron-Cohen, Leslie & Frith, 1985). However more recent research has highlighted that children with high-functioning autism are capable of doing just that (Bauminger & Kasari, 1999; Dahlgren, Sandberg & Hjelmquist, 2003). Sessions therefore provided the opportunity to explore Williams' ability to differentiate between events, thoughts and emotions and his ability to appreciate the link between them, in order to assess whether CBT would be an appropriate intervention for him (Dagnan, Chadwick & Proudlove, 2000).

Concerns are raised within the literature regarding the reliability of self-report measures with the learning disability population as many have not been normed for this population (Wilner, 2005). However the use of gestures, pictures and simplified language is said to improve the reliability of standard measures (Dagnan & Chadwick, 1997; Lindsay & Michie, 1988). As such the Spence Children's Anxiety Scale (SCAS) was used to measure his level of anxiety (Spence, 1997). Once again, its use was justified by Williams' demonstrated ability in previous assessment sessions to introspect.

The scale itself is a 45-item self-report questionnaire. Each item is rated on a four-point scale. It measures symptoms relating to six factors, separation anxiety, social phobia, the fear of physical injury, obsessive compulsive disorder, panic-agoraphobia and generalised anxiety which are consistent with DSM IV criteria. It has a high internal reliability with coefficient alpha of 0.92. Although no validity data has been published for its use with autistic children, research has found it useful in assessing anxiety in high-functioning autistic children (Chalfant, Rapee & Carroll, 2007; Gillot, Furniss & Walter, 2001). For the purposes of this assessment, the questionnaire was modified to a game where William was required to post his answer to one of the four coloured envelopes around the room.

Williams' total score of 59 on the SCAS was above the clinical mean for the measure indicating a high level of anxiety. His highest scores were on the scales of separation anxiety (15/18), Obsessive Compulsive (12/18) and generalised anxiety/overanxious disorder (16/18).

FORMULATION

In light of the findings of the assessment Williams' current level anxiety and most recent referral over the summer, was viewed as having been triggered by his transfer from his primary to his substantially larger secondary school. Predisposing, protective and maintaining factors are illustrated, alongside the presenting problems in Figure 1, below. A more detailed model that incorporates these factors and acknowledges the impact of contextual influences is presented in Figure 2.

Predisposing factors - Personal

Current literature suggests that children with high functioning autism are at greater risk of developing significantly high levels of anxiety (Gillott et al., 2001, Kim et al., 2000). In a study by Muris et al. (1998), with high-functioning ASD, over 80% were found to have significantly high levels of anxiety. Research has also demonstrated that these children are also at greater risk of exhibiting anxiety related symptoms associated with separation anxiety, obsessive worrying and specific fears (Attwood, 2005; Bellini, 2004). Developmental deficits, as a result of his ASD, in his cognitive ability to regulate his emotions are therefore viewed as a vulnerability factor (Dagnan & Jahota, 2006). As such the core features of

Williams' autism, namely difficulties in understanding his environment, the worry generated by social situations, his limited or maladaptive coping skills repertoire and sensitivity to change, are said to contribute to his anxious presentation, as these factors lower his threshold to tolerate and manage his anxiety.

As detailed in the assessment, Williams' parents also presented as anxious. It may well be the case that William may be genetically predisposed to exhibit some symptoms of anxiety.

Predisposing factors -Contextual

Nevertheless, there are a number of contextual factors that are also said to play a part in Williams' difficulties. Developmental models proposed by Rapee (2001) and Ginsburg, Siqueland, Masia-Warner & Hedtke (2004) provide a useful framework with which to conceptualise the link between the personal factors of Williams' ASD and the wider contextual factors (See Figure 2). The models suggest that Williams' genetic vulnerability to anxiety mean that he was likely to exhibit behaviour that elicited an increased level of involvement from his parents in their attempt to alleviate his distress. In addition, his parents' anxiety may have served to intensify their over-involved style of parenting, further increasing Williams' vulnerability to feelings of anxiety and reducing his already limited ability to develop coping skills of his own. Notably, the model outlined by Ginsburg et al., (2004) suggests that Williams' autism itself, in its early presentation of, for example, withdrawal, may have contributed to an insecure attachment with, specifically, his mother.

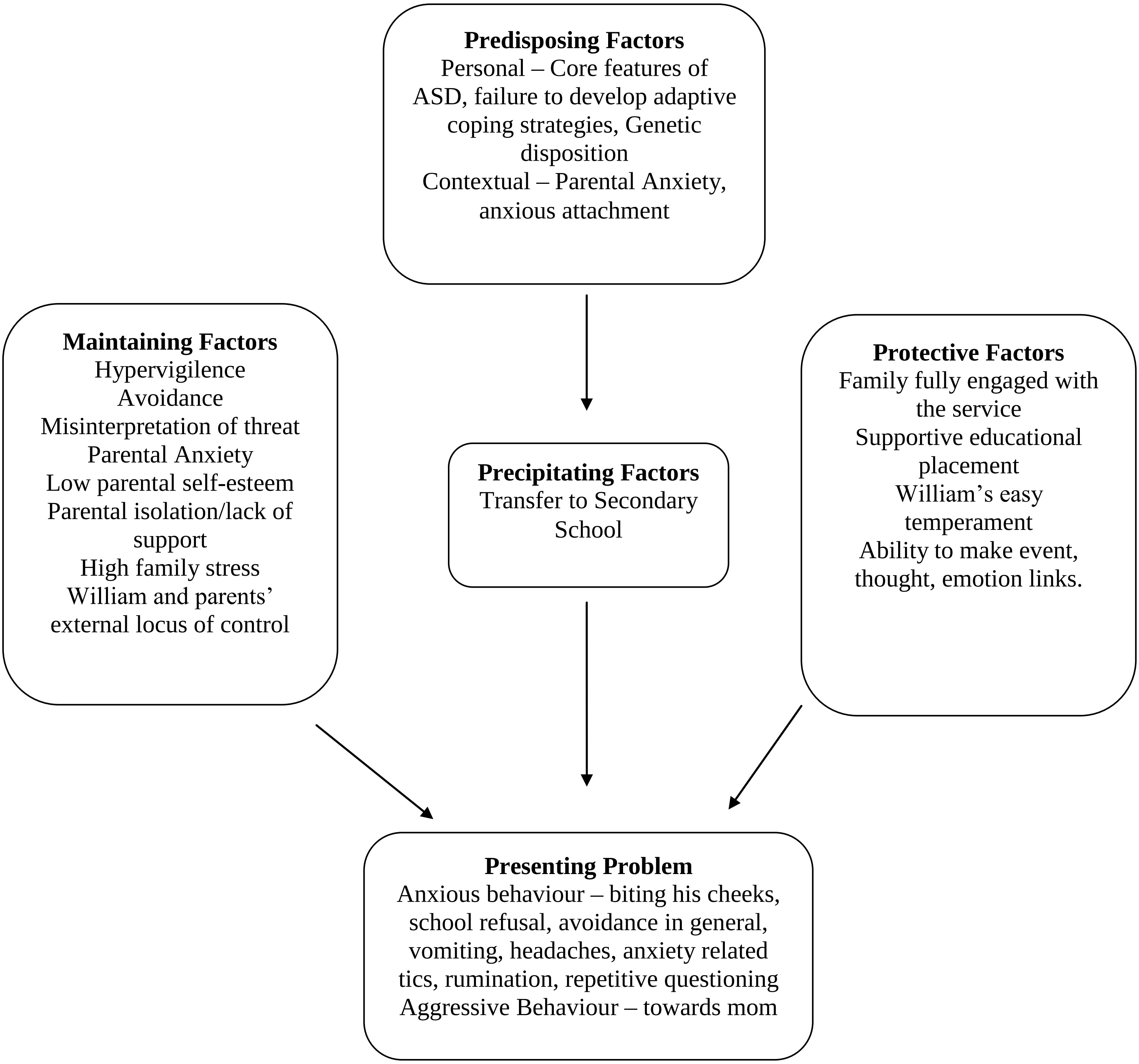


Figure 1: Formulation of Williams' difficulties.

Other contextual factors highlighted in the model and applicable in this case, are the family's lack of support from family and friends. Their experience of the lack of professional support resulting from a lack of a diagnosis for William was, as expressed by his parents, an additional stressor. Their possible unrealistic expectations of Williams' behaviour, that is, being unable to distinguish symptoms of anxiety from typical behavioural reactions of a child with ASD, are also likely to contribute to their parenting styles.

Maintaining factors

In line with the models and additional research, it was also hypothesised that parenting played an important role in maintaining Williams' difficulties (Ginsburg, 2004; Hudson & Rapee, 2001; Wood et al., 2003). Specific responses to Williams' anxiety included permitting school avoidance, catastrophising his difficulties along with him, modelling anxious responses and expressing their doubt in his ability to cope. Parental overprotection, for example, around the swimming issue, therefore served to maintain his anxiety. These factors served to promote and reinforce Williams' experience of anxiety and further hinder him from attempting novel situations. However overprotective parenting is hypothesised to be of specific relevance here, given his transition to secondary school, as research has shown that this style of parenting is a significant causal factor for anxiety during periods of transition from childhood to young adulthood (Neal & Edelmann, 2003).

High family stress, including marital discord is also hypothesised to play a role in the maintenance of Williams' anxiety. His parents acknowledge their approach was often inconsistent, presenting further confusion and anxiety for William. In addition their perceived lack of support around his diagnosis coupled with their lack of social support from family and friends contribute to the high stress levels in the family. So too does their low self-esteem in their belief that they are ill equipped to manage Williams' difficulties.

Other factors contributing to the maintenance of Williams' anxiety include his information processing bias and lack of adaptive coping strategies resulting from his ASD. As a result, he remains hypervigilent to threat and regularly misinterprets situations as threatening; the core features of his autism that make it difficult for him to comprehend his environment. With the smallest change in his environment inducing a great deal of confusion and upset, novel or changing situations are therefore continually misinterpreted as threatening. His avoidance of experiences he finds threatening also serves to maintain his difficulties.

Notably, during the assessment session, it was observed that both William and his parents expressed their dependence on services, demonstrating a distinctly external locus of control with regards to managing Williams' anxiety. The story of the 'Huge Bag of Worries' itself became problematic as, in that story, it is the old woman who sorts through the worries and little girl remains the passive recipient of help. However, it highlighted Williams' expectations of the therapist to take away his problems and his lack of confidence in his ability to do so outside of therapy. Although deficits in self-help skills are a common feature of ASD, the lack of self-determination on the part of William and his parents is thought to contribute to the maintenance of his difficulties, increasing reliance on services to solve their problems and maintaining the idea that Williams' emotions are beyond his control.

Protective factors

Nevertheless the family also presented with a number of protective factors. Despite the high family stress and the evident strains on their relationship, both mom and dad were committed to attending sessions. They were also accepting of the formulation of his difficulties and showed a willingness to work collaboratively as 'co-therapists' within and between sessions.

Other protective factors include Williams' temperament. He is a bright, likable, enthusiastic young man, who was motivated to work on his difficulties in order to reduce his anxiety. His ability to make antecedent, belief, emotion/consequence links and his observed capacity for abstract reasoning, atypical of his diagnosis, is also believed to be a protective factor. In addition it was felt that this would also make him an appropriate candidate for a CBT based intervention.

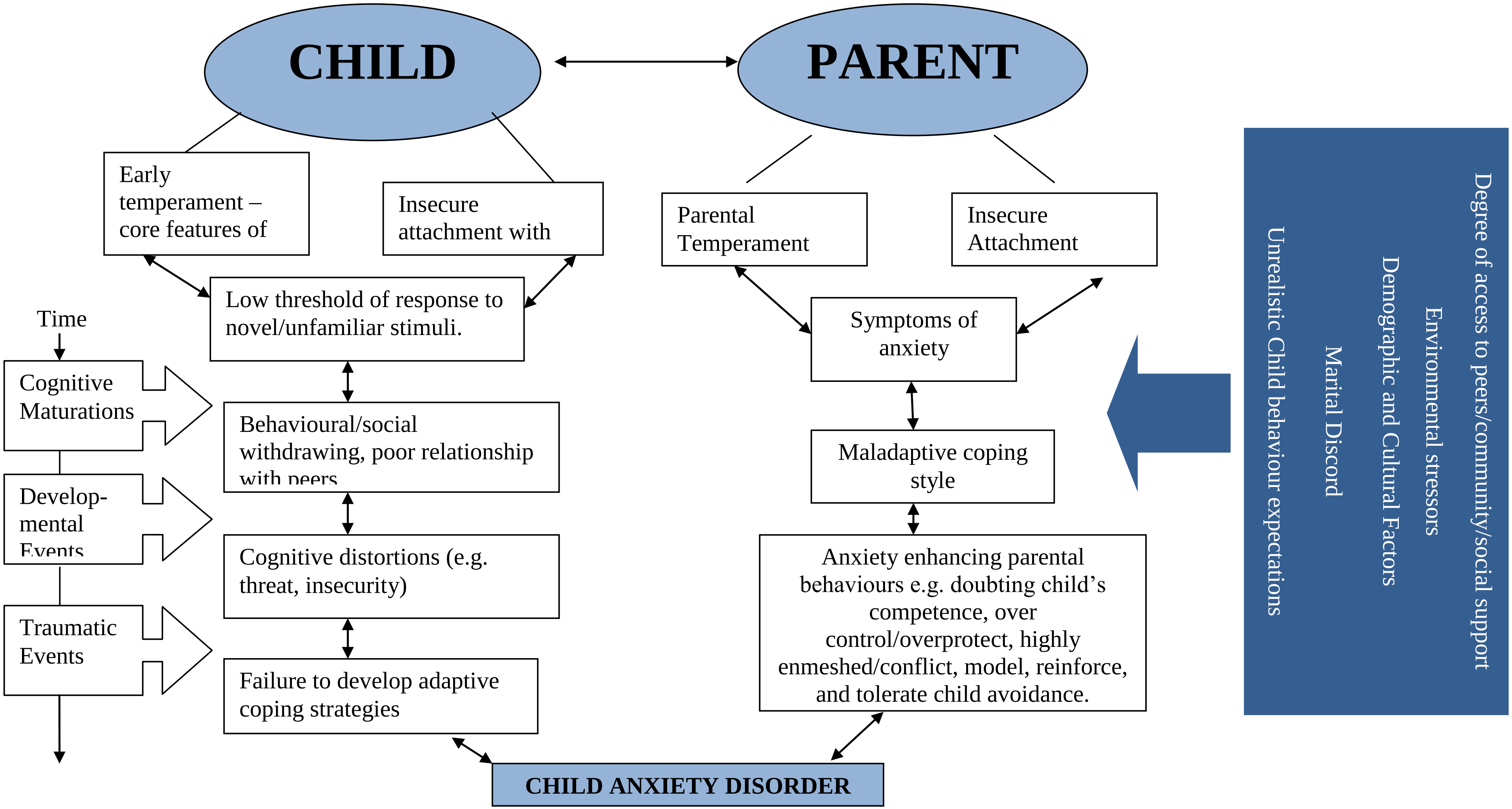


Figure 2: Development Model of Childhood Anxiety (adapted from Ginsberg, Siqueland, Masia-Warner & Hedtke, 2004).

INTERVENTION

As previously stated, a vast amount of empirical evidence supports use of CBT as the treatment of choice for anxiety in children (Kendall et al, 1997; Sze & Wood, 2007). However the use of CBT to treat anxiety in children with ASD is still in its infancy. Nevertheless, these studies show that modified and often enhanced CBT interventions are effective in the treatment of anxiety disorders in children with high-functioning autism (Chalfant, Rapee & Carroll, 2007; Reaven et al., 2008; Sofronoff, Attwood & Hinton, 2005; Sze & Wood, 2008; Wood et al., 2009). Chalfant et al. (2007) further suggest that children with high functioning autism can not only engage with but benefit from structured CBT interventions that matched their learning style.

The main aim of the intervention was to do that outlined above, using the *Think Good – Feel Good* CBT workbook (Stallard, 2002). Although the materials themselves are not designed as a CBT programme per se, they present complex CBT concepts in a child-friendly way. The intervention was designed with the agreed goal to specifically address his cognitive distortions and equip him with coping skills to ‘self-manage’ his difficulties. However, in light of the formulation and the maintenance factors outlined the intervention was also designed to include parental involvement.

William attended 10 sessions in all with his mom and dad. Sessions focused on recognising anxious feelings, recognising cognitive distortions, challenging these distortions and coping skills training. Throughout, efforts were made to play down the role as therapist and model confidence in Williams’ ability to acquire and apply coping skills for himself.

As recommended in the literature, key components of the intervention included the lack of emphasis of verbal-ability (Wood et al., 2007). Although William presented as communicatively highly able, visual aides were employed to maximise his understanding of concepts and aid recall.

Sessions were also highly structured. As requested by William, each session would begin with William and the therapist alone. These would begin with a review of his week, a review of the homework assignment, followed by that weeks' session focus. Once the work was complete, Mom and Dad were asked to join the sessions and William would take great pride in presenting what had been covered that day. Relaxation was also a core feature of the sessions, and as such, an exercise was built into the end of each session with the entire family.

William was presented with an equally structured way to use his new found skills. "Chaining" the process provided a structured way to help William remember the steps "towards successful self-management". As such, he would first identify the worry thought, which would be written in a thought bubble. He would then rate how anxious it made him feel on a scale of 1-10. Pictorial cue cards were used to represent different types of thinking errors, for example, dark glasses for "negative glasses" (only seeing the negative side of things), a magnifying glass for "making a problem bigger than it really is", and a crystal ball for "thinking you can see into the future". William would then select the card he felt matched his anxious thought and place it in the chain. Notably the 'huge bag of worries" was symbolically binned and replaced by a coping toolbox from which William was able to select pictures representing tools such as coping self-talk, rehearsing, relaxation exercises and so on. He would then choose the ones he felt might be most helpful and place these in the chain. We would then practice exercising his coping tool and again rate his anxiety at the end. William ability and confidence to do this increased over the course of the sessions.

Sessions also made use of his specialist interests, such as acting and aeroplanes. As such, role play was utilised to good effect within sessions and aeroplane stickers were given as a reward for completing homework tasks.

Notably, graded exposure was not included in the intervention, as due to the highly generalised nature of his anxiety it would prove difficult to produce an accurate/effective hierarchy to work through. However, given the difficulties with generalisation in ASD, homework assignments were designed to incorporate in vivo exposure to everyday anxiety.

There is a growing amount of evidence to suggest that involving parents in the intervention not only improves outcomes for the child but also yields positive outcomes for the parents (Barrett, Duffy, Dadds & Rapee, 2001). Given the hypotheses outlined in the formulation, it was felt that, as well as supporting the generalisability of skills to context outside of therapy, Williams' parents, given their anxious presentation and parenting style, would also benefit from being taught the effective use of strategies. As previously mentioned, the therapist also modelled confidence in Williams' problem solving ability. This was aimed at decreasing in their need to be over-involved in protecting William from his anxiety and allow him to experience it and work through it for himself.

In sessions leading up to the final session, William expressed a concern that he would not be able to use his skills and would need another psychologist to help him. His parents expressed a similar concern. However this provided an opportunity to place a greater emphasis on the independent use of skills. As such the therapist took an increasingly quieter role within sessions, allowing William and his parents to take a more active role. The final session was used to review the materials used, discuss the progress William had been able to make and contingency plans in the event of "set-backs". However William was pleased to have "graduated" as a "coping expert" and expressed a wish to become a therapist himself.

OUTCOMES AND EVALUATION

Qualitative outcomes were demonstrated in Williams' account of his confidence in being able to manage his anxiety independently. Notably, the end of sessions coincided with a return to school following the summer break. This is typically an anxiety provoking time for him. However despite some anxiety expressed by William and his mother, he was able to return to school at the beginning of term without event. School had since commented on the marked difference in his presentation.

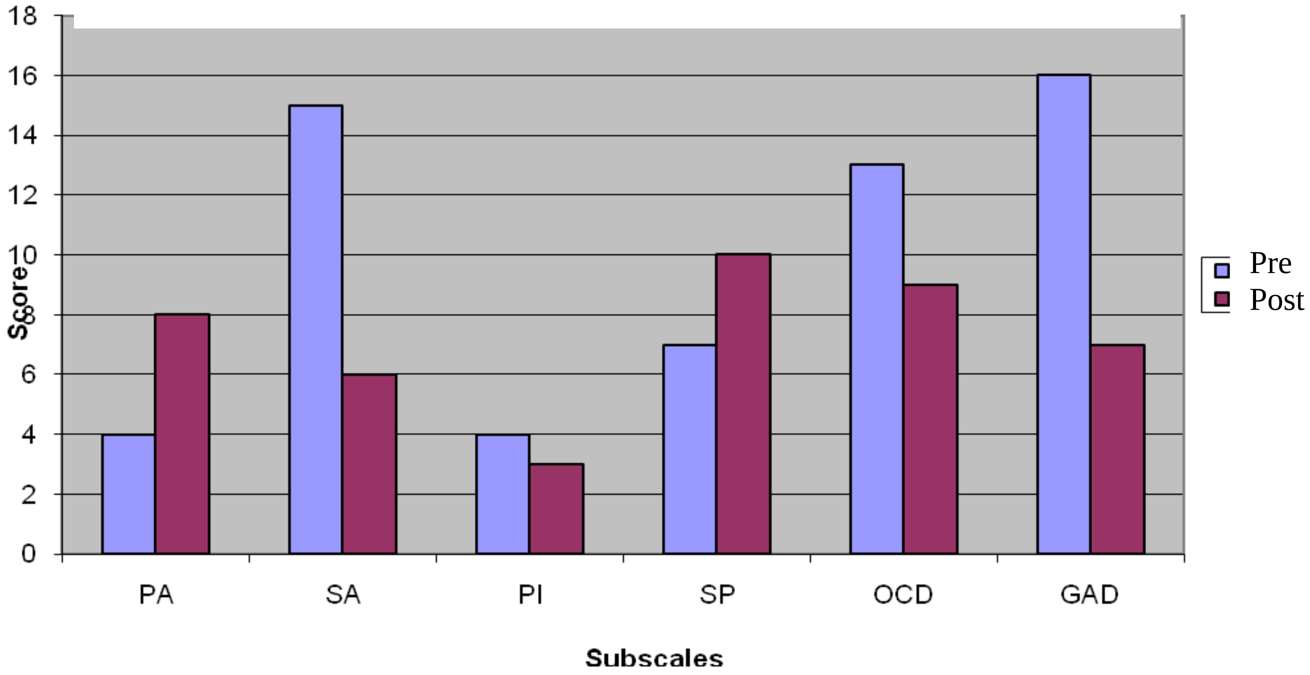
Other outcomes include those observed in the final sessions. Towards the end of the intervention, William had "invented" relaxation exercises of his own and both he and mom were able to facilitate leading this part of the session. Another observable shift was dad's involvement in sessions. In early sessions he had been reluctant to be involved in chaining exercises and relaxation. However, his willingness to take part in later sessions is thought to represent a shift in his attitude regarding his role in helping William manage his anxiety. There was also an increase in warmth expressed towards him by William in session, with a very few, if any, references to him as "the master".

Mom also expressed feeling that the strategies had been useful for her in managing her own anxiety. She added that she had begun to monitor her own cognitive distortions with regard to Williams', for example, catastrophising coughs and sneezes to mean serious ill-health. She also used the relaxation techniques at times when she felt "stressed".

Additional qualitative outcome data was provided by the post-treatment assessment questionnaire that allowed William to comment on the service he received. William was interviewed by a clinician unfamiliar to the case and asked three questions. An analogue scale, similar to the one used throughout treatment to rate his feelings, was used in order to help him indicate his views. The scale itself was selected on the basis of it being less reliant on his language ability (Dagnan & Ruddick, 1995). William ranked each question as 0 (happy), indicating that he felt satisfied to the service he had received, he had felt listened to and that he felt it had been useful to reduce his anxiety.

Quantitative outcome data was provided by the results on the SCAS. Pre and post scores are presented below (Figure 3).

Figure 3: Pre and Post Measures on the Spence Children’s Anxiety Scale



As a decrease in scores represents improvement on factors, visual analysis of the data shows a decrease in presenting symptoms/thoughts associated with separation anxiety (SA), physical injury (PI), obsessive compulsive (OCD) and generalised anxiety disorder (GAD). This is particularly noteworthy given his initial high scores for SA, OCD and GA.

The Reliable Change Index (Jacobson and Truax, 1991) was used to calculate whether the changes in pre and post scores were significantly different. As illustrated in the Table 1, the score for reported symptoms on the subscales of SA, OCD and GA all showed a significant treatment effect, with the symptoms on the GA subscale showing the largest significant effect. There was also a statistically significant change in the total score.

Table 1:

Reliable Change Index Scores for pre and post results on the SCAS.

	Pre Intervention	**Post Intervention**	**Reliable change index**
Panic Attack/Agoraphobia	4	8	-1.89
Separation anxiety	15	6	**5.95***
Physical injury fears	4	3	0.91
Social phobia	7	10	-1.79
Obsessive compulsive	13	9	**2.9***
Generalized anxiety disorder/overanxious disorder	16	7	**6.54***
Total	59	43	**2.27***

*RCI is greater than 1.96 (95% confidence interval) and as such the difference is statistically different.

Although changes in panic attack/agoraphobia and social phobia suggest deterioration on these factors, the changes themselves were not significant. In addition it is thought that these changes may reflect shifts in patterns of behaviour and awareness for William. As such he may be more likely to report more symptoms of panic attacks due to increased awareness of symptoms of anxiety. Also the symptoms themselves may be more prevalent, as William displays less avoidant behaviour and is exposed to more social situations where he is likely to feel anxious. As a consequence the outcome results may have benefitted from an evaluation of his confidence in being able to manage his feelings of anxiety in these situations.

Other limitations of the findings include the lack of a formal measure of Williams' parent's anxiety levels pre and post intervention. Nevertheless this is felt to reflect the general lack of evidence-based assessment measures for the learning disability client group. It is acknowledged that the SCAS itself is normed against non-learning disability client group. There is clearly a case for the development of such measures for children and their families (MacNeil et al., 2009). However, in spite of the current political climate in CAMHS that is demanding of quantitative outcome measures, the qualitative outcomes, particularly for clients with learning disabilities, as shown in this case, can prove to be equally valuable and informative and should therefore not be ignored. The challenge for clinicians may well be to develop ways in which the client's voice can be heard and valued.

REFLECTIONS

Personal and Professional Development

The placement offered a unique opportunity to work with a client group unfamiliar to me. As such, it was both an anxiety provoking and challenging experience. Here, the importance of a clear and comprehensive assessment that was informed by specific diagnoses, for example, (ASD) but not completely overshadowed by it, seemed especially important. As such the temptation to assume, that Williams' learning disability would make CBT too challenging for the clinician and client, was averted. Thus the assessment was of the individual and not the "autistic individual" allowing the formulation and intervention to be informed by Williams' individuality and the needs of his family.

Implications of case for theory and/or practice

The case outcomes are in line with the growing body of literature that supports the adaptation of CBT interventions for use with children with ASD. Not only does it appear to add further evidence that high-functioning children with ASD are good candidates for CBT, it also supports findings that the abstract reasoning capacity of an autistic children is varied rather than non-existent (Chalfant et al., 2007). However, it is worth noting that, in light of Williams' ability to engage and reason at the level he did, the question of 'correct diagnosis' was raised by the paediatrician who issued the diagnosis in the first place. This again gives rise to reflections on the process of diagnosis for both parents and clinicians. However it also highlights the need to design and implement interventions that focus on the goodness of fit for the individual and, in this case, his family, regardless of the specifics of the label.

Systemic Influences on Process

Nevertheless the influence of Williams' ASD diagnosis is not to be ignored. Likewise, the systemic influence of the process of achieving that diagnosis. The impact of the diagnosis and in particular, in this case, Williams' parents previous struggle to gain such a diagnosis was included in the formulation of his difficulties alongside their more recent struggle with the core features of his ASD and symptoms of anxiety (Reaven and Hepburn,2006). The case therefore highlights the need to acknowledge social context of diagnoses and presenting problems in order to better inform treatment intervention packages for clients and their families. In this case it allowed for the treatment of his parent's "symptoms" and behaviour. The outcomes therefore reflect the value of including parents in the intervention. Nevertheless it is acknowledged that CAMHS services are as yet not funded to work with parents and as such many services are not set up to offer this kind of support. Thus highlighting the need to develop population based measures for children and their parents to capture outcomes and provide evidence to commissioners of the value of such intervention designs.

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CLINICAL PRACTICE REPORT

(CPR5)

CASE STUDY

“I Know Why the Caged Bird Sings...” : A case study on the use of a Narrative CBT approach to working with the impact of psychosis.

ABSTRACT

The use of narrative is highlighted as a particularly useful approach in helping clients with severe and enduring mental health difficulties such as psychosis (Roberts, 1999). However the use of such approaches, alongside more heavily weighted evidence-based practice, such as CBT is also encouraged (Rhodes & Jakes, 2009). As a consequence, Rhodes & Jakes (2009) developed Narrative CBT. Being essentially a systemic approach, it considers complex problems, such as psychosis, as occurring within the context of an equally complex system - mental health services. However, it also advocates the use of cognitive behavioural strategies to strengthen resources and develop adaptive beliefs/schema. The case presented outlines the use of this approach whilst working with a 63-year old, man of African-Caribbean descent. The formulation pays close attention to the clients' narrative and the expressed meaning of the experience of psychosis. Social Ranking Theory (Gilbert, 1989, 1992), centrally locates his psychosis as a major, oppressive life event. His resulting appraisals of loss, humiliation and entrapment are also discussed (Iqbal, Birchwood, Chadwick & Trower, 2000). The interventions make use of metaphors expressed in the clients own poetry, brought to session, to work towards constructing a narrative of strengths and resources. The intervention also utilised cognitive strategies to enable the client to develop alternative schemas. The intervention was effective in reducing scores on the Internalised Shame Scale (Cook, 1994) and Calgary Depression Scale for Schizophrenia (Addington et al, 1992). Reflections are made on the impact on clients and staff of such work within the risk focussed service context.

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APPENDICES – CPR1

Questionnaire Results: [redacted]

Completed By: [redacted] **Mother / ~~Father~~**

Strengths and Difficulties Questionnaire				
	Results	Normal	Borderline	Abnormal
Emotional Symptoms	**4**	0-3	4	5-10
Conduct Problems	**3**	0-2	3	4-10
Hyperactivity	**8**	0-5	6	7-10
Peer Problems	**2**	0-2	3	4-10
Total	**17**	0-13	14-16	17-40
Prosocial	**5**	6-10	5	0-4
Total Impact	**6**	0	1	2-10
Total Burden	**1**	0	1	2

Parenting Scale													
Factor	Scores											Total	Factor Score
Laxness	3	2	1	2	2	5	5	4	3	3	2	**32**	(/11)=**2.9**
Over-reactivity	5	4	1	2	2	2	1	5	1	1		**24**	(/10)=**2.4**
Verbosity	2	6	3	1	3	5	1					**21**	(/7)=**3**
.No Factor	1	6	2	4								**13**	
Total	(-4)											**86**	(/30)=**2.87**

Parenting Scale			
Factor	Score	Clinic Group Mean (&s.d.)	Non-Clinic Group Mean (&s.d.)
Laxness	**2.9**	2.8 (1.0)	2.4 (0.8)
Over-reactivity	**2.4**	3.0 (1.0)	2.4 (0.7)
Verbosity	**3**	3.4 (1.0)	3.1 (1.0)
Total	**2.87**	3.1 (.07)	2.6 (0.6)

Being a Parent Scale			
Dimension	Score	Average Scores for Mothers in the Community (& sds)	Average Scores for Fathers in the Community (& sds)
Satisfaction	**31**	37.40 (6.60) – 38.76 (5.67)	39.20 (5.62) – 40.47 (5.72)
Efficacy	**34**	24.79 (5.79) – 25.69 (6.61)	24.95 (4.99) – 25.77 (5.29)
Total	**65**	62.48 (9.72) – 64.19 (10.48)	64.61 (8.98) – 65.91 (8.44)

Parent Problem Checklist Total = **8** (>5 in clinical range)

Relationship Satisfaction Total = **25** (≤ 29 in clinical range)

Depression Anxiety Stress						
Scale	Score	Normal	Mild	Moderate	Severe	Extremely Severe
Depression	**4**	0-9	10-13	14-20	21-27	28+
Anxiety	**1**	0-7	8-9	10-14	15-19	20+
Stress	**9**	0-14	15-18	19-25	26-33	34+

Appendices – CPR2

APPENDIX 2

APPENDIX 3

Consent Form

Title: Experiences of Facilitators in the Delivery of the Triple P Programme in the North and East of Birmingham.

Please tick each of the following boxes, before signing this consent form.

☐ I have read and understand the information sheet

☐ I give permission for the interview to be tape-recorded

☐ I understand that the findings from this service evaluation will be reported to various agencies to inform service delivery.

☐ The participation in this project is voluntary, and I may withdraw my participation at any time

I therefore consent to participate in this project.

Participant's signature…………………………………………………

Date………………………

APPENDIX 4

Topic Guide

1. Prior to delivering Triple P, how much experience had you in delivering behavioural family interventions with parents?
    - Prompt: how confident did you feel in your ability to engage parents?

2. What did you know of the Triple P programme compared with other parenting programmes?
    - Prompt: Did it feel any different from your current practice?

3. What do you think made this particular approach the programme of choice for this area/your service?

4. How satisfied were you with the quality of the training?
    - Prompt: Length of time between training and delivering the group? Confidence post training to deliver group?

5. How supported did you feel post training in your development as a Triple P facilitator?

6. How have you found the materials provided?

7. How do you feel about the fit of the programme to the families you work with in the North and East of Birmingham?

8. What support exists within the workplace to help you deliver the programme effectively?
    - Prompt: What support is in-built into the programme to help you do the same?

9. Are there any barriers within the workplace that impeded effectively delivery of the programme?

10. Have you made any changes/ adaptations to the programme?
    - Prompt -(style of delivery, method, telephone consultations number of weeks- if yes – what were they and what was it that made you feel these were necessary? What might you still change?

11. How do you feel about the issue of adapting the programme to get a “better fit” to your client group?

12. How satisfied are you that it effectively meets the needs of your client group?

13. How confident would you feel to personally recommend the group outside of your role within this service?

APPENDIX 5

Table of Focus Group Codes and Frequency

	Frequency of Code in Focus Group				Total frequency across groups
Codes	**Group1**	**Group2**	**Group3**	**Group4**	
Adjustments	9	16	5	6	36
Appropriateness to community	2	8	4	2	16
Aspirations	6	1	3	10	20
Class	0	2	0	2	4
Complimentary comments to each other within group	2	2	0	0	4
Culture	1	7	0	2	10
Dangers of changing the programme	0	2	1	1	4
Delivery style	4	1	6	6	17
Educating others about Triple P	1	0	2	0	3
Evidence Base	0	0	0	2	2
Feedback from parents	5	0	2	0	7
Language	2	1	0	7	10
Money	3	0	0	2	5
Ownership of parents/families	3	1	2	2	8
Parents' ability	4	4	2	4	14
Power/authority	7	1	0	7	15
Practitioner feelings	3	7	3	12	25
Previous experience	0	2	1	7	10
Principles of the program	1	7	3	4	15
Quality checking of Triple P	0	0	0	2	2
Religious metaphors	0	2	3	8	13
Resources	1	3	4	6	14
Support	3	2	2	2	9
The Product	5	0	1	2	8
Time	4	2	3	2	11
Training (Negative experience)	4	3	3	5	15
Training (Positive experience)	2	6	1	3	12
Views on the practice of others	6	0	1	5	12
What PPP doesn't cover	1	1	0	0	2

APPENDIX 6

Table 1:
Table of Theme 1 and associated sub-themes with example data extracts.

Programme Related Factors **Theme 1: It can make a difference - Belief that Triple P meets the needs of their families** **Sub-themes**
- **Resources** *"..you have those anxieties and that kind of cuts that because it says, we are giving you permission to hold the door closed.."* *"I mean, it's sensible advice.."* *"..we do notice our time when we are doing triple p sessions, it's a chunk of your time isn't it?"* *"..the workbooks I think were fantastic for the parents, I think when they got that book, they're their Bibles aren't they.."* *"I think the DVD, like [name] said, being Australian middle class families and the way they talk and it was so stage managed that if, it's not how life is, erm, for our parents.."*
- **Making adjustments to suit the families** *" the only reason our parents do it is because you [her colleague] sold it to them in a different way than how Triple P dictate that you do"* *"you have got to adjust it for that, for your target audience, you know, your target group.."* *"I had two parents who couldn't read so I have to talk through it.."* *"I struggle with it being standardised on some level, erm, because I am slotted into a service that does it a certain way.......sometimes I just want to stop it and erm, sit down and have a discussion ... just peoples facial expression sometimes and I tam torn between knowing I have 20 minutes to present the next section and the fact that someone clearly doesn't get something"*
- **Staying true and faithful to the principles** *"I think there has got to be some flexibility in fidelity".* *"We had everything that needed to be there, Triple P in its truest form, however we just delivered it in a much more relaxed manner.."* *"I'm Triple P'd. I've been converted, so it's a good, I think the principles of triple p are excellent. I think, you know, you can tweak it but you still obviously use those principles.* *"if you are adapting it, you know it hasn't been evaluated so I stick to the content"*

- **Factors increasing belief in the effectiveness of the programme.**

"...the feedback has been really good".

"we've got the wonderful thing that when they do come back and say, 'she's been a little sod, look what she's done' we can say, 'think Triple P' and they go 'Oh yeah!'.

Table 2:
Theme 2 and associated sub-themes with example data extracts.

Individual Factors
Theme 2: Engaging Practitioners.

Sub-themes

- **The Powers that be**

"We were told we had to do the course, I'm gonna be honest!"

"..God knows how much money they had spare to buy this in. Were they swayed by media hype whatsoever? You're keeping quiet! You can't say? God knows, Birmingham City council thought we need one blanket parenting programme....and my only, my guess is about 25% of those trained are actually delivering it!

- **Experience of training**

" I actually felt less confident after training..."

"I hated it from the word go! The three day intense training I thought was horrendous"

"I think what we weren't prepared for is the hours and hours of training you have to?"

"I actually spoke to them about maybe a little bit adapting it and they was like, NO, NO you can't do that...so erm, I still felt a little bit of doubt when I came away".

"..there was a lady, she was very nice, but she got the entire quiz wrong... So for me that undermined the whole thing..."

- **Continued Development**

"... the fact that we went ahead and did one at a late stage supported by [name] established practitioner which was fantastic"

"I did it with someone in another centre and that really helped – pairing up with somebody else"

- **Expressed feelings of practitioners**

".. we feel exhausted at the end of it"

"...it is quite a directive programme, erm, and that doesn't, doesn't necessarily sit well for me".

"I had to get my head around all the material and do it the right way, which I find extremely stressful"

- **Confidence in the practice of fellow practitioners**

"I know how we've struggled and I know how we've adapted it... but as far as I am aware everyone else has Triple P is still in a Triple P mindset and its bumf bumf bumf..."

"I have heard people who have come to our service , say they have been to triple P and it was rubbish and it's been run by somebody else erm and we have kind of started to review some of the things they found difficult and helpful and they came across as surprised as though they have never heard them before so I don't know what goes on in other Triple P groups"

Table 3:
Theme 3 with example data extracts.

Suggestions for Future Practice
Theme 3: Hope - Aspirations for Triple P

Sub-themes

- **Improving quality and evaluation of the programme in Birmingham**

"the more we persevere with that language, even if it becomes a Birmingham thing, actually that is very facilitating and helpful rather than us all making up our own models, our own packages, because we are still talking Dutch, Chinese.."

"if you are giving a WAIS and the child doesn't hear and....you give a third prompt when actually you are meant to do two, you know.... you make that decision at the time and in the WAIS you record that, what do you do with Triple P?"

"One of the mom's was saying that the thing that has worked most for her is that she no longer sits in the living room and bawls at them, she gets up and goes and does eye contact and. But whether she'll be doing that in 6 months time or whether she'll be saying 'I can't be arsed' I don't know and I'd like to know that"

- **Improving Training and Resources**

"...realistic expectations, I couldn't translate that in Urdu... but if I have a training in Urdu then I might be able to do that"

"...and you'd think with all that money they could do a better DVD..."

- **Supporting Practitioners**

"ensure that people who have been trained are supported and we are not just there in

the group with ideals but the outcomes as well, with the pre post and feeding that back and how we support people if they have queries and you still have those doubts."

- **True Multi-level delivery**

"..it's the antenatal classes, that's the bit where you want to read about childhood and babies, you are not tired yet..."

"the key thing was the levels and it was the fact that it, the emphasis was on prevention, which it could, despite what we are saying we haven't really taken up very much in Birmingham, we are doing more the interventions stuff which is exactly what the other programmes are doing. In fact, that, but there is the possibility of having these other preventative, you know, the early intervention preventative levels"

"I think the problem is that we don't do enough of the early intervention stuff"

APPENDIX 7

THE CHALLENGING BEHAVIOUR SCALE (CBS) FOR OLDER PEOPLE LIVING IN CARE HOMES

Name…………………………………………………..

Age…………………………….. Sex M / F Diagnosis of Dementia? Y / N / Don't Know

Residence……………………………………………………………….. Date ………………………..

Checklist Completed by: ……………………………………………………………………………………..

PHYSICAL ABILITY (delete as applicable)

1. Able to walk unaided / Able to walk with aid of a walking frame / In a wheelchair
2. Continent / Incontinent of urine / Incontinent of faeces / Incontinent of urine + faeces
3. Able to get in or out of bed/chair unaided / needs help to get in or out of bed /chair
4. Able to wash and dress unaided / needs help to wash and dress
5. Able to eat and drink unaided / needs help to eat and drink

Over the page is a list of challenging behaviours that can be shown by older adults in residential or nursing settings. For each behaviour listed consider the person over the past 8 weeks and mark:
INCIDENCE: Yes / Never. If Yes move to Frequency
FREQUENCY:
4: This person displays this behaviour **daily or more**
3: This person displays this behaviour **several times a week**
2: This person displays this behaviour **several times a month**
1: This person displays this behaviour **occasionally**
DIFFICULTY
Then *for each behaviour shown* mark down how difficult that behaviour is to cope with, when that person shows it, according to the following scale:
4: This causes a lot of problems
3: This causes quite a lot of problems
2: This is a bit of a problem
1: This is not a problem

N.B. If a person does not show a behaviour no frequency or difficulty score is needed.
If the person causes a range of difficulty with anyone behaviour, mark down the score for the worst it has been over the past eight weeks.

	BEHAVIOUR	INCIDENCE		FREQUENCY		DIFFICULTY		CHALLENGE	
		Yes	Never	1 = Occasionally 2= Several/Month 3= Several/Week 4= Daily or More		1= No Problem 2= Bit of Problem 3= Quite a lot of Problems 4= Lots of Problems		Frequency Score X Difficulty Score	
1	**Physical Aggression (hits, kicks, scratches, grabbing, etc)**								
2	**Verbal Aggression (insults, swearing, threats, etc)**								
3	**Self harm (cuts/hits self, refuses food/starves self, etc)**								
4	**Shouting**								
5	**Screaming/Crying Out**								
6	**Perseveration (constantly repeating speech or actions, repetitive questioning or singing)**								
7	**Wandering (walks aimlessly around home)**								
8	**Restless (fidgets, unable to settle down, pacing, ‘on the go’ etc.)**								
9	**Lack of Motivation (difficult to engage, shows no interest in activities, apathy, etc)**								
10	**Clinging (follows/holds on to other residents/staff, etc)**								
11	**Interfering with other People**								
12	**Pilfering or Hoarding (possessions, rubbish, paper, food etc.)**								
13	**Suspiciousness (accusing others, etc)**								
14	**Manipulative (takes advantage of others, staff etc.)**								
15	**Lack of Self Care (hygiene problems, dishevelled, etc)**								
16	**Spitting**								
17	**Faecal Smearing**								
18	**Inappropriate Urination (in public, not in toilet, etc)**								
19	**Stripping (removes clothes inappropriately, flashes, etc)**								
20	**Inappropriate Sexual behaviour (masturbates in public, makes inappropriate ‘advances’ to others, etc)**								
21	**Sleep problems (waking in night, insomnia, etc)**								
23	**Non-compliance (deliberately ignores staff requests, refuses food, resists self-care help, etc)**								
24	**Dangerous behaviour (causes fires or floods, etc)**								
25	**Demands attention**								
26	**Lack of Occupation (sits around doing nothing, etc)**								
	TOTALS Add scores (1-25) for each column		**25**		**100**	**100**	**100**		**400**

APPENDIX 8