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CLINICAL PRACTICE REPORTS 1 - 5

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Formulating the case of Henry, a three year old with anxiety, from a behavioural and a psychodynamic perspective
Abstract

This report presents the case of Henry, a three-year-old boy referred for anxiety problems. Assessment information is detailed regarding the presenting problem, the history of the problem, problems with development, and the family background. Results of the psychometric measures used in the assessment are also discussed. A behavioural formulation of the origins and maintenance of the anxiety is discussed based upon classical and operant conditioning models. The case was also formulated using a psychodynamic model based upon Malan’s ‘Two Triangles’ and theories of child development. The formulations are reflected upon, in terms of limitations, areas for expansion and synthesis.

All names have been changed in this report to maintain client confidentiality
1. Introduction

This clinical practice report was completed while on placement in a Child and Family Service. The report details background information about the case before presenting two formulations of the origins and maintenance of the presenting difficulties. Formulations are presented first using a behavioural approach and then a psychodynamic approach, before reflection on both approaches.

2. Background Information

2.1 Reason for referral

Henry was referred to the Child and Family Psychology Service by the Specialist at the Child Development Centre because of concerns about stuttering and ‘extreme anxiety’. It was reported, that his mother had been through a very stressful time with him and his twin Peter, and that “the latest development has caused a lot of stress. Mother is very keen to accept support”.

2.2 Assessment

Henry and his mother Margaret attended the initial assessment session. Assessment information was also collected during subsequent sessions. In these sessions, Henry and his mother were seen separately, as well as together.
2.3 Presenting difficulties

By the time of the initial assessment, Margaret no longer had concerns about Henry’s stuttering. She reported that Henry’s anxiety was her main concern. Margaret reported that Henry would ‘panic’ and worry on a daily basis. These episodes were reported to last from 15-20 minutes, and involved Henry running around, flapping his arms and looking terrified. According to Margaret, this behaviour occurred both at home and at school. She reported that the triggers for his anxiety were new environments or activities, or changes to his current environment. Henry would then seek repeated verbal reassurance from family members and teachers. Family members and teachers would respond by giving Henry verbal reassurance until he calmed down. Henry would generally calm down after 5-10 minutes of verbal reassurance.

Margaret reported that Henry also became very distressed when others changed their appearance, for example by dressing or putting on make-up. He refuses to allow anyone to put make-up on him or his brother, or to dress up in costume.

2.4 History of difficulty

According to Margaret, Henry’s problems with anxiety developed around the age of two. She believes that the trigger was an incident involving a family member. Henry was reportedly close to one of his uncles who developed cancer. Henry was taken to see him before he died. His uncle’s physical appearance had changed drastically on this occasion,
which appeared to cause Henry a lot of emotional distress. Henry was reported to have said that his uncle had turned into a ‘monster’.

2.5 Pregnancy and developmental history

Margaret and Robert (Henry’s father) had problems conceiving and had fertility treatment in order to conceive. Margaret had a number of miscarriages before the birth of the twins. Margaret reported having a difficult pregnancy, developing pre-eclampsia and diabetes.

Henry had some mild developmental delay, but this is no longer a problem. His twin, Peter, had a number of medical problems and was very delayed in his development. However, he made rapid developmental progress in his second year. Peter’s medical problems necessitated a number of lengthy hospital stays.

2.6 Family background

Both Margaret and Robert are employed, Margaret on a part-time basis and Robert on a self-employed basis. Margaret has worked since the birth of the twins. Henry has had experience of day care from birth. Henry’s paternal grandmother also provides regular childcare for the twins. (See Appendix 1 for a family genogram).

Margaret is an only child. She describes herself as ‘happy go lucky’ and ‘laidback’. She describes having a ‘wonderful childhood’, being a ‘spoilt brat’, and wanting to be centre of
attention as a child. Margaret reports a close relationship with her own mother who she describes as ‘fantastic’ and was the sort of person who ‘just got on with things’ despite difficulties in her personal life. However, Margaret stated that her mother had been labelled as ‘neurotic’, and had a nervous breakdown in her later years. She developed cancer when Margaret was fifteen. Margaret looked after her from then until she died, when Margaret was 26. Margaret reports that as a child she hero-worshipped her own father. She reports that he expected high standards and did not praise her very often. Her father re-married only two years after the death of Margaret’s mother. Margaret reports that she is no longer close to her father. He visits briefly on a weekly basis, but ‘just gives the children money and not time’.

Margaret reports that she wants her children to be happy but that it was important for her to ensure they were well-behaved, she did not want them to be ‘spoilt brats’. She worries about dying young, like her own mother, and wants her children to remember her as a great mother. She reports that she gives the children all the material goods and attention they could want. One of Margaret’s recurring concerns was about whether she was doing the best she could do as a parent and whether she was ‘a worrier’ and joking whether she needed help herself. In a later session, Margaret reported identifying with Henry’s present difficulties. Since coming to the sessions, she reports remembering being told that she was hyper-active (like Henry), and having a vivid imagination (like Henry). She also remembers being very angry as a child, but could not remember why. She remembered going to see a child psychologist for a number of years, between the ages of four and six.
Margaret stated that she liked to make the time she spent with the children highly structured. This is in contrast to her husband, Robert who ‘lets the children do what they want’. As a child, Robert came from a family where the children took care of themselves. Both parents also have a different attitude to discipline. Margaret reported that she has high standards of moral conduct, whereas Robert is more relaxed in his expectations of the children.

2.7 Clinical observations

During the sessions with Margaret, a lot of time was spent talking about her experiences, thoughts and feelings. In sessions where both Henry and Margaret were present, Henry had difficulty occupying himself, and would seek the attention of the trainee. During these times Margaret was observed to be quite directive towards Henry. During the time spent alone with Henry, he appeared to enjoy having the attention of the trainee, but moved from one activity to another. He did not want his mother to join the session, although initially he had been a little wary of being away from her. When Henry was asked about the things he was frightened of, he identified ghosts and monsters.

2.8 Psychometric measures

2.8.1 Strengths and Difficulties Questionnaire (SDQ), (Goodman, 1997).

Margaret completed this behavioural screening tool. Henry scored in the abnormal range for emotional symptoms, conduct problems, and hyperactivity (see Appendix 2).
2.8.2  *Parental Stress Index - Short Form (PSI-SF)*, (Abidin, 1995).

This questionnaire assesses sources of stress within the parent-child relationship. Two sub-scale scores were outside the normal range. Margaret scored low on ‘Parental Distress’ and ‘Defensive Responding’ scores, which in the face of her reported stress suggests an ‘over controlling parent’ who wants to portray themselves as very competent in their parenting role (see Appendix 3 and 4 for completed form and summary).

2.9  *ABC charts*

Margaret collected information about anxiety behaviours and their antecedents and consequences (see Appendix 5 for anxiety chart). From the information collected by Margaret, it appears that Henry becomes anxious in situations where he is faced with some sort of change or activity that he does not want to occur. He then exhibits symptoms of anxiety, and this behaviour then elicits verbal responses from adults, which involve either verbal reassurance or avoidance of the change.
3. **Behavioural Formulation**

3.1 *Introduction*

The behavioural model is characterised by a focus on the importance of learning to the development and maintenance of psychological problems (Hudson, 1999). Within the behavioural model, both adaptive, and maladaptive behaviours, are viewed as the product of the same learning mechanisms. The categorisation of problematic behaviours is essentially based on a social evaluation of the behaviour (Herbert, 1995). The behavioural approach has undergone considerable development over time and currently incorporates classical conditioning, operant conditioning, social learning theory, and cognitive behavioural approaches (Corey, 2005; Goldfried & Davison, 1976). This formulation will focus on a traditional behavioural approach, and use classical and operant conditioning to understand the relationship between Henry and his learning environment. A behavioural formulation involves the identification of the interplay between the following variables: these are the stimulus antecedents, organismic variables, response variables, and consequence variables (Goldfried & Davison, 1976). These variables will be considered in order to understand the development and maintenance of Henry’s problems. This formulation will focus on the development and maintenance of Henry’s anxiety about new situations, as this was the main problem identified by his mother during the initial assessment.
3.2 **Development of difficulties**

Mowrer (1947, cited in Borkovec, Alcaine, & Behar, 2004) suggests that fear develops in two stages. The first involves classical conditioning of fear, followed by maintenance of fear through operant conditioning. This model will be used to understand the development and maintenance of Henry’s anxiety.

During the pre-school period, certain types of stimuli will be associated with a fear response, some of which will have an imaginary origin (Carr, 2006). Problems with fear are reported in almost half of boys of school age (MacFarlane, Allen, & Honzik, 1954 cited in Achenbach, 1986, p.132). In Henry’s case, his fear and anxiety appear to be excessive, and having a detrimental effect upon his life at home and school. His SDQ scores indicate that his anxiety is at the high end of the normative range for his age.

Classical conditioning is an important mechanism for the learning of new emotional responses (Sheldon, 1982). In Henry’s case it is not completely clear how a fear of new situations has been conditioned, although Henry’s mother identified an event that she believed was the trigger for Henry’s anxiety. It is possible to build a speculative formulation for the development of Henry’s anxieties based on this information and using Davey’s (1997 cited in Field and Davey, 2001) updated model of classical conditioning.

Henry reported that he had a fear of monsters. ‘Monsters’ could be an unconditional stimulus (UCS) that would elicit an unconditional response of fear (UCR). From mother’s
report when Henry saw his uncle with cancer, he looked different and Henry thought he had turned into a monster. He was reported to have been very distressed on this occasion. It is possible that the ‘monster’ elicited a fear response.

There are possible mechanisms for the association of monsters with situations being different or new. According to Davey, verbal information can influence the association between stimuli and produce a conditional response even before the actual pairing of stimuli through the process of expectancy evaluation. In Henry’s case he may have been told by his mother that he was going to see his uncle who would look different in such a way that made him fearful that he might be encountering something scary like a monster. Also, an association may have been formed between facing something different and fear through vicarious learning. Henry may have observed his mother being emotionally distressed either in anticipation or during the encounter with the uncle. Hence, he may have learnt that going to see something different is associated with fear. Alternatively, actually seeing his uncle, ‘the monster’, may have evoked a fear response that was then associated with situations that involve something being different.
One off traumatic events can be enough to condition fear responses, in other cases a repeated pairings are necessary. It is difficult to decide the mechanism of the association in this case, and the aversive event that has been identified may not necessary for the development of Henry’s fear of situations that involve something different. In some instances of conditioned fear there does not appear to be an identifiable aversive conditioning event (Field and Davey, 2001).

Mother’s view of Henry as not being ‘mentally strong’ compared to his twin, may indicate that he tended to be anxious about new situations anyway, which would have made it easier to form an aversive association to new situations. There is some evidence that infants vary with regard to their temperament, which includes their behavioural style (Achenbach, 1986). Children who do not have an easy temperament have strong negative emotional reactions and are generally avoidant of new situations (Chess & Thomas, 1995, cited in
Carr, 2006, p44). Henry’s strong negative reactions to new situations, suggests that he does not have an easy temperament. However, child temperament on its own does not predict whether the child will have psychological problems. The ‘goodness of fit’ between child and parent appears to be an important factor in the development of problems – children with a difficult temperament benefit from responsive parenting (Carr, 2006). In the case of Henry and his mother, there may be a difficult fit between child and parent behavioural styles. Margaret’s PSI scores suggest she may be an over-controlling parent. There is evidence to suggest that ‘parental overcontrol’ is associated with anxiety in children (Rapee, 1997, cited in Barrett, Duffy, Dadds, & Rapee, 2001). Margaret’s parental style could be characterised as being authoritarian and over-intrusive, which gives Henry little opportunity to be autonomous. Children who are given less autonomy appear to be more anxious (Sigueland, Kendall, & Steinberg, 1996, cited in Barrett et al., 2001). The evidence from the ABC charts suggests that the response of others, particularly Henry’s mother, is maintaining his anxiety problems.

3.3 Maintenance of difficulties

A model for the maintenance of Henry’s anxiety is produced below, (see Figure 1) and will be considered in terms of operant conditioning and the information provided by mother.

According to theories of operant conditioning, behaviour can be understood in terms of the consequences of that behaviour for the individual, in the environment in which the behaviour takes place (Sheldon, 1982). A response that is reinforcing is one that makes a
behaviour more likely. This can either be through it being contingent with something pleasurable - positive reinforcement, or contingent with the removal of something aversive - negative reinforcement (Hudson, 1999).

The first step of the model (1), involves Henry being told that he is going somewhere new, or doing something different. Henry has learned a conditioned response (2), he fears the new situation as being threatening and scary and so becomes anxious about it. So for instance, when Henry hears that he will be starting full time school in September, he becomes anxious (See Appendix D, ABC chart). Henry’s anxiety is an antecedent stimulus, which is followed by anxiety symptoms and behaviour, which can be observed by others. The anxiety symptoms and behaviour, are aversive for Henry (3), and mother respectively (5). Henry seeks verbal reassurance(4). Henry’s mother responds with verbal reassurance for Henry (6). She tells him that the new situation will not happen for a long time and that his parents will go with him until he is happy. The verbal reassurance tells Henry, both that he does not have to face the change immediately and that he will not have to face the change on his own. Hence, the verbal reassurance removes the threat of the new situation. This verbal reassurance is associated with a reduction in anxiety for Henry (7) and his mother (8) respectively. As the verbal reassurance involves the removal of something aversive, it is negatively reinforced, and so is more likely to occur in the future. Similarly, Henry’s anxiety behaviour and reassurance seeking, also has the consequence of removing his anxiety, which is aversive, and so these behaviours are also negatively reinforced.
1) Henry is told that he is going somewhere new, or going to do something different by his mother.

2) Henry associates new situations’ as being threatening and scary

3) Henry experiences fear and anxiety which are both aversive

4) Henry exhibits anxiety and seeks reassurance from mother

5) Mother experiences Henry’s anxiety as aversive

6) Mother gives verbal reassurance

7) Mother’s reassurance is associated with a decrease in Henry’s anxiety

8) Mother experiences a decrease in her own anxiety

Figure 2. Model for the maintenance of Henry’s anxiety
There may also be some positive reinforcement occurring which has not been included in the model. It could be speculated, that Henry may find that his anxiety behaviours bring him attention that is focused on him. If he finds this attention pleasurable, then his anxiety will be positively reinforced.

Henry’s anxiety appears to be maintained by the responses of those around him. One of the longer term consequences of the these interactions between Henry and Margaret, is that Henry does not learn to regulate his own emotions, which is an important developmental task at his age (Carr, 2006). The responses of those around him, mean that Henry avoids exposure to his anxiety. If all the consequences of his anxiety behaviour were removed, this behaviour would reduce by the process of extinction (Hudson, 1999). However, at present Henry does not have the opportunity to learn that his anxiety will eventually reduce without the intervention of others.
4. Psychodynamic Formulation

4.1 Introduction

One of the core components of a psychodynamic approach is the importance attached to the unconscious and the role it plays in producing psychological conflict within the individual (Bateman, Brown and Pedder, 2000). The dynamic relationship between the conscious and unconscious arises out of the need to minimise psychological pain (Leiper, 2006). Defence mechanisms are used by individuals to defend against feelings that may cause anxiety, or pain that the individual fears they cannot manage (Bateman, Brown and Pedder, 2000). Psychological problems are believed to be a result of this intrapsychic conflict (Brenner, 1982, cited in Fonagy, 1999).

Malan’s (2001) ‘Two Triangles’ will be used to understand Henry’s psychological difficulties. The ‘Two Triangles’ consist of a ‘Triangle of Conflict’ and a ‘Triangle of the Person’. The ‘Triangle of Conflict’ allows a conceptualisation of the individual’s psychological problem into three parts, a defence, an anxiety and a hidden feeling.
The ‘Triangle of the Person’ incorporates the individual’s relationship with three key people. These are the ‘Other’—people in the individual’s here and now; the ‘therapist’—encompasses the transference relationship with the therapist. The ‘past’ incorporates the individual’s relationship with key carers in earlier infancy. This time plays a key role in emotional development and developing a sense of self (Horne, 1999). Some of the theories regarding emotional development in early infancy, will be drawn upon in order to hypothesise about the origin of Henry’s difficulties. Each corner of the ‘Triangle of the Person’ can be viewed as having a ‘Triangle of Conflict’ superimposed upon it and will be used to understand the maintenance of Henry’s present difficulties.

A ‘Triangle of Conflict’ and a ‘Triangle of the Person’ are produced below, to illustrate how Henry’s psychological conflict is manifested in his relationship with others.
Defence
Hyper-active behaviour

Anxiety
Henry’s anxiety is that if he expressed a wish for separation and individuation he would be overwhelmed by other people’s needs which threaten the annihilation or disintegration of his self

Hidden feeling
Wish for separation and individuation

Figure 4. ‘Triangle of Conflict’ – in relation to problem of hyperactivity

Other
Henry’s hyperactivity is a defence against the anxiety of being overwhelmed by others, especially his mother

Therapist
Henry’s hyperactivity in sessions is a transference of his anxiety about being overwhelmed by other people’s needs

Past
Mother was unable to separate her own needs from Henry’s needs, and he felt overwhelmed by her needs, which threatened the annihilation and disintegration of his self

Figure 5. Triangle of the person – in relation to problem of hyperactivity
4.2 *Triangle of conflict in relation to ‘other’*

Henry was three going on four, years old, by the time of the assessment. The age of three is an important developmental point according to both Freud and Erikson, marking the end of the stage for the development of autonomy and independence (both cited in Corey, 2005, p.62). This stage involves the child learning to express negative emotions and test boundaries. Henry’s anxiety symptoms and behaviour indicate that he has not yet become autonomous or feel able to express negative feelings. Anxiety can often be a defence against aggressive impulses (Freud, 1926, cited in Bateman, Brown, & Pedder, 2000, p. 18). Henry’s anxiety symptoms and behaviour may be a defence against feelings of anger. These feelings of anger have to be hidden because of the anxiety that Henry has that expression of these feelings would result in punishment, or abandonment by others. It is hypothesised, that these anxieties originate in his early experiences, which will be discussed later.

Margaret never identified Henry’s over-activity as a problem. Yet during sessions involving Henry, it was quite a pronounced feature of the time spent with him. He found it difficult to concentrate on any activity for more than a minute or two and had difficulty occupying himself without the attention of adults. It could be hypothesised that Margaret did not find this behaviour an issue, as she over-identifies with Henry. She reports that she was like this as a child, and as an adult, she likes to keep occupied and does not like to spend time on her own. For her, over-activity is denied as a problem, within either Henry or herself. Denial acts used as a defence against anxiety about ones own feelings (Corey, 2005). Being a
parent may have triggered Margaret’s memories of childhood and the anxieties she felt as a child. From Margaret’s report of her idyllic childhood, it appears that she may be in denial about the negative aspects of her childhood, particularly the anger she felt as a child. She appears to continue to be in denial of her negative emotions in the present time as evidenced by her defensive responding on the PSI. It could be hypothesised that the attention that she gives her children, is a projection of her own childhood need for attention. The use of projection as a defence allows an individual to attribute their own unacceptable feelings to another (Corey, 2005). As an adult, and particularly as a parent, Margaret may think it unacceptable to want to be the centre of attention, so she projects this need on to her children.

For Henry, his hyperactivity may be a defence against over-identification with his mother. He is at an age where he should have achieved a degree of separation and individuation (Bateman, Brown & Pedder, 2000) yet this is something he has not achieved. He may fear identification with his mother, yet feel ambivalence about being separate from her as he does not have a sense of himself as an autonomous being. The reason for this may be in his past and his early attachment experiences.

Henry is also reported to have a phobia about engaging in pretend play that involves a change in either his own or other’s appearance, for instance he would become upset at people putting on face paint or having his own face painted. It could be speculated that this could be traced back to his experience with his uncle and godfather. His last contact with his uncle, before his death, was associated with a radically changed physical appearance.
Henry’s anxiety may be that a change in physical appearance in himself, or others, is associated with death. Henry’s sense of himself may still be quite primitive, where he sees himself as being omnipotent and responsible for the world around him. Hence, his anxiety may be a defence against his own aggressive instincts.

4.3 *Triangle of conflict with regard to transference with therapist*

Transference and counter-transference are important aspects of a psychodynamic assessment. Transference occurs in the client therapist relationship, when the client responds to the therapist on the basis of past relationships, particularly early experiences with significant others (Bateman, Brown, & Pedder, 2000). Counter-transference is the feelings that the therapist feels in the session. They may have two sources. Either, feelings that are a transference of emotions from the client, or emotions that are invoked in the therapist relating to their own emotional issues.

Time was spent alone with Henry during the second session. The trainee was aware of feeling frustrated, lost and overwhelmed at times and felt the need to set some boundaries with Henry. He appeared happy to spend time with the trainee, and was reluctant for Margaret to join the session. When Margaret joined the session, the trainee was aware of feeling hostile and critical of Margaret, especially when she interacted with Henry. Margaret was observed to be quite directive in her interactions with Henry. Henry appeared to have difficulty occupying himself, and stated that he didn’t want Margaret and the trainee to talk to each other. The third session involved just Margaret. The trainee was
mainly aware of warm feelings towards Margaret. However, there was also a sense of being overwhelmed and lost at times.

Although the referral was for Henry, much of the therapist’s time and attention was spent thinking about Margaret. This was both in and outside the sessions. This may have been a transference of Margaret’s need to be the centre of attention. Even in sessions involving Henry, there was a strong feeling of wanting to behave in a way which would meet with Margaret’s approval. In these sessions, there was also a feeling of anger in the therapist towards Margaret, which may have been counter-transference from Henry. It is possible, that these may have been the therapists own feelings towards Margaret, for not being sensitive to her children’s needs, however, they were not prominent in sessions where Margaret was seen on her own. In writing up this formulation, the therapist’s initial idea was to base it around Margaret and relegate Henry to a minor role. Again, this seems to reflect how Margaret’s needs appear to dominate this case.

In sessions with Henry, the therapist was aware of feelings of being overwhelmed, chaotic and lost, which may have been transference of Henry’s feelings. During time alone with Henry, he was asked if he wanted his mother to join the session, and whether she would be worrying about him, to which he replied ‘I want her to worry’. The therapist was aware of strong negative feelings at this statement, which again may have been transference of feelings Henry had about his mother. Henry also appeared over-active in the time alone with the therapist. This may have been a defence against the anxiety that the therapist would not be able to contain his or her own emotions, which would overwhelm him if he
let them. In this session, Henry also denied being scared of anything apart from monsters and ghosts, which he said were only pretend. His denial may have been a defence against the anxiety that if he acknowledged this aspect of himself his self would be overwhelmed. He may also defend against these feelings as they are identified with his mother, who is not able to acknowledge or contain either her own or his distress. With the therapist being female like his mother, Henry may also fear identifying with females as it being a threat to his masculinity.

4.4 Past

In Henry’s case, it can be hypothesised that his current anxiety symptoms originate in his early experiences. The primary care giver, usually the mother, plays an important role in a child’s emotional development. In early infancy, the individual is characterised by ‘omnipotent functioning’ (Horne, 1999). A number of theories have been developed to describe how a baby and care-giver manage this important stage of development. Issues that are pertinent, at this point in time, are the quality of the attachment between mother and child and whether the mother is able to ‘contain’ the infant (Bion, 1962 cited in Horne, 1999). According to Winnicot (1953, cited in Horne) mother and baby must also have the ‘experience of disillusionment’ at a manageable pace. According to Winnicott, if there are problems with this process, this will trigger anxieties about annihilation, abandonment and disintegration. In Henry’s case, there is some evidence of disruption to these processes, which may be the origin of some of his present difficulties. As already discussed, Henry’s mother appears to have difficulty distinguishing between her own emotional needs and
those of her children. It can be hypothesised that this has been characteristic of their relationship. This would mean that Margaret would have had difficulty being responsive and containing Henry. In addition, there appears to have been other sources of disruption as Margaret reports that she spent more time physically with Henry’s twin as he had to spend considerable time in hospital. Henry is reported to have had time in childcare from birth as well as spending time with maternal grandmother. This passing from one care giver to another may have been a source of inconsistency for Henry. According to Bowlby (1969, cited in Bateman, Brown, & Pedder, 2000, p.38) disruption of the attachment process can be associated with insecurity about attachments.

Observation of the interaction between Henry and his mother suggests some insecurity in their attachment. Henry did not want his mother to come into the session and when she was in the room, he could not occupy himself, but wanted the attention of the adults in the room. Henry’s behaviour is characterised by anxiety and ambivalence, which is a pattern of insecure attachment (Ainsworth et al. 1971, cited in Hopkins, 1999). Henry’s current anxiety appears to be a regression to his early experience of an insecure attachment, which in turn will trigger these early anxieties. Henry feels ambivalence about separation and independence from others, wanting yet fearing the wish to be separate. His experiences of insecure attachment leave him angry yet unable to express the anger due to anxiety about abandonment and disintegration.
5. Reflections

The process of formulation has highlighted how different models view psychological problems. From the behavioural perspective, anxiety problems can be understood as maladaptive behaviours, which are learnt through the interaction of the individual with their environment, through conditioning processes. Pure behavioural models appear to explain the development of phobias quite well. However, in Henry’s case, anticipation of going somewhere new, appears to play an important role in his anxiety problems, which suggests there are some cognitive aspects to his anxiety. Anxiety is produced not only in response to an external stimulus, but also in response to internal i.e. cognitive stimuli (Nietzel & Bernstein, 1981). A number of more recent behavioural models have included a cognitive element to their behavioural formulations of anxiety (see Reiss, 1980 and Beck, 1976 both cited in Laurent and Potter, 1998). Vicarious learning and personal efficacy can also play a part in maintaining psychological problems, according to Bandura (1977). The way in which others respond to Henry’s anxiety may provide a model for him that makes him think that his anxiety is indeed serious and unmanageable for him on his own.

Although the behavioural model gives some consideration to intrapersonal variables, the focus is on interaction between the individual and their environment. The psychodynamic approach gives a much greater emphasis to the role of intrapersonal factors to the development and maintenance of psychological problems. Anxiety has a different meaning within a psychodynamic formulation, it is essentially an intrapsychic phenomena. Psychodynamic approaches aim to help the individual to be a better adjusted, rather than to
simply eliminate the symptoms of anxiety, which makes it more difficult to evaluate outcomes. Behavioural and psychodynamic approaches essentially have different aims, which may appear incompatible, yet both have approaches appear to have given relatively coherent formulations. Psychodynamic approaches are increasingly turning to behavioural research in order to provide empirical support for core components of psychodynamic theory (Emele & Fonagy, 1997, cited in Fonagy 1999), which suggests a synthesis of these two approaches is possible.
6. References


CLINICAL PRACTICE REPORT 2

SERVICE EVALUATION PROJECT

An evaluation of the experiences of clinical nurse specialists in using the Distress Thermometer to screen for distress.
Abstract

Distress is relatively common in cancer patients and has a negative impact on an individual’s quality of life and may be associated with poorer physical and psychological outcomes. Distress is under-identified by clinicians with the consequence that individuals are denied beneficial interventions that may be associated with better outcomes. Screening tools such as the Distress Thermometer may have a role in identifying clinically significant distress.

Government guidelines have identified the need for cancer services to provide supportive care. Psychological distress has been specifically identified as an under-identified need within the guidelines and recommendations made for assessment and intervention. Clinical nurse specialists have been identified as having a role in screening for psychological distress.

The need for a tool to assess psychological distress was identified by a cancer service in the West Midlands. The Distress Thermometer was identified as an appropriate tool and piloted as a screening tool by the clinical nurse specialists within the breast cancer service. A qualitative evaluation was carried out of the clinical nurse specialists’ experience of identifying distress before and during the pilot. The clinical nurse specialists were interviewed using a semi-structured format and the data subjected to a thematic analysis. A number of themes and sub themes emerged and are discussed in relation to the concept of
distress, the assessment of distress and the role of the distress thermometer as a screening tool. A number of recommendations are made for service development at an individual, professional and organisational level.
1. Introduction

1.1 Distress and cancer

Having cancer can be a psychologically challenging, life changing and potentially life threatening experience (Kelly, Ghazi & Caldwell, 2002). As well as providing a physical challenge, cancer can also have a psychosocial impact on the individual (Turner, Kelly, Swanson et al., 2005) and their family (Segrin, Badger, Darros et al., 2007). Research exploring breast cancer patients’ experiences found that physical and psychosocial concerns were prominently identified as sources of distress (Steginga, Occipinti, Wilson & Dunn, 1998). The issue of distress in cancer has become an important focus for research and service consideration. The National Comprehensive Cancer Network (2005) has formally conceptualised distress in cancer as a multi-dimensional emotional experience that has the potential to impede an individual’s ability to cope effectively with cancer and its consequences. The dimensions of distress include psychological, social and spiritual concerns, which can occur anywhere along a continuum from normative emotional experiences to crisis and psychiatric disorder. Research indicates that distress is relatively common among people with cancer. Typically, around a third of people with cancer will experience significant levels of distress, although prevalence varies with type of cancer (Zabora, BritzenhofeSzoc, Curbow et al., 2001) and at different points in the individual’s cancer journey. In breast cancer, around 40% of patients will experience psychological distress (Palmer, Kagee, Coyne & De Michele, 2004).
Distress in cancer may be associated with a number of negative outcomes. Distress may have a negative impact on the quality of life of people with cancer (Vitek, Rosensweig & Stolling, 2001), and may also be associated with poorer physical outcomes (Groenveld, Petersen, Idler et al., 2007). There is research to suggest that distress can be alleviated through support and psychological intervention. Professionals can provide beneficial support in helping individuals to adjust to their condition (Gallagher, Parle and Cairns, 2002). The alleviation of distress through psychological interventions has been associated with improvements in physical health for people with cancer (Andersen, 2007).

Unfortunately, research indicates that distress is poorly identified by health professionals, with the consequence that relatively small proportions of people are offered appropriate interventions (Bredart, Didier, Robertson et al., 1999). There may be a number of reasons for this. Patients’ beliefs and expectations may present a barrier to them actively communicating their concerns to professionals (Maguire & Pitceathly, 2002). Similarly, professionals may believe that patients will raise concerns if they have them and so neglect direct questioning about their concerns (Detmar, Aaronson, Wever, et al., 2000).

Assessment and screening tools have been identified as having an important role to play in helping healthcare professionals identify distress in cancer patients (NICE, 2004). The Distress Thermometer and accompanying Problem Checklist have been recommended by the National Comprehensive Cancer Network (2005) as a brief screening tool for the identification of distress in cancer patients. The Distress Thermometer has been the subject of a number of validation studies in the U.K. and internationally (Jacobsen, Donovan, Trask et al., 2005) and has been successfully used by nurses in an oncology setting (Larouche &
Edgar, 2004). This study also found that severity of distress was associated with number of concerns identified by patients.

1.2 Guidelines for improving supportive care for adults with cancer

Distress is increasingly recognised as an important issue for health professionals and services to consider when providing care for people with cancer. The psychosocial support needs of people with cancer have been explicitly identified by government guidelines (NICE, 2004) and have also been considered an essential part of the holistic assessment of the needs of people with cancer (Cancer Action Team, 2007).

Improving Supportive and Palliative Care for Adults with Cancer (NICE, 2004), makes a number of key recommendations with regard to meeting the support needs of people with cancer. These include:

- The routine assessment of patient needs at key points in the patient pathway (including at diagnosis, during and end of treatment, at relapse and before death)
- Assessment should include physical, psychological, social and spiritual needs.
- There should be a consistent approach to assessment
- Patients should be involved and supported in meeting their needs
- All clinicians involved in the care of people with cancer should be skilled and effective communicators
The guidance offers a number of more specific recommendations with regard to meeting psychological needs. It points out that psychological distress is often under-identified. Recommendations are made for the systematic assessment of psychological needs at key points in the patient pathway.

The guidance suggests a four level model for professional assessment and intervention. Staffs at level two are identified as professionals who have some special expertise; this would include clinical nurse specialists. It is recommended that professionals at this level should be involved in screening for psychological distress and should be able to provide a certain level of psychological intervention and to refer on where appropriate. Intervention at this level should focus on improving self care, providing information, improving control and adjustment and helping with physical symptoms.

The recommendation for professionals at level 3, is that they are able to assess psychological distress and deal with common psychological problems using counselling or specific psychological interventions. There is an acknowledgement that there may be some overlap between level 2 and 3 professionals. At level four of the model, professionals would be mental health specialists, ideally with expertise in cancer. It is envisaged they would assess more complex cases and offer specialist psychological interventions, as well as support and supervision for professionals working at lower levels.
2. **Statement of aims**

The general aims of this project were to evaluate how the clinical nurse specialists within a particular cancer service were identifying distress, and to evaluate the use of the Distress Thermometer as a screening tool. There were a number of specific aims, these were:

1. To explore the clinical nurse specialists concepts of distress in relation to their patients
2. To explore how the clinical nurse specialists routinely assessed distress
3. To explore the clinical nurse specialists experience of using the Distress Thermometer as a screening tool.
4. To evaluate the appropriateness of the Distress Thermometer as a screening tool and to make recommendations about its use
3. **Method**

3.1 **Service setting**

Within the West Midlands trust that was the subject of this evaluation, health psychology provides input into stroke, cancer and palliative care services. The trust had set up a working group to look at screening for psychological need within the cancer services as there was a lack of consistency in screening for psychosocial needs. A clinical psychologist from the health psychology department was involved in a consultancy role within the steering group and provided a lead role in identifying appropriate psychometric tools. The Distress Thermometer was identified as useful user-friendly holistic screening tool. It has been endorsed by the Special Interest Group in Oncology and Palliative Care (SIGOPAC), which is the main body for psychologists working in oncology and palliative care. The working group decided to pilot the Distress Thermometer within one of its cancer services and to carry out an evaluation of its utility within the identified service before deciding to implement its use on a wider scale. The breast cancer service was identified and agreed to pilot the Distress Thermometer.

3.2 **Sample**

Three clinical nurse specialists (CNSs) work within the breast cancer service. All three had over twenty years of experience as nurses and worked in breast care between five and twenty years. One of the clinical nurse specialists worked on a part-time basis in the clinic.
settings. The CNSs were involved in seeing women with breast cancer through the diagnostic and treatment phase of their journey. The CNSs would subsequently see the patients at yearly follow-up for between five and ten years. All three of the CNSs were interviewed prior to the pilot and the two full-time CNSs during the pilot phase.

3.3 Design

A qualitative design was chosen to explore the detail and complexity of the CNSs understanding of distress and their experience of using the Distress Thermometer as a screening tool.

A semi-structured interview format was used to interview the nurses. Two sets of interviews were carried out (see Appendix 8 for details of the interview schedules).

3.4 Procedure

A meeting was arranged with the breast care CNSs to discuss the Distress Thermometer and the pilot project. They were asked to identify a point on the patient’s cancer journey where they felt it was appropriate to use the tool. They identified that the point at which the patients received the results of surgery would be appropriate for them to use the tool. They were each asked to use the Distress Thermometer with the next five patients who fulfilled this criterion and were given a written protocol for the use of the Distress Thermometer (see Appendix 7 – Distress Thermometer and protocol).
Before the pilot period, each of the CNSs was interviewed individually in a quiet room within their work setting. Originally, the plan was to interview them again at the end of the pilot period. Unfortunately, the original pilot period had to be extended as the CNSs were unable to carry out five interviews in the period identified. A pragmatic decision was taken to carry out the second set of interviews as planned due to personal time constraints. The second set of interviews were carried out with both the full-time CNSs together, at their request, again for pragmatic reasons. (See Appendix 8 for interview schedules).

3.5 Ethical issues

The CNSs were asked and consented to being interviewed, with the interviews being recorded and transcribed, and to the use of verbatim quotes in the final report. They were informed that the extracts would be anonymised.

3.6 Data analysis

The transcribed interviews were read a number of times before being individually analysed for themes. The data relating to each theme were then collated and sub-themes identified.

One of the transcripts was analysed by a colleague with experience of carrying out qualitative analysis in order to check that the themes identified were grounded in the data. There was general agreement over the themes and sub-themes identified in the chosen transcript.
4. Results and discussion

A number of themes and sub-themes emerged from the interview data. These are presented below with direct quotes from the interviews as illustration.

4.1 Theme 1 – Distress in cancer patients

Distress was reported to be multi-dimensional by all the clinical nurse specialists:

‘I would say it (distress) can be emotional, physical and spiritual... so it is looking at a holistic thing’

Psychological aspects of distress were identified. Anxiety and depression were both mentioned in the context of distress.

There was some variation in ideas about how important the intensity and chronicity of distress was. One nurse explicitly mentioned distress in terms of ‘psychologically struggling’. In contrast, for one of the other CNSs, distress was seen as being important at any level if it interfered with an individual’s functioning or adaptation, or was identified to be an issue for the individual:

‘I would say it (distress) is anything that causes, I suppose anything that upsets the patient, anything that affects the patient’s day to day activities... I suppose not just necessarily have to be any significant degree, anything that worries or concerns the patient really.’
The belief that distress was to be expected at certain times in the patient pathway was reported a number of times, particularly in the interviews during the piloting of the Distress Thermometer.

4.2 Theme 2 – Assessing distress prior to pilot

4.2.1 Sub theme (i) - Methods of assessment

Communication was identified as an important means of assessing distress. Skills were reported to have developed through training and experience:

‘I think both A and I, have done quite a lot of work around communication...my M.Sc, I did a module in communication and there was a lot about getting patients to open up and talk...ask open ended questions....try to let them know that it is okay to be feeling how they are feeling’

Distress was reported to be communicated non-verbally at times:

‘how the patient communicates with me, their non-verbs, their posture, just how they are in the consultation really...patients can be very closed and not display any emotion and you can still clearly see that they are struggling’
'we tend to know from our experience and from knowledge and courses what to look for, so we are looking at whether they are able to look or touch a wound...are they sleeping...eating...crying...sexuality (issues)...knowing full well from a breast cancer point of view the impact it can have on somebody’s life...looking at literature and things we try and utilise when we assess ladies’

Clinical experience was a strong, recurrent theme in regard to assessing distress, which was mentioned by all the clinical nurse specialists. It was seen as the most important way of assessing distress for the clinical nurse specialists in this service:

‘my experience. I think the longer I am in the job, again, you tend to see patterns of behaviour. So, I suppose it’s looking at my previous experience.’

4.2.2 Sub theme (ii) - Barriers to assessing distress

The nurses were explicitly asked to identify any barriers to assessing distress with their patients. A number of external barriers were explicitly identified by the nurses. These included the patients themselves, other professionals, time and organisational factors.

‘doctors don’t enquire as to patients’ well being...(they) want to do the operating and then push the patients off...have many heated discussions about patients who have psychological
issues and doctors will say “well, I’m not going to ask that one because I don’t want to know the answer”…because they are not interested in psychological care generally’

The CNSs had definite views about when it was and wasn’t useful to assess distress which appeared to be a barrier to assessing distress, although these were not identified as such by the CNSs. They identified a number of points in the patient pathway when they did not think that the formal assessment of distress was appropriate. Initially, they identified that diagnosis was an inappropriate time, due the view that distress was to be expected at this time. Before the pilot, the CNSs had identified that the point when patients received the results of surgery would be an appropriate time to assess for distress. However, since using the Distress Thermometer, their views had changed. They reported that they no longer saw this as an appropriate point for its use.

4.2.3 Sub theme (iii) - Previous experiences of assessment tools

The use of assessment tools to assess distress was explicitly explored in the interviews, before and during the pilot. The nurses reported previous experience of an assessment tool which had been introduced by a clinical psychologist. They all reported a negative appraisal of its usefulness and the decision not to make routine use of it.
4.3 Theme 3 – Using the Distress Thermometer

4.3.1 Sub theme (i) – Thoughts and feelings about using a formal tool prior to pilot

Before the pilot, the nurses generally reported being positive and open to the use of a formal tool:

‘we have said for a long time, really, that we would like a formal tool...we CNSs are under pressure really to prove how we spend our days. A lot of people don’t now what we do in a day because it is difficult to measure...we live in a world where you have to have evidence written down so I am more than happy to trial it.’

There were some anxieties about the use of the Distress Thermometer. There was some concern about time constraints and patients’ attributions about it use:

‘I have a slight concern that maybe patients again think we are making a judgement about how they are coping. I think, because, at the moment we do it on a very informal basis, it’s just like a discussion and chat. I think writing things down, making notes, might make the patient think, “Oh, they are assessing me”.’
4.3.2 Sub theme (ii) – Barriers to the use of the Distress Thermometer

There was a consensus evaluation of the Distress Thermometer as being a time-consuming assessment tool, and this point recurred a number of times in the interview. The evaluation of the Distress Thermometer as a time-consuming tool appeared to be associated with a rejection of the tool being used routinely within the present clinic set-up.

‘I think for us, and if you speak to any nurses, it’s always going to be a time issue… it would pick up a lot of things when you’ve got clinic responsibilities, almost every day. Like I say it’s trying to find time’

There were some concerns that the assessment using the tool was in conflict with their own clinical judgement:

‘another thing I felt was …that she was identifying lots and lots of problems and when you looked at the form you’d of thought she was really quite distressed… in reality she wasn’t … I didn’t think what was written down on the form was a true reflection of how she actually was’.

There was also the view that the tool was identifying concerns that were no longer an issue:

‘I think a lot of things that they identified as problems, they’ve actually worked out how to deal with themselves anyway… so we found it was a bit retrospective………..One lady was
up here for nervousness, was a nine and now (she’s) at a one… if you’d done that to this lady so many weeks ago you might have been looking at nervousness, anxiety, all up there…it was all because she wanted to know her results…and today she’s “I’m down here”.

The clinicians’ negative appraisal of its utility appear to be associated with their beliefs about distress:

*It’s knowing there are going to be certain times in their journey when we expect them to be highly anxious and to have lots of problems…at diagnosis we expect them to be highly anxious. At results, we expect them to be highly anxious…for the vast majority of the time that settles down, doesn’t it? It’s trying to pick out for who it doesn’t settle down and when to intervene with them.‘*

A number of external barriers were explicitly identified to the routine use of the Distress Thermometer. As already mentioned, the time taken to use the tool within the constraints of the clinic setting was reported to be a barrier and this appeared to have some association with the appraisal by themselves and others that it was an inefficient use of staff resources, by managers and colleagues:

*‘It’s the impact when you’re 30, 45 minutes with them; people are knocking on the door getting you to come out.’*
The views of colleagues in other services may also have been a barrier, although this was implicitly, rather than explicitly identified:

‘other CNSs, I know there was a bit of, ...I think some people felt that we shouldn’t be using it in breast...it might be more appropriate to use elsewhere’

4.3.3 Sub theme (iii) – Benefits of the Distress Thermometer

The clinicians identified times when they would use the Distress Thermometer, namely for patients they had some concerns based on their clinical experience. However, this would be a non-routine use at a more convenient time:

‘I think there will be specific ladies that you definitely ear-mark for using...there are definitely people who don’t open up a lot or you just think things aren’t quite right. For specific patients it would be excellent’

A number of benefits of the Distress Thermometer were implicitly identified. It highlighted that at times there was a difference between the clinician’s perceptions of a patient’s distress and the concerns that were elicited by the assessment tool. These included the identification of issues that the clinicians had not considered to be problematic for the individual, and the prevalence of problems being different than expected. They also reported that their assumptions about information giving and retention were challenged by their experiences of using the assessment tool.
5. Conclusions

Clinical nurse specialists have been identified as having an important role to play in meeting the psychological needs of patients with cancer (NICE, 2004). For instance, support from clinical nurse specialists at time of diagnosis has been found to be associated with enduring improvements in psychological distress (Booth, Beaver, Kitchener et al., 2005). In order to do this they have to be able to assess and provide a suitable level of intervention. The aims of this evaluation were to explore how clinical nurse specialists within a breast cancer service were assessing and providing interventions for distressed patients and how useful they found the Distress Thermometer as a screening tool. Recommendations will be made at a number of levels as research suggests that in order for any changes to practice to occur, recommendations need to made at individual, professional, team and service level (Grol & Grimshaw, 2003).

The clinical nurse specialists’ concepts of distress were explored in order to identify how they might be assessing distress. The CNSs appeared to have a clear belief that cancer had a multidimensional impact on the individual. This knowledge and understanding reflects a holistic understanding of the impact of cancer. Their conceptualisation of distress accords with patients’ experiences of distress in breast cancer (Steginga, Occipinti, Wilson & Dunn, 2005). In addition, they had an appreciation of the psychological aspects of distress. This understanding would appear to facilitate them as professionals in identifying the psychosocial impact of distress on their patients and to support them with these needs. Providing support was identified and valued on an individual and professional level. This
would appear to put them in a key role to provide for the supportive needs of patients with cancer, in line with NICE (2004) guidelines. They also appeared to be knowledgeable of, and valuing of their role as skilled communicators, which again would facilitate them in eliciting concerns from their patients. However, there appeared to be a number of barriers to them fully identifying and meeting the support needs of their clients.

There appeared to be some limitations in the clinicians’ assessment of distress in their patients, which appeared to reflect previous research in this area. Madden (2006) has identified a number of reasons why nurses in cancer services may neglect the assessment of distress, including, organisational, professional and individual barriers. Each of these factors appeared to be present to some degree within the service. On a professional and individual level, there appeared to be a view that some level of distress was to be expected and this appeared to be associated with a behavioural block to assessing distress at these times and the belief that the distress would naturally resolve. These beliefs may be a barrier to the introduction of a routine screening tool at key points in the patient pathway as recommended by NICE (2004) guidelines. **Recommendation 1:** In order to overcome these barriers, it may be useful for clinical psychologists to provide further training about the impact of distress and the role of psychological intervention at all levels in helping to alleviate that distress.

The CNSs’ beliefs about the value of their clinical experience also appeared to act as a barrier in some instances. Although some of their beliefs about detecting distress appear to be borne out by research, on other occasions it appeared that they were overestimating their
ability to detect distress, which is in line with research about clinicians’ abilities to identify distress in cancer patients. An instant where their clinical experience appeared to be validated, was in the belief that emotional suppression may have been an indicator of distress. Research indicates that patients with breast cancer who tended to emotional suppression experienced higher levels of distress before and after diagnosis (Iwatmitsu, Shimoda, Abe et al., 2005). In such a case, a screening tool may have been able to assess this distress and opened up a means of communication. On some occasions, it appears that the clinicians may have experienced the screening tool as a challenge to their clinical experience, and this again may have acted as a barrier to its routine use. From the interview data, it appears that the Distress Thermometer was clearly identifying individuals with distress who would otherwise be missed, which appears to indicate that there is a clear need for an appropriate screening tool to be used routinely. **Recommendation 2:** For the Distress Thermometer to be used as a routine screening tool. However, screening tools such as the Distress Thermometer, should not be viewed as a replacement for clinical experience, but to be used in association with clinical experience. It would be useful for a clinical psychologist to provide training and ongoing support into the use of the Distress Thermometer as a screening tool and to clarify the level of support that CNSs would be expected to give to patients.

The present format of the Distress Thermometer appears to have provided a barrier to its routine use. The protocol that was in place during the pilot appears to have made it a time consuming and lengthy tool. In fact, it does not appear to have been functioning as a screening tool, but as an assessment tool which may be why the CNSs have decided not to
use it routinely. The CNSs identified that the Distress Thermometer has a use non-routinely in cases where they suspect a patient is distressed but are unable to elicit this distress. **Recommendation 3:** In order to make the Distress Thermometer practicable to be used routinely as a screening tool, it is recommended that the one page thermometer and problem list are given to the patient to fill in before seeing a clinician and a cut-off score used to decide whether further assessment of distress needs to be carried out. The study by Larouche and Edgar (2004) found that some patients actually found it easier to communicate their concerns through writing, than verbally. If a further assessment needs to be carried out, then the full version of the Distress Thermometer can be used to elicit specific concerns and support the patient to resolve them or to refer on as appropriate. It may be useful for clinicians to have clear guidelines for screening and when to intervene or refer on to other services.

There appear to be a number of systemic blocks to the assessment and meeting of support needs within the service. Time constraints and the lack of staff resources were identified as major barriers to the routine assessment of distress and to the meeting of support needs. In addition, the clinical nurse specialists’ beliefs that their managers and colleagues did not understand or value their support role also poses a major barrier to improving services in this area. **Recommendation 4:** An understanding and commitment to meeting patients support needs to be present at all levels of the service and to be reflected in service targets, training and resources. There may be a need for services to be reconfigured to meet these support needs.
There were a number of limitations to this evaluation. The evaluation was carried out in the breast cancer service with the clinical nurse specialists in that service. Hence, the findings of this report are context specific. However, the issues identified in this report may be transferable to other contexts. Some of the findings concerning the use of the Distress Thermometer also need to be treated with caution. The data collected from the second interview was collected before the pilot phase was fully completed and therefore may not reflect the experience and views of the clinical nurse specialists at the end of the piloting period. In addition, this interview only involved the two full-time CNSs, who were interviewed together. The part-time CNS had not had an opportunity to use the screening tool and a decision was taken not to interview her. However, her experience of not using the Distress Thermometer may have provided some interesting data about the barriers to the use of the tool. Interviewing the two full-time CNSs together may have also influenced the account that they gave of their experiences. As colleagues who work together closely, they may have been influenced to give a ‘team account’ rather than an account of their individual experiences in order to minimise any difference and conflict.

This report has only chosen to focus on specific aspects of the data in order to meet the stated aims of the evaluation. The inclusion of patients’ experiences was beyond the scope of this evaluation, but would add an important and valuable perspective on how the service could develop its supportive care for people with cancer.
6 References


CLINICAL PRACTICE REPORT 3

CASE STUDY

The case of Anna, a 28-year-old woman with anger and relationship difficulties
Abstract

This report presents the case of Anna, a 28-year-old-woman, who was referred to the CMHT for anger management. Her presenting difficulties are discussed in the context of the referral. Background information is provided about the history of Anna’s difficulties, her family background and her contact with services. Assessment data are presented, along with discussion of the methods used, the process of implementation, and interpretation of data. Theories and research about the origin and maintenance of anger difficulties are discussed in relation to a formulation of Anna’s difficulties. A cognitive behavioural framework was used as a basis for formulation and intervention. Methods and results of evaluation are discussed in relation to the identified difficulties. Reflections about the therapeutic relationship and issues for professional development are also discussed.

All names and identifying details in this report have been changed to protect client confidentiality.
1 Referral and Presenting Difficulties

Anna was a 28-year-old woman with complex and long-standing difficulties. Her referral for psychological input was quite complicated due to the involvement of a number of professionals and services, with Anna and her family. Anna was being seen by a Community Psychiatric Nurse (CPN) in the Community Mental Health Team (CMHT), who was monitoring and supporting her with her mental health difficulties. She referred Anna to SureStart due to concerns about Anna’s relationship with her youngest son. Anna had taken an overdose several months previously while alone in the house with her children, and she had also told her CPN that she hated her youngest son.

Anna was seen by a clinical psychologist at SureStart, who identified that Anna had difficulties in her attachment with her youngest son, Matt. The service offered her extra support for the children, but unfortunately, the clinical psychologist was unable to offer Anna any direct input at the time. She was told that she would have to wait for a number of months before psychological input could be offered at SureStart. The clinical psychologist at SureStart, also identified that Anna had difficulties with anger, which she thought would be more appropriately dealt with by adult mental health services, and this was the path by which Anna was referred back to the CMHT for psychological input.

When Anna was seen for assessment in the CMHT, she identified a number of difficulties. These were: (i) difficulties in her relationship with her youngest son, and a lack of confidence in herself, as a parent; (ii) difficulties in her relationship with her partner; (iii) a
wish to explore the impact of her childhood experiences; (iv) a wish to increase her self-esteem. At the time of the assessment, she had difficulty in prioritising these difficulties. It is of interest that Anna did not identify anger as a problem.
2 Background Information

2.1 History of difficulties and previous contact with services

According to Anna’s notes, she had a history of depression and mania going back ten years. She was given a formal diagnosis of bipolar illness four years ago, and had received input from psychiatrists and CPNs from the CMHT for a number of years. She attended a psychoeducational bipolar group for ten weeks in 2004. Her bipolar illness was being monitored by her CPN and she was taking a mood stabiliser (carbemazepine) and anti-psychotic medication (haloperidol). She was taken on by her present CPN following the breakdown in her relationship with her previous CPN. Anna had also received support from the Home Treatment team on a number of occasions over the past two years, when she contacted the service at a point of distress and crisis. Some of the professionals involved with Anna, reported difficulties in their relationship with her. There were reports that she had been verbally abusive and made complaints about several members of staff. Anna reported receiving counselling at the age of fifteen, for six to eight months.

2.2 Information about family and significant Relationships

Anna was the third child of a family of four, with two older sisters and a younger brother (see Fig. 1, Family genogram). She described her parents as being Irish Catholics. They divorced when she was twelve, with her father gaining custody. Anna reported having
regular contact with her father and sisters, and being particularly close to her brother who was away at university.

Anna had been with her partner, Paul, for four years. According to her, he had been violent in his previous relationship. She also believed that he had his own mental health difficulties, and problems with alcohol use. She stated that he physically assaulted her while pregnant and that she had been violent towards him on occasions. Paul has two daughters from a previous relationship. Anna has two children with Paul, Will, aged just over two and Matt, aged 14 months.
Figure 1. Family genogram
3 Assessment

3.1 Methods

In cases where there are interpersonal or anger problems it is particularly important to have multiple levels of assessment and not to just rely on client self report (Spence, 1994). Hence, a number of methods were used to inform the assessment, including clinical interviewing, gathering information from notes and discussion with other professionals involved in the case, client self report, diary recording, observation in the sessions and the use of psychometric measures. Assessment of risk issues was also carried out due to concerns about Anna and her children. Direct observation of Anna with her children was not carried out, as this information was readily available from other sources. Only one psychometric measure was used in this case, the Depression Anxiety and Stress Scale (DASS-21) (Lovibond and Lovibond, 1995) to monitor Anna’s mood. The DASS has been validated for use in clinical populations and can be used to assess the severity of depressive, anxiety and stress symptoms. It may have been useful to use a psychometric measure such as the State-Trait Anger Expression Inventory –2 (STAXI-2, Speilberger, 1999) which is a validated and widely used instrument, to assess the severity and nature of Anna’s anger difficulties. However, it was not available at the time of the assessment and may well have alienated her, as she had not identified anger as a difficulty.
A joint assessment had previously been carried out by my supervisor and the psychologist from SureStart. The information from this session and Anna’s case file provided data about her family background and her involvement with services. Another joint clinical interview involving my supervisor and I, was carried out in order to assess whether Anna would like to or was able to, engage with a trainee, and to identify the areas of difficulty that she would like to address.

Following this interview, Anna was asked to record data about her difficulties. The purpose of this was to identify trigger situations. Assessment continued during the second session with the aim of gathering further detail about the difficulties in Anna’s relationships mainly through clinical interview and review of her written report. Anna recalled triggers for distress and difficulty in her relationships, and provided information about her thoughts, feelings and behaviours in these situations. Due to information disclosed by Anna about her responses to her youngest son, issues of risk were also investigated in this session.

Following this session, Anna was asked to keep a written diary record of her activities and interactions, and to rate how positively or negatively she felt in these situations. A simple bipolar scale with a zero point was used to monitor her emotional response (see Appendix 9 – Diary sheet). The aim of this monitoring was to have a more accurate record of the frequency and intensity of Anna’s distress and difficulties, as client recall is often biased in favour of over-estimation of difficulties (Lindsay and Powell, 1994). There was on going
assessment of Anna’s interpersonal difficulties through assessment of her engagement in sessions through observations and reflections about the therapeutic relationship in the sessions and in supervision. Assessment of this issue was subjective, and therefore open to observer bias. However, the use of supervision can help to reduce some of this bias (Lindsay and Powell, 1994). In order to have a wider perspective on these difficulties, information about Anna’s engagement and difficulties was gathered from verbal discussion with other professionals from the CMHT and SureStart.

It was particularly important to have multiple perspectives and sharing of information due to the concerns about the impact of her difficulties on her children. Her CPN was also able to provide information about Anna’s mood and relationships outside of the sessions. Two workers meetings were held as part of wider on-going assessment of her care needs. These Care Programme Approach (CPA) reviews were a further opportunity to clarify and review Anna’s difficulties.

3.2 Early Difficulties

Anna reported a difficult childhood. She stated that both her parents were heavy drinkers and recalled conflict and violence between them from an early age, with her mother being the perpetrator of the violence. According to Anna, neither of her parents were around much particularly after the birth of her brother. She reported feeling angry with both parents for their neglect of her and her siblings. She took on the role of caring for her brother at the age of eight and this was something she found fulfilling. Anna reported that
at the age of thirteen she witnessed her mother stab her father, and also saw her mother
taking an overdose and slitting her wrists. As a teenager, Anna reported she felt a sense of
shame and anger about her mother’s violent behaviour. She also reported feeling angry with
her father for ‘abandoning the family to heal his own wounds’. This was the time she
started drinking and self-harming. Anna also recalled having few friends at school, being
bullied, and feeling that her school years were a ‘black abyss’. She remembered ‘wanting
to do better’ and take her 11 plus, but lacked support from her family and felt that she failed
academically.

The information about Anna’s childhood difficulties and feelings were based on her recall
in the sessions and so were subject to recall bias. However, the account she gave was
consistent with the account that she gave to other professionals.

3.3  Difficulties with son, Matt

From the information provided by Anna and the observations of other professionals, it
appears that she was experiencing difficulty in relating positively with her youngest son,
Matt, from the time of his birth. Anna reported having a difficulty pregnancy and birth, and
felt that she did not bond with her son. She also believes that she had post-natal depression,
although professionals did not identify this at the time. Anna reported negative perceptions
of Matt, that he ‘was always screaming and whining…never happy’. Her attributions of his
behaviour were that it was deliberate and malevolent, that he was ‘trying to wind me up’.
These cognitions were associated with intense feelings of anger, and at times accompanied
by thoughts of harm ‘I want to throw him against the wall’ and/or antagonistic behaviour, such as shouting at Matt.

In the sessions, Anna was observed to be distressed by her thoughts and behaviour. She stated ‘there’s nothing I can do…I can’t make him happy’, and at this point she became tearful. It appeared that she attributed Matt’s crying to her failure as a mother. These negative self-appraisals appeared to be a source of intense distress for Anna. She stated that she did not want to harm her children, and she would rather harm herself than harm her child. There was evidence from Anna’s notes to corroborate this statement. She had taken her overdose at a time of extreme distress about her ability to cope with her children, which suggested that at times she was at risk of harm to herself due to the intensity of her anger and distress. A review of Anna’s diary revealed that the majority of the time, Anna’s interactions with Matt were not a source of negative feelings. In a typical week, there were three to four episodes of Anna becoming angry with Matt. These episodes tended to occur at the end of the day, and at the end of the week or at the weekend, when Anna was on her own with the children. Although, the episodes were of relatively low frequency, they were of high intensity and posed the potential for behaviour that was harmful to either Anna or Matt.

3.4 Other difficulties

Anna reported intense levels of anger towards her mother that appeared to be triggered by contact with her or by thinking about her past. Although contact was irregular, it appeared
to be a source of stress and distress. Her anger towards her partner, Paul, was less intense, but appeared to occur more regularly due to the greater contact that she had with him. When Anna felt angry with him, she tended to have a verbally aggressive outburst. She reported a number of triggers for these outbursts, including Paul spending time on his own, his excessive drinking, not paying attention to the children, not doing things to her standards and, behaving in ways that she appraised as indicating that he did not find her physically attractive.

3.5 Observations in sessions

During our second session, Ann became visibly agitated and reported that she was angry when I had told her that I would have to take action due to her disclosure of possible risk of harm to her son. Her level of anger increased when I told her that I would not be seeing her the following week due to annual leave. She told me that she ‘felt let down’ after ‘opening up a can of worms’. Anna told me she would have to leave because she did not want to do something she might regret. Despite this episode, Anna continued to come to the sessions and only cancelled one appointment.

3.6 Psychometric data

Anna’s scores on the DASS-21 were: in the moderate range for depression, in the mild to moderate range for anxiety, and in the moderate range for stress. Both Anna and her CPN reported that her mood was relatively stable at the time of the assessment.
4 Formulation

A case formulation of the possible origin and maintenance of Anna’s difficulties will be presented (see Figure 3 – longitudinal case formulation), along with a formulation of the maintenance of her anger and difficulties in her relationship with her son.

4.1 Predisposing factors

There appear to be a number of factors that may have predisposed Anna to having difficulties with anger and her relationships. These include her core beliefs about herself, others, and the world; the modelling of anger and relationships by others; difficulties in emotional regulation; and possible attachment issues.

According to cognitive behavioural theorists, early developmental experiences lead to the formation of core beliefs about the self and others (Dudley & Kuyken, 2006). Anna’s early experiences of parental neglect, bullying and isolation at school, may have led to her forming negative core beliefs, such as ‘I am unlovable’, ‘I am a failure’, ‘nobody cares about me’, ‘others let you down/abandon you’. Her experiences with her parents, in particular, may also have led her to believe that the world is threatening, violent and unpredictable, and that ‘life is hopeless’. Emotional distress is triggered when these core beliefs are activated, so people generally protect against this through the use of rules, assumptions or coping strategies (Dudley & Kuyken, 2006). Anna appears to have formed a number of dysfunctional assumptions and strategies to guard against her negative core
beliefs. For example, beliefs about how she should be; ‘I must be perfectly competent’, and ‘if I take care of others then they will love me’, how others should be; ‘others must not let me down’, ‘others must not make me feel incompetent’, and how the world should be; ‘life should be fair and predictable’.

In Anna’s case, her parents may have also provided maladaptive models for how to cope with anger and distress. She appears to have a low frustration tolerance for distress, which may have developed through her parents modelling ‘acting out’ as a way of dealing with distress. Anna’s reactions to perceived rejection and abandonment in current relationships, suggests an underlying insecurity in her relationships. Given her childhood relationships, one could speculate that she was likely to have an insecure attachment style as a child and as an adult. According to Bowlby (1973), people with insecure attachments display an ‘anger of despair’ in contrast to people with secure attachments whose anger is functional and characterised by hope. In Anna’s case, there appeared to be some evidence that her anger was a defence against underlying feelings of despair and distress at perceived rejection and abandonment.

Anna’s bipolar illness may also mean that she had difficulty regulating her mood. She reported that her illness was of the rapid cycling type, where people experience four or more episodes of mania or depression in a year (Ramirez Bosco & John Rush, 1996). Anna reported that she felt more irritable both when she was feeling ‘high’ and ‘low’, which may make her more vulnerable to feeling angry at times.
4.2 Precipitating factors

Becoming a parent often means coming terms with one’s own experience of parenting (Hopkins, 1999). For Anna, this may have been particularly challenging given her childhood experiences. From Anna’s reports, it appears that it was important for her to be different from her own mother. Anna reported that her experiences with her first child, Will, were very positive. In fact, she stated that she felt like she had a ‘perfect family’ and that she felt ‘normal’. Paradoxically, it is possible that Anna’s experiences with her first child, gave her some unrealistic expectations of herself as a mother and of Matt. These high expectations, may have added to the stress of coping with two young children. In addition, the difficulties she reported around Matt’s birth have been associated with post-natal depression, which has been associated with relationship difficulties (Daws, 1999).

4.3 Perpetuating factors

Difficulties in relationships have been identified as a primary negative consequence of dysfunctional anger (Diguiseppe & Tafrate, 2001). In Anna’s case, anger appears to play a key role in the perpetuation and maintenance of the difficulties in her relationship with Matt.

Gorenstein et al. (2007) have produced a cognitive behavioural model for anger which will be used to describe how Anna’s anger may perpetuate the difficulties in her relationship with her son, Matt, (see Figure 2, below). Anna’s appraisal of the trigger event, in this case
Matt crying, indicates an attribution of malevolent intent, which is common in people with persistent anger problems (Gorenstein et al., 2007). According to Dahlen (2007), a person’s pre-state level of arousal plays an important role in anger response. This makes sense in Anna’s case, as there appear to be many occasions where she does not feel angry at Matt crying. On occasions where she may be more physiologically aroused, possibly either from feeling irritable due to fluctuations in her mood or levels of stress, Anna would be more vulnerable to feeling angry.

Figure 2 - A cognitive behavioural conceptualisation of persistent anger adapted from Gorenstein et al., 2007
When feeling angry, Anna typically responded antagonistically, for instance by shouting at Matt. This behaviour is unlikely to soothe him and probably more likely to increase his crying. Anna’s behavioural response then becomes a triggering event, which Anna appraises negatively as evidence of her inability to meet her child’s needs. Given her already aroused state, this cognition is likely to reinforce her subjective feelings of anger, but perhaps also produce feelings of distress and despair.

It appeared that Anna found it difficult to tolerate her feelings of distress, with the result that she would act impulsively to relieve her distress. It could be hypothesised, that feeling emotionally distressed evoked her childhood experiences of being powerless and vulnerable, and this is something Anna defended against by becoming angry. When angry she may feel less vulnerable, but more out of control, and may feel at risk of harming her son. These thoughts present a conflict with the expectations of herself as a mother. At times, it appeared that the conflict between her anger and distress may become overwhelming, and these may be the times when she would be at risk of harming herself.

The longer-term difficulties in Anna’s relationship with Matt, appeared to be maintained by her cognitions about her interactions with him. For instance, she appeared to personalise his behaviour, over-generalise the negative situations and discount positive interactions. These cognitive distortions appear to be maintaining her view of herself as a failure, and Matt as the cause of her inadequacy, and the perpetuation of difficulties in their relationship.
Figure 3 – Longitudinal case formulation adapted from Dudley and Kuyken (2006)
5 Intervention

In Anna’s case, her difficulties were complex and long-standing, and for interventions to have a long term impact it would be important to address the relationship between her all her difficulties and share these with team. In the longer term it would also be helpful to look at Anna’s difficulties in regulating her mood and not just her anger problems. However, initially the decision was taken to focus the intervention on the relationship difficulties identified by Anna, and the role that anger played in her interpersonal difficulties, as this appeared to be an immediate source of distress and risk, and offered a starting point for engaging Anna in a therapeutic relationship.

Diguiseppe and Tafrate (2001) have provided a comprehensive treatment model for anger based on a review of available research. They noted that compared to other emotional disorders, this is a relatively less well understood and researched area. However, there is evidence from meta-analyses of the available research, that treatment can be lead to clinically significant change, although effect sizes are less than for other emotional disorders. Much of the research for anger interventions has focused on group treatment with populations that may be different from clinical populations. Diguiseppe and Tafrate (2001) have identified a number of core components of a comprehensive treatment model for anger. The components include; maintenance of a therapeutic alliance, assessing motivation to change, addressing physiological arousal, cognitive change, behavioural change and
relapse prevention. More recently, Dahlen (2007) has provided evidence for the efficacy of cognitive therapy with an individual with clinically significant anger problems.

It is of note that there was discrepancy between the difficulties identified by the referrer and those identified by Anna. Like many people referred for anger problems, she herself did not identify anger as a problem, which can prove problematic for engagement (Diguiseppe & Tafrate, 2001). A key part of the intervention with Anna was in maintaining a therapeutic alliance, and this was done by focusing the clinical work on the difficulties that she had identified. However, as discussed in the formulation, anger played an important role in maintaining the difficulties in her relationship, and so was an indirect focus of the intervention. The main therapeutic approach taken was cognitive behavioural, due to the evidence for its efficacy with anger management. The therapeutic relationship was also used to explore Anna’s possible underlying emotions, and relationship difficulties.

Following the first two assessment sessions, a further ten intervention sessions took place. Due to the risks of harm to Anna and Matt, their relationship difficulties were addressed as a priority.

The first four sessions were spent in looking at the difficulties in Anna’s relationship with Matt. The following session was a review of progress and Anna’s goals for the remaining sessions were discussed. The remaining sessions addressed difficulties in Anna’s relationship with her partner, the impact of her past, her bipolar illness, the ending of the intervention, and planning for the future. A session-by-session summary of the intervention
is provided in Appendix 10. At the beginning of each session, an agenda was agreed with Anna. The intervention was also discussed with my supervisor, and with other workers involved with Anna at two ‘Workers Meetings’.
The intervention was evaluated in a number of ways, including Anna’s report of changes she observed, changes observed in the sessions, and changes observed by others. According to Diguiseppe and Tafrate (2001), in cases where anger is the focus of the intervention, it is desirable that one of the outcomes of the intervention should be an improvement in the client’s relationships, and that this change should be observable by others.

Evaluations were made formally at a mid and end-points of the intervention. Anna was asked to report on changes that she observed in her relationship with her son, Matt, her relationship with her partner, her understanding of the impact of her past and her self-esteem. Her report was subjective and mainly qualitative, although she was also asked to numerically rate the changes on a one to ten scale.

At the mid-point of the intervention, Anna verbally reported that her relationship with her son, had improved from being ‘abysmal’ in her words, to 8/10. Based on her verbal and written reports, there appeared to be a clear qualitative improvement in her relationship with her son, Matt, that continued until the end of the sessions (see Appendix 11 – Self Help Blueprint). Her report indicated a change in her negative cognitions, her attribution of malice to Matt and her negative self appraisal of herself as a mother. Anna reported a positive change in her behavioural responses. She reported that Matt responded positively to these changes, with improvements to his emotional, cognitive and social development. In
terms of her own emotions, although his distress still aroused feelings of initial agitation, she reported she no longer felt distress or anger in these situations. In fact, she reported that she felt positive emotions towards Matt, ‘I feel bonded to him now – and I feel in love with him’. This appeared to provide evidence of a significant positive qualitative change in her relationship with Matt.

It is possible that Anna’s positive self report is subject to ‘social desirability’, however experience of working with Anna’s indicates that she is unlikely to inflate her social desirability. Also, the positive changes in Anna’s relationship with Matt, were corroborated by the observations of the CPN, during her regular home visits. She reported that Anna appeared to interact more positively with her children, appeared more relaxed and happier in their company, and that Matt also appeared less anxious. Staff involved with the children at nursery, also reported that Matt’s level of development seemed to have improved, previously there had been some concerns that he may have been developmentally delayed.

Originally, the plan from the Workers Meeting had been for psychological involvement from SureStart once our sessions had ended, to focus on attachment work. Anna was unsure whether this work needed to continue as she felt that her relationship had improved significantly. However, it was thought it would be useful for a formal assessment of Anna’s relationship to be carried out and further intervention offered if necessary.

Anna reported some improvement in her self-esteem. Her self-esteem issues were not addressed directly, but appeared to have improved indirectly as a result of her improved
self appraisal. Towards the end of the intervention, she appeared to have taken more
interest in her own physical appearance, had made plans to meet up with old friends, and to
spend time developing her own interests.

Anna reported some improvements in her relationship with her partner, Paul, at the mid-
point of the review. She identified that her previous expectations of him had been
unrealistic, and she had made some positive changes in her behaviour towards him, that had
resulted in him reacting positively. At that stage, she reported that she felt more
comfortable and affectionate towards him, but wished to improve their sexual relationship.

By the end of the intervention, it appeared that she although she had a greater
understanding of her own negative emotional responses, it was difficult to sustain positive
changes to her relationship. Anna attributed this to her partner’s own emotional problems
and his difficulty in accepting her growing self-confidence. Paul corroborated some of
Anna’s reports of improvement in their relationship, during the session he attended,
however, he was unavailable to give his view of the longer term effects on their
relationship. The longer term effects on Anna’s relationship appeared uncertain at the end
of the intervention.

Anna had an opportunity to explore her past throughout the sessions, and by the end
reported having a better understanding of its impact in terms of her current relationship
difficulties. However, from observation and Anna’s own report, it appeared that she had not
accepted the negative aspects of her past, and still continued to feel intense levels of anger
towards her mother.
Clients with anger problems can present a particular difficulty, as it can be difficult for therapists to empathise with them and hence build a therapeutic relationship. (Digiuseppe & Tafrate, 2001). Developing and sustaining a therapeutic relationship with Anna was a key, but challenging part of working with Anna. During my time with Anna, I tried to develop trust between us, facilitate ‘emotional expression’ and to show a genuine interest in her as a person. These are factors that clients report as being important in a therapeutic relationship (Bachelor et al. 2007). In Anna’s case, initially I felt disturbed when she laughed when recounting situations when she had been violent towards her partner, and when I listened to her talking about the violent thoughts that she had about her son. However, I felt that this presentation of her feelings might be a defence for her underlying vulnerability, and I tried to have a genuine empathy for her, and give her an opportunity to express all her emotions. As Anna’s trust in me appeared to grow, she appeared more able to reveal her vulnerability and it felt that our therapeutic relationship developed.

The development of the therapeutic relationship appeared to be reflected in a growing attachment between Anna and myself. At times, I was aware of feeling quite protective and maternal towards Anna, although this was something that was never explicitly discussed. It could be speculated, that given Anna’s perception of neglect by her own mother, that part of her was seeking an idealized maternal figure. For this reason, it was important to consider the imperfections and the reality of our relationship, and the fact that our
relationship would be ending. The ending of therapy is an important part of the therapeutic relationship as it involves the loss of a relationship (Lanyado & Horne, 1999). In Anna’s case, there was a possibility that it might re-evoke feelings of abandonment, and so the ending was talked about quite early on. At times it seemed that Anna was quite defended against this, saying she felt it would be okay without really allowing herself to consider the reality. By the end of the sessions, I felt that Anna was more prepared for the possible pain of the ending, and this would be an important part of the intervention, that she could survive my ‘abandonment’ without feeling unduly angry or distressed.

Working with Anna, made me reflect on the high expectations I had of my therapeutic work. Given the number of goals that Anna had, it was unrealistic to expect that we could address each of these equally well in the relatively short period of time that we had. Although we had discussed ‘realistic goals’ at the beginning of the intervention, Anna’s positive progress led me to believe that other goals would be equally achievable. It is interesting to note the parallels with Anna’s positive experiences with her first child and her high expectations of her second. By the end of the intervention, Anna seemed to have changed her expectations. The concept of the ‘good enough mother’ is widely used in therapeutic work with parents. As I came towards the end of my sessions with Anna, I felt that I had also moved in my expectations of myself as a trainee and in my therapeutic work, from unrealistically high expectations, to perhaps being ‘good enough’ myself. However, this is an area where I feel the need for further exploration and development.
References


CLINICAL PRACTICE REPORT 4

SINGLE CASE EXPERIMENTAL DESIGN

The case of Rose, a 76-year-old woman referred for difficulties related to childhood sexual abuse
Abstract

This report presents the case of Rose, a 76-year-old woman with a history of recurrent depression, who was referred for psychological input following the disclosure of childhood sexual abuse (CSA). Details of the presenting difficulties, background history, the assessment, formulation, and intervention are outlined. The case is discussed in the context of research into responses to CSA and subsequent difficulties in adulthood. Data collection is discussed in the context of clinical aims in this case. Intervention in this case was based on ‘eclectic pragmatism’ and included narrative, schema, and exploratory approaches. An AB design was used to evaluate the effectiveness of the intervention, with data collected in the assessment and intervention phases. Difficulties in the implementation of the design are discussed in the context of the realities of clinical practice. Results are presented and analysed using a variety of methods including time-series analysis and the outcomes of the intervention discussed in the light of limitations in the case design. The single case design is discussed in the context of the complexity and subjective and inter-personal nature of therapeutic work.

All names in this report have been changed to protect client confidentiality
1 Case summary

1.1 Presenting difficulties

Rose was a 76 year old woman of white British origin who was referred to the psychology service by one of the consultants in the older adult service. She had been referred because she had told the consultant that she had experienced sexual abuse as a child, and the psychiatrist felt that she lacked experience of dealing with this issue. Rose had a long history of recurrent depression.

At the first session, Rose identified that she needed to talk about this childhood sexual abuse, as she believed that it continued to have an impact on her. She had trouble sleeping at night, on average, only having two hours of sleep a night. She also experienced distressing ‘flashbacks’ of the abuse at night. Rose linked her sleep difficulties and the flashbacks to her childhood experiences of abuse. She also identified that she had feelings of guilt and worthlessness, which she attributed to the abuse.

1.2 Background information

Rose came from a large family, being the second to youngest (see Figure 1). As a child she felt that she never ‘fitted in’. Her mother would compare her unfavourably with her siblings, particularly her sisters. Rose remembers her father largely being absent and that he spent a lot of time in the pub drinking, which was something she felt ashamed about.

There were a number of traumatic deaths on her mother’s side of the family. One of her uncles died in the first world war. Rose was actually born on the day that her maternal grandfather died. As an adult, she found out that he had drowned himself. The aunt that abused her also eventually committed suicide. This aunt, who was her mother’s sister, came to live with them when Rose was twelve. At this time, most of her siblings were living away from home. At night, her mother would lock them together in a downstairs room,
which was when her aunt would sexually abuse her. On one particular occasion, Rose felt that her life was in danger and pushed her aunt away, with the result that her aunt hit her head. When Rose tried to explain what had happened, her mother refused to believe her. However, her father refused to have her aunt in the house and she was sent away to a mental institution, where she spent many years, before she committed suicide by gassing herself. Rose’s mother would visit her sister in the hospital and tell Rose that she looked skeletal with staring eyes. This was an image that haunted Rose for many years. In addition, when her aunt died, her mother told that she could not go to the funeral and that it had been her fault that the aunt had been sent away and committed suicide.

Rose married in her early twenties. She described the sexual side of her relationship as being ‘terrible’ initially. She characterised her husband as being a ‘good man’ and felt that she never deserved him. She had one son, who is now married with children. Rose described feeling inadequate as a mother. When her son was a few months old he had pneumonia and suffered a number of febrile fits. Rose recalls panicking and thinking she was responsible for his fits, believing that she had somehow contaminated him with her badness. Rose took an overdose to deal with the distress she felt. Subsequently she suffered recurrent episodes of depression and tried to kill herself on four other occasions. She was prescribed anti-depressant medication and admitted to hospital numerous times and had several courses of ECT and a leucotomy. Following this leucotomy she started to see a skeletal image during the day. Rose was seen by a number of professionals including several psychologists. She saw one psychologist over four years and through that intervention was able to identify the skeletal image as being that of her aunt.

Over the years, Rose experienced the loss of many of her siblings. Her husband also died ten years ago. Prior to his death, he went into hospital for a while, and Rose reported feeling guilty about this. Rose found the transfer into older adult services particularly difficult. She had come to regard one of the psychiatrists she had known for many years as a friend, and reported feeling angry when he discharged her
Figure 1. Family genogram
1.3 Assessment

There were two main aims of the assessment. The first was to identify the nature and severity of Rose’s difficulties. The second was to assess the therapeutic relationship between myself and Rose.

The initial clinical interview was used to assess whether we could establish a therapeutic relationship where Rose might feel safe to discuss the abuse she had experienced. Given the relatively short period of my placement, it was also important to establish what would be realistic and helpful in a limited time period. Rose’s medical notes contained a lot of useful information about events in her life and interventions that she received. Unfortunately, the psychology notes were missing and so it was difficult to gather direct information about these interventions. The information that was available seemed to indicate that Rose found the end of her longest relationship with a psychologist, quite difficult. Moreover, as already noted, she had reported difficulty with the ending of her relationship with one of her psychiatrists. In a later, session, Rose explicitly identified that she did not want to become ‘dependent’ on me. My assessment of the above information was that the therapeutic relationship with Rose needed to be carefully thought about and monitored. This was done by trying to be aware of process issues in the session, reflection in supervision and by engaging Rose in explicit discussions about the therapeutic relationship.

Rose had identified that she had sleep difficulties and was distressed by flashbacks at night. It was decided that it would be useful to gather quantitative data about these difficulties. Unfortunately, this only occurred on a systematic basis after the second session. Data about sleep and the flashbacks before the assessment and between the first two sessions were only available able through Rose’s retrospective recall. According to her report, she averaged two hours of sleep a night and had flashbacks almost every night. Data about her sleep was collected using a diary sheet which was also used to monitor her daily activities (see Appendix 12 – Activity and Sleep Monitoring Form).
After the initial session, there was enough information from the clinical interview and her medical notes to suggest that it would be useful to use psychometric measures to assess the severity of her difficulties in relation to: depression, anxiety, shame, self-esteem and the impact of trauma. These measures were used in the assessment phase, at two points in the intervention phase, and at the end of the intervention (see Appendix 13, 14,15 – Psychometric measures used)

The Depression Anxiety and Stress Scale 21 (DASS 21) (Lovibond and Lovibond, 1995) was used to assess Rose’s current emotional difficulties. The scores can be used to assess the severity and locus of somebody’s emotional difficulties and to measure changes in these difficulties. The measure that has been normed in the UK (Henry and Crawford, 2005) and validated for use with an older population (Gloster et al., 2008). Rose’s scores for depression, anxiety and stress put her in the severe to very severe range of the population. She reported a sense of hopelessness about her life, past and present. In addition, it appeared that depression had become part of her self-identity, that she was and always would be somebody who was depressed.

The Impact of Shame Scale (ISS) (Cook, 1994) and the Impact of Event Scale (IES) (Horowitz, Wilner & Alvarez, 1979) are both short self-report measures that have been widely used with people who have experienced trauma. The ISS has two sub-scales giving scores on internalised shame and on self-esteem. Rose’s scores on the ISS indicated that she had extreme levels of shame and very low self-esteem. The IES has two subscales, looking at avoidance and intrusion of the trauma, and these sub-scales can be summed to give a Total Stress Score. Rose’s scores indicated that she was experiencing high levels of avoidance and intrusion, as well as stress from her childhood trauma.

1.4 Formulation

The research suggests that childhood sexual abuse has been associated with a number of negative outcomes in adulthood, including mental health difficulties, greater risk of suicide
attempts, PTSD, difficulties in interpersonal functioning, communication and social introversion (Barker-Collo & Read, 2003). Although there is a high incidence of negative outcomes for people who have experienced CSA, the research suggests that this is not inevitable (Barker-Collo & Read, 2003). Several models have identified how various factors may moderate and mediate the response to childhood sexual abuse. Barker-Collo and Read (2003) review a number of these models and have identified a number of psychosocial factors that act as moderators or mediators of the effects of CSA. These include, abuse related factors, the social context of the abuse and individual characteristics. A number of factors appear to be associated with negative outcome, including other child abuse, closeness of the perpetrator, stigmatizing responses to disclosure, insecure attachment and use of avoidant cognitive coping strategies.

In Rose’s case, a number of factors associated with negative outcome appear to be present. Her reports of her relationship with her mother suggest the possibility of emotional neglect, and perhaps an insecure attachment. The disclosure of the abuse was met with disbelief and this response appears to have been quite stigmatizing, in that Rose felt guilty and shameful about the abuse. Rose’s background and the response to the abuse may have contributed to her forming her negative core beliefs about herself, for example, ‘I am unlovable’, ‘I am bad’, ‘I am powerless’. She also seemed to have some negative core beliefs about others and the world: ‘others are better than me’; ‘the world is dangerous’; ‘life is hopeless’.

Rose had chronic difficulties and her core beliefs were quite explicit early on. According to Padesky (1994) chronic difficulties may be maintained by maladaptive schemas, which are core beliefs that influence what a person attends to or remembers. In Rose’s case, the negative core beliefs that she developed early on in life, appear to have been maintained by her attendance to and negative attribution of stressful events in her life.

The stressful events in her life may have been a trigger for her depressive episodes. However, the attributions she made about having an episode of depression may have contributed to maintaining maladaptive schemas about herself, particularly, that she was
bad or powerless. This would likely be associated with negative affect which would make it
more likely that she would have negative cognitive biases and appraisals. This would
continue to maintain her schemas and over time, as she experienced recurrent episodes of
depression, the depression is likely to become part of her core identity, I am a depressive.

Rose’s flashbacks and her avoidance of her trauma memories were suggestive of symptoms
of PTSD. After the abuse, she coped with the trauma, by repressing her emotions and her
memory of it. When her flashbacks were triggered, she tried to cope with it by avoiding
thinking about the trauma. This avoidance of the trauma is associated with continued
anxiety and symptoms such as flashbacks and it does not allow the processing of material
associated with the trauma (Ehlers & Clark, 2000). In addition, avoiding thinking about the
trauma may have maintained her early feelings of shame and guilt and these may have
contributed to her developing a schema about being bad. Rose’s belief that she was bad
appear to have led to her isolating herself socially and emotionally from others, which in
turn would have reinforced her belief of being unlovable.
Figure 2. Formulation for the origin and maintenance of Rose’s difficulties based on Weerasekera’s (1996) integrative formulation
1.5 Intervention

There were a number of clinical aims in this case. These were to produce a formulation based on a shared understanding of how Rose’s current difficulties related to her past experiences and how they continued to be maintained, and for the intervention to reduce her emotional distress and the psychological impact of her difficulties. A flexible case formulation driven intervention is recommended when working with complex cases (Persons, 2006). In this case, the intervention reflected a ‘pragmatic eclecticism’ (Dallos, 2006, p.182) in that a variety of therapeutic approaches were used over the course of the intervention.

Guidance from NICE (2004) regarding PTSD, suggests that interventions need to focus on exposure to the traumatic experience, however it needs to be done in the context of a therapeutic relationship where the client is able to trust the clinician and feel safe emotionally. Building a trusting therapeutic relationship was a key part of the intervention in enabling Rose to talk about her traumatic experience. She was also given information about the role of avoidance in the maintenance of key symptoms traumatic responses, such as flashbacks.

From the assessment, it appeared that depression and worthlessness had become part of Rose’s identity. A narrative approach was used in the early intervention sessions to externalise Rose’s difficulties and to create a psychological distance between Rose and these problems. This was done following White’s (2007) narrative approach. This involves client and therapist having a ‘near-experience’ conversation, where the therapist suspends their expert position, in order to gain a qualitative account of the individual’s perception and relationship with their difficulties. The essence of the approach is to enable the client to understand their problems and to gain some power and distance between them and the problem. One of the ways in which Rose’s relationship with depression was changed was to explore her understanding and ability to have some control over her episodes of depression. This was done on an on-going basis throughout the intervention.
At the start of the intervention, there was evidence that Rose was experiencing considerable emotional distress and was low in mood. The psychometric measures indicated severe levels of symptoms associated with depression and anxiety. It was important to address these difficulties not just for Rose’s emotional well-being but because it would limit her ability to address other issues.

There is evidence for the effectiveness of both cognitive behavioural and psychodynamic approaches in depression in older adults, (Frazer, Christensen & Griffiths, 2005). A largely cognitive behavioural approach was taken to reduce symptoms of depression. This included using a diary to monitor mood and activity, and looking at the links between thoughts, feelings and behaviour.

As already mentioned, it appeared that Rose had a number of negative core beliefs that appeared to be maintained by her negative biases and self-appraisals. Given the long-standing nature of these a schema approach was taken looking at initially building adaptive schemas rather than trying to address maladaptive schemas. This was done by exploring evidence of being worthwhile and valued by others.

The therapeutic relationship is an important part of working with clients who have experienced CSA (Barker-Collo & Read, 2003). A key part of the intervention was to use the therapeutic relationship to look at difficulties in Rose’s interpersonal relationships and communication, this was done by being aware of and exploring dynamic processes in the therapeutic relationship. For instance, following the fourth session, there was a gap of a number of weeks, some of which was unplanned. Due to some of the issues that Rose had had in her previous professional relationships, there was concern that this might reflect difficulties in our therapeutic relationship, which could in turn have an impact on the intervention. Hence, Rose was explicitly asked whether she had concerns about therapy or our relationship. She identified that she had concerns about becoming dependent on our relationship. We discussed how we could minimise this difficulty and decided that we
would increase the time between sessions from weekly to fortnightly, and then to three weekly. As a consequence we had eight therapy sessions in total (including the assessment) over a period of four months. In later sessions, we reflected on how effectively Rose was able to draw on her own resources and support network to manage times of stress and distress. As our sessions progressed there appeared to be some evidence that Rose felt less dependent on me. Initially, she had attributed the positive changes in her mood and relationships solely to me. In later sessions, she took greater responsibility for these changes which we reflected on as being a positive indicator of the change in our relationship and her increasing sense of agency and autonomy.

The ending of therapy was also discussed explicitly on a regular basis in order to prepare Rose for this potentially difficult time. At our last session we discussed how it felt to be ending our relationship. Rose stated that although she felt sad she did not feel overwhelmed. This appeared to indicate that her attachment to the therapeutic relationship was relatively secure and that she would be able to manage its ending without becoming too distressed. At the last session, Rose was given an ending letter to act as a therapeutic resource for herself and other professionals. She was also given the option of a follow-up appointment with my supervisor in three months time. So in essence, although our therapeutic relationship had physically ended, she would be able to carry on the therapeutic work by herself and with support if needed.
In this case, an AB design was chosen as it reflected the two main stages of the therapeutic work and it would enable the effectiveness of the intervention to be evaluated. In this case, the therapeutic approaches involved modification of Rose’s beliefs and meanings that she gave to her experiences and hopefully in turn, of her emotional responses to events. The essence of such interventions is that change is internalised such that the end of therapy, i.e. withdrawal of the intervention would not be associated with a return to prior baseline state. For similar reasons, reversal of the intervention would not be possible, or ethical, in this case.

The single case design has been advocated as method of providing scientific evidence of the effectiveness of interventions with individuals in clinical practice. According to Borckardt et al. (2008) it provides a practice based alternative to research evidence based on a nomothetic approach. Among the different approaches to single case design that have been identified, case based time-series design has a long and distinguished history in psychology (Borckardt et al. 2008). The time series approach is commonly associated with an AB design with clear and distinct assessment and treatment phases. Ideally, data is collected at equal time points in the two phases and trends in the baseline data are compared to trends in the intervention phase. The hypothesis is that if intervention is effective then the trends in the data in the two phases should be different, and this may be taken as evidence of the effectiveness of the intervention. An alternative statistically based approach to evaluating the effectiveness of intervention has been proposed by Jacobson & Traux (1991) using pre and post-intervention scores to assess whether clinically significant change has occurred. One of the criticisms of testing of pre and post scores is that other effects, such as regression to the mean or maturation effects may confound treatment effect (Morley, 1994).

Morley has also discussed the usefulness of an ‘assessment evaluation funnel’ as a strategy in single cases to help the clinician to decide which measures to use with individual clients.
He provides a rationale for using both standardised and individualised measures and using them at different time intervals. For instance using standardised measures pre and post intervention and using individual target measures regularly throughout the assessment and intervention phases. Hence, this would potentially combine testing for reliable clinical change and time series approaches to single case design.

The strategy also fits in with the realities of clinical practice. The difficulties identified in the referral may not correspond to the difficulties identified following the assessment, which can make it difficult to identify the appropriate measures to use in the first session. This was the case with Rose, it was only after the first session, that I was able to decide which psychometric measures might be useful, and also to identify that she was having difficulties with sleep and flashbacks and that these might be target symptoms. Data about sleep and flashbacks was collected during the assessment and intervention phase. The data was not collected systematically during the first session; data about this period was collected retrospectively, by client self-report. In the case of sleep, this retrospective data was not used for the analysis as it was judged to be quite unreliable. Retrospective data about the flashbacks was deemed to be more reliable and used in the analysis. There were a minimum of seven time points for each phase for the sleep and flashbacks.

The case also suggested that multiple baseline measures would be useful in this instance as there were multiple inter-related difficulties. Hence, in this case the psychometric measures were used pre and post intervention in order to evaluate whether clinically significant change had taken place.

There were other limitations to the implementation of the AB design in this case. According to Morley (1994) practitioners often proceed to intervention without spending long enough in the assessment phase. In this case, after the first two sessions, there was enough information to suggest a rough formulation and early intervention plan. I felt a pressure to focus on intervention rather than continued assessment. However, this meant that the assessment phase was quite short. As a consequence, it was not possible to collect
enough data to establish trends in the psychometric measures and so a time series analysis could not be carried out on the psychometric data.

The scores on the psychometric measures during the intervention phase were also used to evaluate progress and provided information that could be used to target particular difficulties. So, for instance mid-way in the intervention, there appeared to be improvements in emotional distress as measured by the DASS, but self-esteem scores had not improved. This suggested that it would be helpful to change the focus of the intervention, and this was done and progress again monitored through changes in scores on the measures. In effect, assessment was an on-going process in this case and used to reformulate. Similarly, in this case it could be argued that some degree of intervention began right from the first session because talking about traumatic experiences is a form of exposure. In reality, assessment and intervention were not clear and distinct phases in this case, which meant the implementation of the AB design was not ideal.

The less than ideal implementation was one of a number of limitations to the experimental design of this case. Ideally, the assessment phase would have been longer to allow trends in the psychometric data to be established and for assessment to be more distinct from the intervention phase. There is a case to be made for baseline data to be collected while people on the waiting list, but this would be depend on service level action.
3 Results and analysis

Singe case research has a particular difficulty that must be recognised otherwise, one may be drawing erroneous conclusions from the results. Where the data come from a single individual, it is likely that there will be serial dependency in the data, in effect, measures are not independent, this in turn limits the statistical analyses that can be carried out on the data (Morley, 1994). Borckardt et al. (2008) argue that serial dependency is inevitable in the data generated by a single individual and unless one corrects for autocorrelation, there is a high risk of concluding that interventions are effective when they are not.

A graph representing the presence or absence of flashbacks is detailed below in Figure 3. A visual inspection of the data indicate that data in both phases are relatively stable with little variance. The start of the intervention phase is marked by a clear shift from the assessment phase. The trends and shifts in the data suggest that the intervention had an effect. Although, the graph does not show data for the whole of the intervention phase, Rose reported that she had not experienced flashbacks for the remainder of the sessions. As the change was quite clear, auto-correlations and statistical analyses were not carried out.

![Figure 3. Data for flashbacks over the assessment and intervention phases.](image)
A graph of sleep is presented below in Figure 4. Only data for week two and three are presented as data was not available for week one, and the data for four was missing so later data have not been included. In this case there is large variability in both the baseline and intervention phases, with no clear shifts or trends in the data. This is a case where visual inspection of the data does not provide clear evidence of changes between the assessment and intervention phases. In such cases, statistical methods need to be used in order to evaluate whether there are differences in the trends in the data for the two phases.

Traditional time series analyses requires a minimum of 50 data points in each phase and statistical modelling methods (Morley, 1994). In this case, these methods would not be viable. Alternative ‘bootstrapping’ statistical models are available which require fewer data points and which can correct for autocorrelation (see McKnight, McLean & Huitema, 2000).

Figure 4. Sleep data over the assessment and intervention phases
Graphical presentations of data for the DASS, IES and ISS measure are detailed below in Figures 5, 7 and 8. (For raw data see Appendix 16 – Table of psychometric data). The first data point is the pre-intervention score, and the final data point is the post-intervention data point. Although there was not enough data for a time series study, there were clear trends in the data across the three measures.

According to Jabobson and Traux (1991) there are a number of criteria that can be used to determine whether clinically significant change has taken place using pre and post-intervention scores. Criteria for assessing clinically significant change include whether the shift in scores brings the individual into the range of the non-dysfuncional population or outside the range of the dysfunctional group.

![DASS Scores Diagram](image)

**Figure 5.** Scores for the DASS-21 across the assessment and intervention phases
In this case (see Table 1 below), scores for depression and anxiety have moved out of the dysfunctional range into the non-dysfunctional range, which is suggestive of clinically significant change (see Appendix 17 - for guide to converting raw scores into percentiles and severity ratings).

<table>
<thead>
<tr>
<th></th>
<th>PRE-INTERVENTION Raw score &amp; severity range</th>
<th>POST-INTERVENTION Raw score and severity range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression score</td>
<td>19 – very severe range</td>
<td>2 – normal range</td>
</tr>
<tr>
<td>Anxiety score</td>
<td>12 – severe range</td>
<td>2 – normal range</td>
</tr>
<tr>
<td>Stress score</td>
<td>9 – mild range</td>
<td>3 – normal range</td>
</tr>
</tbody>
</table>

Table 1. - Pre and post-intervention DASS scores

![Figure 6. Scores for the IES across the assessment and intervention phases](image-url)
With regard to IES scores, Briere and Elliott (1998) report means and standard deviations for groups with a history of no trauma and those with a trauma history. Pre-intervention, Rose’s scores were above the mean for those with a history of trauma. Post-intervention scores were below the mean of scores for the no history of trauma group.

![ISS Scores Graph]

**Figure 7. ISS scores across the assessment and intervention phases**

Turner and Lee (1998) report the means and standard deviations for shame scores on the ISS. Rose’s scores on the shame scale were almost one standard deviation above the mean for a PTSD group pre-intervention. Post-intervention scores were within one standard deviation of the non-clinical population. The shift in scores is suggestive of clinically significant change on the shame scale. Although there was a considerable shift on the self esteem score, the score was still more indicative of low self esteem than positive self esteem.
5 Discussion

In many ways, this case was not ideal for the choice of a single case study, however, it is probably representative of the realities of clinical work and the difficulties of single case research in clinical practice.

As already discussed, the implementation of an AB design was not ideal in this case. There is an argument to be made, that in practice this would have been difficult to achieve given the nature of the referral, unless there was scope for collecting data before the first session. Even in this case, some of the data could not have been collected until the assessment had taken place, and the nature of the difficulties became apparent. In order to establish baseline trends in the psychometric data, data should ideally have been collected over a minimum of five weeks, which would equate to a relatively long assessment phase. This is likely to be impractical in clinical practice as being ethically dubious. In addition, there is the argument that in many clinical cases assessment and intervention phases do not proceed in a linear fashion, but can co-exist. In this case, there was a significant degree of overlap between assessment and intervention, and there is a case to be made that in complex cases, such as this, assessment, intervention and reformulation are continuous processes.

On a clinical and therapeutic level, there did seem to be some evidence of a positive outcome in a number of areas for Rose over the course of the intervention. There appeared to clear evidence of an improvement in terms of experiencing flashbacks which appears to have been associated with psychological input. Although, there appears to have been clinically significant improvement in symptoms of emotional distress and trauma related symptoms, one cannot say with certainty that it was due to the intervention. However, given that these difficulties were inter-related and the trends in the data are similar, it would be quite improbable that the trends in the data would all be in the same direction over the course of the intervention by chance. In terms of quantifiable, reliable and objective results, the case was far from ideal, which limits the ‘scientific’ validity and reliability of the conclusions that can be drawn. On a therapeutic level, a focus on data collection and
analysis feels like a reduction of the intervention and the therapeutic encounter, and particularly of Rose’s experiences. In a sense, the outcomes that have been reported and discussed here do not really reflect what was most important about the work, which was the meaning of this work for Rose. Although, both Rose and I were probably highly motivated to focus on the positive aspects of the intervention, we both subjectively felt that there was a qualitative improvement in Rose’s emotional, psychological and social well-being and functioning, and in fact we were both surprised and initially cautious and questioning of the gains made by Rose.

The process of carrying out a single case study raised a number of interesting points. In general, I found the use of measures and the collection of data useful in terms of informing my clinical practice and in evaluating the intervention. However, there seemed to be a qualitative gap between the objective data and the subjective experience, and between the single case design and the complexities of therapeutic work. The aim of the profession to be ‘scientist practitioners’ seems to demand that one attends to the former and discards the latter part of the therapeutic encounter. It also reflects a classical interpretation of science, that the world can be understood in reductionist, objective and mechanical terms. In fact, mainstream science has moved on from this paradigm to seeing the world as complex, chaotic, uncertain and one where the observer does not stand outside but is a crucial part of the system. One of the limitations of conventional single case experimental studies and nomothetic research is that they are based on simple reductionist paradigms which cannot reflect the complexity and uncertainties of the real world and the nature of inter-subjective processes. One hopes there will be growing room for research which can combine qualitative and quantitative methods, and a greater acknowledgement that therapeutic work cannot be simply be reduced to the sum of its parts, but that it is a complex and meaningful interpersonal process.
6 References


CLINICAL PRACTICE REPORT 5

CLINICAL PRESENTATION

Case study of a recidivistic arsonist with a mild learning disability

referred to a forensic service for assessment and treatment
Abstract

The case of a 38-year-old man with a mild learning disability and a history of fire setting is discussed in the context of his referral to a forensic learning disability service for assessment and treatment. The purpose, content and process of the psychology admission assessment are discussed, along with details of the psychometric measures used in this case. The results of the assessment were used to identify factors that may have contributed to the development and maintenance of the offending behaviour, and a formulation presented based on Jackson Hope & Glass’ (1987) ‘only viable option’ theory of arson.

Recommendations for treatment are made based on the formulation. Reflections are made on the assessment process in this case, and in relation to wider systemic factors, with recommendations for greater inter-disciplinary liaison in the assessment and treatment of offenders within the service.
Appendix 1 – Family genogram CPR1

Margaret

Henry

Peter

Robert
Appendix 2 – Strengths and Difficulties Questionnaire (CPR1)
Appendix 3 – Strengths and Difficulties record sheet (CPR1)
Appendix 4 – Parental Stress Index CPR1)
Appendix 5 – Parental Stress Index summary (CPR1)
Appendix 6 – Anxiety chart (CPR1)
Appendix 7 – Distress Thermometer and protocol (CPR2)
Appendix 8 – Interview schedules (CPR2)

Interview schedule – pre-pilot

1) Can you tell me what you do in your present job and how you came to be in your present job?

2) How do you define distress?

3) How do you assess distress?

4) How do you deal with patients’ distress?

5) Can you tell me about the things that help you, and the things that hinder about identifying and dealing with patient distress?

6) How do you feel about using a screening tool to assess distress with your patients?

7) What would help and what would hinder you in using a screening tool?

8) Can you tell me about your experiences of introducing change in your job?

9) What helped and what hindered introducing change?

10) How do you think other people will view this change?
Interview schedule – post-pilot

1. Can you tell me about your experiences of using the DT with your patients? 2. How and when did you use it?
3. What was useful, and was not so useful about the DT?
4. How are things different since using the DT?
5. How have your ideas and experiences of dealing with distress changed since using the DT?
6. Can you tell me about what helped and what hindered you in using the DT as a screening tool?
7. Can you tell me about how you feel about using a screening tool for distress with your patients?
8. How do you think others see you using the DT in your work?
Appendix 9 – Diary sheet (CPR3)
Appendix 10 - Summary of Session (CPR3)

Session 1. Joint assessment with supervisor:
- Clinical interviewing
- Identification of difficulties.

Session 2. Assessment:
- Engagement and development of therapeutic relationship
- Identification of triggers for difficulties, thoughts, feelings and behavioural responses
- Observation of emotional responses in session
- Risk assessment.

Session 3. Assessment and intervention:
- Engagement and therapeutic relationship
- Plan for intervention
- Plan to monitor mood and difficulties using diary
- DASS

‘Workers meeting’ – CPA review with other professionals involved with Anna.
- discussion of needs
- discussion of risk issues
- plan for input from professionals

Session 4. Intervention:
- Review of diary
- Link between thoughts, feelings and behaviour
- Continue diary monitoring

Session 5. Intervention:
- Continue monitoring and reviewing interactions
- Explore dysfunctional assumptions about self and others
- Explore impact of past

Session 6. Intervention:
- Continue monitoring and reviewing difficulties
- Changing behavioural responses
- Explore impact of past re. expectations of self and others
- Discussion of endings

Session 7. Review of progress and goals:
- Difficulties in relationship with son
- Difficulties in relationship with partner
- Revised goals and plan for future sessions

**Session 8.** Intervention:
- Exploration of impact of past on relationship difficulties
- Time line started and discussed

**Session 9.** Intervention:
- Exploration of impact of past
- Thoughts and feelings about mother using ‘empty chair’ technique

**Session 10.** Intervention:
- Joint session with partner
- Exploring difficulties in relationship
- Early warning signs monitoring re. bipolar illness

**Session 11.** Intervention:
- Exploration about thoughts and feelings about endings,
- Relapse prevention plan

‘Workers meeting’ – CPA review with other professionals involved with Anna.
- discussion of progress/changes
- identification of needs
- plan for input

**Session 12.** Review and ending letters
- Sharing of ending letters
- reflections on therapeutic relationship
- Review of progress, lans for future, and relapse prevention
  - ‘self-help blue prints

**Handover session** – joint session with trainee at SureStart
Appendix 11 – Self help blueprint (CPR3)
Appendix 12 – Activity and sleep monitoring form (CPR4)
Appendix 13 – DASS form (CPR4)
Appendix 14 – Impact of Events Scale (CPR4)
Appendix 15 – ISS form (CPR4)
### Appendix 16 – Table of psychometric data

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<thead>
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<th>TIME WEEK</th>
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Appendix 17 – Guide for converting raw DASS scores