VOLUME II: CLINICAL PRACTICE REPORTS

By

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OVERVIEW

This thesis consists of research and clinical components and is submitted as partial fulfilment of a doctorate degree in Clinical Psychology. Volume 1, the research component, comprises of a literature review, an empirical paper and a public domain paper. The systematic literature review looks at evidence linking attachment and caregiving in adult couples. The empirical paper explores the experiences of individuals with a partner diagnosed with Motor Neurone Disease (MND). Lastly, a public domain provides a summary of the empirical paper.

Volume II, the clinical component, contains clinical practice reports conducted within placements from adult, child, learning disability older adult specialities. The first report contains a behavioural and systemic formulation of a 3 year-old who was referred as her mother was having difficulties managing her behaviour. The second report describes an evaluation of the Experiences of practitioners interpreting and delivering Triple P (Positive Parenting Programme) groups in South Asian Community languages. The third report presents a single case experimental design concerning a behavioural approach to challenging behaviour displayed by a 7-year old boy with learning disabilities and autism. The fourth report is a case study of a Cognitive Behavioural approach used with a man diagnosed with Persistent Paranoid Delusional Disorder. Finally, the fifth report is an abstract of an oral case presentation of a small-scale service related project around a multiple family therapy group for adolescents with anorexia nervosa.
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VOLUME II

CPR1: PSYCHOLOGICAL MODELS ESSAY

Title: A behavioural and systemic formulation of the case of Sam aged 3 years, who was referred as her mother was having difficulties managing her behaviour

Abstract
Introduction and Assessment
Behavioural Formulation
Systemic Formulation
Discussion
References

CPR 2: SMALL SCALE SERVICE RELATED PROJECT

Title: Experiences of practitioners interpreting and delivering Triple P (Positive Parenting Programme) groups in South Asian Community languages

Abstract
Introduction
Method
Results
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Title: A Multiple family therapy group for adolescents with anorexia nervosa: A Small Scale Service Related Project

Abstract

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Title: A behavioural and systemic formulation of the case of Sam aged 3 years, who was referred as her mother was having difficulties managing her behaviour

Word Count: 4,330
ABSTRACT

This clinical practice report considers the case of Sam, a three-year-old girl, and her family, who was referred with behavioural difficulties, presenting mainly in the home environment. Sam’s mother, Kathy, was having difficulties managing aspects of Sam’s behaviour and had particular concerns around her biting herself.

The report begins with information about the referral and presenting problems. The case is formulated from two psychological perspectives. Firstly, a behavioural formulation is presented, drawing upon principles of operant conditioning, to suggest how the behavioural manifestations of boredom were developed and maintained. It is hypothesised that through a process of mutual reinforcement others within the environment interact with Sam with a consequence of maintaining her behaviour. Secondly, a systemic formulation is offered based upon the Coordinated Management of Meaning model (Cronen and Pearce, 1985), including issues around family transitions and maintaining cycles of behaviour. Limitations of both formulations are considered and discussed within the report.

(All names and identifying features have been changed to maintain confidentiality)
INTRODUCTION

Background to the Case

Referral

Sam, aged 3 years, was referred to the Child and Adolescent Mental Health Service (CAMHS) by her Health Visitor. Sam’s mother, Kathy, had raised her concerns regarding Sam’s behaviour at home and in public if Sam did not get her own way.

Sam was throwing objects across the room at her mother and at the time of the referral she had started biting herself on a daily basis. Sam had no contact with her biological father, and her mother reported that Sam had a good relationship with her partner, who she had known for eighteen months. No further information was given.

Initial Assessment

The family were sent a letter inviting them to attend at the clinical base for CAMHS. The initial assessment was conducted by a Clinical Psychologist and a Clinical Psychologist in Training. Sam, Kathy, and her partner, Calvin, attended the appointment.

Presentation

Throughout the initial assessment, Sam played with the toys in the clinic room and responded independently to basic questions about her and her family. She switched from one activity to another and did not involve Kathy or Calvin in her play. Kathy appeared slightly anxious throughout the assessment, showing some ambiguity in her responses. She explained how she did not wish to disclose any information regarding Sam’s biological father, as she felt that he was not part of their lives anymore.
**Presenting Problem**

The presenting difficulty was described by Kathy as Sam having “tantrums” when she did not get her own way. She explained how the “tantrums” had started last summer, during a period when contact with her biological father stopped and the family moved to a new area to live with Calvin. At this time, Sam was throwing objects at her mother and biting herself on a daily basis. Kathy explained how the incidents of Sam biting herself had decreased dramatically and the last incident was before Christmas. Sam was no longer throwing objects, and her “tantrums” currently consisted of screaming.

Kathy reported that Sam’s “tantrums” were particularly difficult for her and Calvin to manage when they were out in public, as they became embarrassed by her behaviour. Kathy described how they had stopped taking Sam out as much, especially to supermarkets where her tantrums appeared particularly prominent. She explained how she responded to Sam’s “tantrums” by shouting or giving in to her request after giving several verbal warnings. Kathy reported that she had a lack of confidence in her ability to manage her daughter’s difficult behaviour and described feeling guilty after shouting at her. She also stated that she separated from Sam’s biological father two years ago. Sam initially had minimum contact with her father and because this contact became inconsistent, Kathy made the decision to end it. Sam’s last contact with her father was before Christmas and her mother told her that he had gone away.

Calvin described himself as stricter than Kathy and stated that he sometimes resorted to “smacking the girls on their bottom” if they continued to disobey him after several warnings. He believed that the fact that he followed through after warning the girls that this is what he will do, meant that Sam and her sister, Noami, listened to him more than they did their mother. He also explained how his parents taught him that
children should respect adults and he believed that if Sam continued to defy him and Kathy that she would become “out of control”. Calvin’s concerns were around Sam and her sister, Naomi’s lack of self-discipline, as he described their inability to eat meals without talking, arguing, and frequently leaving the table. The children ate their meals in a separate room to Kathy and Calvin and spent their evenings playing with each other upstairs, whilst Kathy and Calvin spent some “quality” time together downstairs. These were the rules set by Calvin, and were new to the family, as they had previously spent mealtimes and evenings together.

When asked to describe Sam’s strengths and to identify her positive behaviours, both Kathy and Calvin found this difficult and consequently any positive behaviour that Sam was displaying was not being rewarded. It was evident during the assessment that Kathy and Calvin’s parenting skills needed improving and their different parenting styles also came to light. Kathy was from a white British, working class family, who believed that parents should have close, loving relationships with their children. Calvin was from a Jamaican, working class family, whose cultural beliefs around parenting were that children need strong discipline and a sense of respect and duty to all adults.

**Family Background**

Kathy described always being close to her family, especially her parents and her two sisters, who she called on a regular basis for support. Moving away to live with Calvin was the first time she had been separated from them. Kathy previously worked as a Sales Assistant, but had not worked since moving. Calvin worked as an I.T. Technician. Figure 1 below illustrates the family genogram. The nuclear family
consisted of Sam, her sister, Kathy, and Calvin. The extended family is also shown, and current family relationships are shown within the figure.

*Figure 1. Family Genogram*

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Key

Close relationship

Close relationship with some conflict
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**Figure 1. Family Genogram**

[Diagram showing family relationships with numbers and names, including relationships such as close and conflict.]
**Developmental History**

Kathy described both the pregnancy and the birth of Sam as normal. There were no developmental concerns regarding Sam’s toileting and feeding, and her health was unremarkable apart from a “left turn in her eye”. Kathy reported no concerns around her social development.

**Assessment**

The assessment of Sam’s difficulties was based upon self-report in the form of three clinical interviews, each session lasting approximately one hour. The assessment was a continual process, with Kathy and Calvin, being seen on a regular basis by a Clinical Psychologist in Training. Information for the behavioural formulation was obtained largely during assessment sessions. Information gained during the assessment is also presented within a systemic model, hypothesising the development and role of the problem for the family system. Although several aspects of Sam’s behaviour were reported by Kathy and Calvin as being problematic, the formulations will concentrate on Sam’s “tantrums” in public as this was the main concern for the family at the time of assessment.

**BEHAVIOURAL FORMULATION**

This formulation will approach the case of Sam and her family from a behavioural perspective. According to the traditional behavioural model all human behaviour is determined by learning, and symptoms are viewed as behaviour that has arisen through faulty learning. Objectivity is the central theme of behaviourism. It focuses on overt behaviour and the environment rather than subjective experiences or the internal forces that are assumed to underlie the problem (Dryden, 1996).
Several models have been represented within the behavioural perspective, but this case will be hypothesised using the theory of operant conditioning (Skinner, 1938, cited in Atkinson, Atkinson, Smith, and Bem, 1993) to explain the development and maintenance of Sam’s behavioural difficulties.

Operant Conditioning

According to Skinner’s model of Operant Conditioning (1938), individuals learn behaviours based on a trial and error process whereby they remember what behaviours elicited positive responses and which elicited negative ones. The likelihood that an action will be repeated is dependent upon its consequences and is in turn controlled by these consequences. There are four types of Operant Conditioning: Positive Reinforcement, Negative Reinforcement, Punishment, and Extinction. Both Positive and Negative Reinforcement strengthen behaviour, while both Punishment and Extinction weaken behaviour. In Positive Reinforcement, a particular behaviour is strengthened by the consequence of experiencing a desirable condition. In negative Reinforcement, a particular behaviour is strengthened by the consequence of avoiding an aversive condition. In Positive Reinforcement, a particular behaviour is strengthened by the consequence of experiencing a desirable condition. The concept of reinforcement will be used to formulate this particular case. In Punishment, a particular behaviour is weakened by the consequence of experiencing an aversive condition, whereas in Extinction, a particular behaviour is weakened by the consequence of not experiencing a desirable condition.

Table 1: Positive reinforcement of Sam’s behaviour

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Behaviour</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bored when out in public</td>
<td>Cries, screams or throws something</td>
<td>Gets attention off mother</td>
</tr>
<tr>
<td>In supermarket</td>
<td></td>
<td>Gets sweets off mother</td>
</tr>
</tbody>
</table>
Table 1 shows how the consequence of the addition of the desirable stimuli would decrease Sam’s feeling of boredom, therefore increasing the likelihood of having a “tantrum” in the future to achieve the same result.

As shown in the above examples, it appears to be the consequences undertaken by others that have lead to the reinforcement of Sam’s “tantrums”. It is therefore important to consider the role of her mother in the maintenance of the behavioural difficulties.

Patterson’s (1982) coercion hypothesis illustrates how family members get trapped into playing certain roles within conflictual situations, to such an extent that it becomes a vicious circle. Each member has a part to play in an unfolding family drama, which is often reciprocally reinforced. Developmentally within parent-child interaction, normal coercive infant behaviour, which is used to ensure that basic needs are met, can continue beyond infancy as it proves to be an effective control strategy. The parent and child become stuck in a “negative reinforcement trap” where each reinforces the others behaviour. For example, a child can stop an aversive parental command by compliance but learns that coercive behaviours such as non-compliance, and tantrums with increasing intensity may also stop the aversive parental command. The parent in turn, may negatively reinforce the child’s non-compliance and other difficult behaviours by withdrawing the command for an “easy life” and therefore not punish the difficult behaviour or may react with a coercive behaviour of their own such as yelling. The child may then respond by complying (reinforcing the yelling) or “up-the anti” by intensifying their coercive behaviour and so it goes on. Consequently, patterns become well established particularly as more “pay-offs” and control passes to the child (Patterson, 1976; Patterson and Reid, 1973).
In addition, parenting style and the effectiveness of learned child management skills plays a vital role in what a child learns. Parents who have not acquired effective parenting skills have a greater tendency to lack confidence, to be more critical, to lose their temper and resort more readily to physical punishment, to be more permissive, erratic and inconsistent, to have difficulties tracking and monitoring children’s behaviour and to be more likely to reinforce poor behaviour whilst ignoring or punishing pro-social behaviour (Sansbury and Wahler, 1992; Webster-Stratton, 1992, 1985; Patterson and Stouthamer-Loeber, 1984; Patterson, 1982). It was evident from the assessment information gained in the clinical interviews that both Kathy and Calvin were having difficulties identifying, encouraging and rewarding positive behaviours. In addition, Kathy’s lack of confidence in her ability to manage Sam’s behaviour, and Calvin’s report of resorting to smacking as a punishment for difficult behaviour were all implications that their parenting skills were likely to have influenced Sam’s behaviour.

Culturally embedded beliefs and expectations are also thought to give shape to the child rearing practices and other elements in the environmental context of the developing child (DeLoache & Gottlieb, 2000). For example, time parents spend in close physical contact with their children by holding them and soothing them with close physical contact, are both likely to reflect the customs of parents’ culture (Webb, 2001). In this case, Calvin’s cultural beliefs around the importance of having distance between parents and children meant that close physical contact was something he had not experienced with his parents. His parenting style was therefore very different to Kathy’s, who came from a very, close and loving family. It may be hypothesised that as a consequence of their conflicting parenting styles, Calvin and
Kathy were being inconsistent in their responses to Sam’s behaviour, which is a likely cause of difficult behaviour in children (Webster-Stratton, 1992).

Applied to this case, Figure 2 shows how Sam’s behaviour may have impacted on her mother’s behaviour, leading to mutual reinforcement.

**Figure 2. Mutual reinforcement of the behaviour of Sam and her mother**

Sam’s feelings of boredom manifested in terms of having a “tantrum”, which involved screaming. The consequence of this was Kathy feeling embarrassed by her daughters behaviour and giving her something that she would find desirable e.g. sweets. In response to this, Sam stopped screaming and so her behaviour was being negatively reinforced. At the same time, Kathy became less embarrassed, therefore
reinforcing her response of giving sweets. Kathy was able to identify her response to Sam’s behaviour in accordance with the above formulation. Figure 2 shows how both Sam’s behaviour and her mother’s responses have been reinforced and are consequently more likely to occur in the future. This hypothesis suggests the need for the intervention to involve Kathy.

**SYSTEMIC FORMULATION**

This formulation will approach the case of Sam and her family from a systemic perspective, where individual problems are seen as the product of family relationships. As a system, families go through lifecycle changes, but patterns and rules for interaction remain relatively stable. At times of transition, existing patterns may no longer be helpful. According to systemic theories, “symptoms” may arise due to problems in interaction and communication between people, rather than lying with the individuals (Hayes, 1997).

The hypotheses presented below are mainly based around the Milan Systemic approach. Within this school of thought, two traditions were developed, one that was largely concerned with family belief systems and the other which emphasised a social–constructionist approach to problem maintenance within systems (Carr, 2000). The most recent developments in systemic theories emphasise the social constructionist approach, focusing on the importance of language and the joint construction of understanding between family members (Dallos and Stedmon, 2006). An assumption of social-constructionist theories is that formulations are socially constructed versions of reality (Burr, 1995), which means that the following hypotheses should not be accepted as the absolute truth. Hypothesis should be viewed as speculations based on information available at the time, which continually evolve.
For Sam and her family, the termination of contact with her father and the move to a new area in order for Kathy to be with Calvin, signifies a significant transition for the system. Kathy described how she had always relied on her family for support. Moving away meant that her support network was significantly reduced, and along with having no job, she described being more dependent on Calvin for support. From this information, and the observation, it may be hypothesised that Kathy would find it difficult to challenge Calvin’s beliefs around parenting. The author was curious about the fact that Sam started biting herself around the time that the family moved house, and stopped this behaviour when contact with her biological father ceased. It may be hypothesised that Sam was finding this transition difficult and her self-injurious behaviour was a way of communicating to her mother that she did not like the change. Based on this information, Sam’s behaviour may also have been the result of something around the interaction between Sam and her biological father. Additional information around Sam’s relationship with her biological father would be required to support this speculation.

Amid transition points, habitual and repetitive patterns of behaviour allow a range of acceptable behaviours within situations. These behaviours are defined by family belief systems around interactions and definitions of relationships (Burnham, 1986). This process maintains homeostasis within family systems and during periods of change, such as the entrance of a new relationship, different ways of interaction may occur. Families may experience problems if there is a large amount of disagreement between family members. Consequently symptoms may serve to maintain homeostasis in terms of preventing change within the system (Burnham, 1986).
The termination of contact with Sam’s father may be described as a second order change, defined by Bateson (1979, cited in Burnham, 1986) as “a difference that makes a difference”. This is when changes occur to the family system due to a significant reorganisation of relationships and roles. The fact that the exit of Sam’s father and the addition of mother’s new partner to the family took place over a short period of time meant that opportunities to prepare for the transition were negligible. It may be hypothesised that the behavioural difficulties displayed by Sam may have served to delay the redefinitions of family members by preventing change within the family. The importance of the cultural contexts is a significant part of systemic theories, and for this case, the difference in cultural beliefs between Kathy and Calvin were considered. When Calvin was asked in the initial assessment what he felt the problem was, he replied: “I don’t think Kathy is strict enough with Sam and Sam needs to learn to have respect for her elders”

Calvin’s Jamaican ethnic background was believed to have a significant influence on his beliefs around parenting and are worth considering within the wider framework in which they developed. Evans and Davies (1997) pointed out that corporal punishment is a convention in Jamaican schools and is not only used as a means of discipline for misbehavior; it is very much a part of the pedagogical strategy. The dominant Caribbean parenting style is authoritarian (Baumrind, 1991) and Jamaican parents in particular, as a rule do not engage in positive verbal interaction with children, neither do they offer warm and gentle guidance and direction. Evans and Davies (1997) contended that Caribbean parents lacked the propensity to have extended conversations or to reason with their children. Evans and Davies (1997) noted that parents often complained about their children talking too much or asking too many questions, ideas reinforced by the cultural belief that
"children should be seen and not heard." Several articles have expressed the view that this authoritarian style, stems from the region's West African heritage combined with learned behavior, specifically from the brutality of slavery. These dynamics are bolstered by the religious sanction of "saving the rod and spoiling the child" (Arnold, 1982; Barrow, 1996; Leo-Rhynie, 1997). This style of parenting goes against the modern thinking on child rearing in society in general, and conflicts with Sam’s mother’s beliefs of being tentative and caring and having connectedness with children, rather than alienation.

The following hypotheses will be offered around the development and maintenance of the symptoms, based on the Coordinated Management of Meaning theory (Pearce and Cronen, 1985). The theory is based on the assumption that meaning is socially constructed hierarchically, with levels providing a context for the interpretation of others. Social meaning is believed to be entrenched within levels of context, which are formed and maintained through a recursive relationship, where higher levels have a downward influence on everyday life and lower levels may have an upward influence. Burnham simplified this model, which can be seen in figure 3.
Following the move to live with Calvin, the family suffered an unexpected transition. In today’s modern society, it is an accepted concept that parents may separate, and yet it is difficult for children to cope with a sudden exit such as the loss of a primary caregiver. At the same time as the father’s exit, there was a new addition
to the family, which is likely to bring about a reorganisation and redefining of
relationships. From the information gained from Kathy and Calvin, it is clear that his
belief that both parents should take on the role of disciplinarian has impacted greatly
upon the definition of Kathy’s role in the family. The previous family script was that
mothers care and fathers discipline, which may explain Kathy’s feelings of guilt when
attempting to chastise Sam for her behaviour. Proctor (1991) describes families as
holding contrasting beliefs, which encapsulate and maintain patterns of relationships
in the family. In order to check out problem-maintaining belief systems, the author
asked Kathy and Calvin the following question: “Do you think the problem is to do
with Sam or your different beliefs around parenting?”

In response to this question Kathy stated;

“I know I should be more strict with Sam like Calvin tells me, but I try to ignore her
and end up shouting, which makes me feel guilty and I end up giving in”

When asked to describe her childhood, Kathy described her parents as “very kind and
loving” and said;

“My mum always used to take us to the shops or the cinema as a treat at the
weekend and we all used to cuddle up and watch T.V. together at night, we’ve
always been close as a family”

In contrast, Calvin described his parents as “strict” and stated;

“They encouraged me to do well at school, but we were never allowed to sit with
them at mealtimes and they were never really there for me emotionally”

From this information, it was hypothesised that a cycle may have been occurring
whereby Kathy was trying to support Calvin in his view that children should be
alienated from parents and that parents should show authority. In response, Sam may
have been displaying difficult behaviour in order to gain the attention back from her
mother and rebel against the change. As Kathy explained after going around this loop several times her guilt made her give in, as this conflicted with her beliefs around parenting.

**Figure 4: Feedback Loop**

![Diagram showing the feedback loop between Sam and Kathy. Sam tries to get her mother's attention, feels rejected, and has a “tantrum.” Kathy ignores or shouts to show authority.]

**DISCUSSION**

**Critical Appraisal**

Although both formulations reflect the main points of concern for this family from information gathered during the assessment, it was felt that the systemic formulation best captured the complex nature of some of the difficulties this family were experiencing. However, further information around Sam’s relationship with her biological father would have filled some gaps in this formulation, as the author hypothesised that the change in this relationship may have been imperative to the development of Sam’s behavioural difficulties.

Limitations of the behavioural formulation relate to the assessment information gained. Due to the self-report nature of the assessment, the information was subjective and may have been biased. The behavioural assessment would have been improved by gathering information from ABC recordings or carrying out direct observation of Sam’s behaviour the interactions between her and others outside of the therapeutic setting. This would have provided important information around the
frequency and duration of the “tantrums” and any inconsistencies in parental responses. Psychometric assessments such as the Child Behavioural Checklist (CBCL) (Achenbach & Rescorla, 2000) would have also aided the author to carry out a functional analysis of Sam’s behaviour. The family were asked to complete ABC charts by the author, but unfortunately they did not attend any further sessions after this request. It is acknowledged that this lack of information is a threat to the validity of the formulation. It may also be argued that the behavioural formulation did not account for free will and internal influences such as moods, thoughts and feelings. The hypothesis using operant conditioning could be considered as having too narrow a focus, as the author was unable to consider the wider context of Sam’s behaviour within this framework. In light of the recent life events this family had endured and the clear cultural differences influencing conflicting beliefs around parenting, excluding these issues from any formulation would be difficult.

The systemic formulation considered Sam’s behaviour in terms of the total context of the relationship between people, actions, thoughts and external objects or people in relationship. However, this can be a drawback when families only want to address symptom relief in their family (Young, 1991). By formulating from a systemic approach, it is recognised that families are connected to multiple systems and that the formulation needs to include all of these. However, Ferch (2000) stated that systemic theories ignore or negate the responsibility of the individual. Rather than suggesting that it may be appropriate for Sam to learn that she does not always get her way and that she needs to learn to control her emotions when this occurs, the systemic formulation suggests that she is just responding to difficulties within the system. This approach implicitly removes responsibility for inappropriate behaviour from the person referred, and suggests that the systems around the person are responsible.
Within a systemic hypothesis, the position of the therapist should be considered. Jones (1993) explained the problems around producing a truly objective description, as an individual with their own perspective and history constructs the description. Consequently, it may be said that the therapist is part of that which is being observed. Through becoming part of the system, the therapist’s own scripts may be triggered (Byng-Hall, 1988). In hypothesising, it is essential to consider the therapist’s personal and professional scripts, for this may impact upon the interaction of the system within the therapeutic relationship. For example, the author’s professional script may be that parents and children should interact as much as possible in order to have a positive and loving relationship. This may have influenced the author to be less understanding of Calvin’s parenting style, which may have been detrimental to the therapeutic relationship. Through awareness of such scripts and the impact they have upon relationships between individuals within the system, a more comprehensive formulation may have been offered, acknowledging the therapist as being part of the system.

**Conclusions**

By drawing on two conceptually different models, it was possible to offer different hypotheses from the information presented by this family. Different interventions would be required for each formulation. The behavioural interpretation may lead to a goal-orientated intervention to decrease the target behaviour using behavioural techniques, and some education around parenting techniques. Whereas, the systemic approach may require an intervention to change communication patterns within the family and support the family in breaking problem-maintaining cycles. It is important to remain open to the use of different approaches to formulation, and
consider the individual needs of each family when identifying a model and intervention.

**REFERENCES**


CPR 2: SMALL SCALE SERVICE RELATED PROJECT

TITLE: Experiences of practitioners interpreting and delivering Triple P (Positive Parenting Programme) groups in South Asian Community languages

Word Count: 3,620
ABSTRACT

This small-scale service related project evaluates the experiences of practitioners interpreting and delivering Triple P (positive parenting programme) groups in South Asian Community languages. Triple P is a unique, multilevel family intervention program for the prevention and treatment of behavioural and emotional problems in children. Triple P has translated its materials into eight community languages, but this does not include South Asian. However, there is a need to provide a service to children and families in Birmingham from Black and Minority Ethnic groups (BME), many of whom speak South Asian Community languages. Semi-structured interviews were conducted with the practitioners to explore their experience of delivering the groups so far. By carrying out thematic analysis, three main themes emerged; what practitioners found helpful, their experiences of practical difficulties whilst interpreting for the groups, and their suggestions for the future. The main themes and their sub-themes are discussed. Most of the practitioners have experienced difficulties with some aspects of interpreting Triple P groups, but feel that formal translations into South Asian Community languages would improve the delivery of this programme.

(All names and identifying features have been changed to maintain confidentiality)
INTRODUCTION

The National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) issued guidance in July 2006 recommending the implementation of parenting programmes for children with conduct behaviour. There is also evidence that group programmes are more cost effective than those run on an individual basis. This guidance is formed by a comprehensive review of the research evidence to date (Scott et al. 2001; Turner & Sanders, 2006).

Triple P (Positive Parenting Programme) has been developed by Professor Matthew Sanders and his colleagues from the School of Psychology at the University of Queensland, Australia. The Triple P model draws on social learning, cognitive behaviour, and developmental theory, as well as research into risk factors associated with the social and developmental problems in children. The educative approach to promoting parental competence, considers the development of a parent’s capacity for self-regulation as a central skill. This involves teaching parents skills that enable them to become independent problem-solvers.

Triple P has the strongest empirical support of any intervention with children (Sanders, 1999, p.72). However, most of the studies have been dominated by programmes in Australia and North America, and do not include families from a wide range of ethnic backgrounds. There has been a growing recognition of the need to improve the mental health of black and minority ethnic groups and the care and treatment they receive from mental health services. The Government published Inside Outside (Department of Health, 2003) in readiness for a National Plan for Ethnicity and Mental Health (part of the Government's Modernisation Programme, outlined in the NHS Plan launched in 2000). Inside Outside recognises the need to improve the service experience and service outcomes for people from black and ethnic minorities.
who experience mental ill health, especially those coming into contact with mental health services as users or carers. It sets out three overarching strategic objectives:

- Reducing and eliminating ethnic inequalities in mental health service experience and outcome
- Developing a Mental Health Workforce that is capable of delivering effective mental health services in a multicultural context
- Enhancing and building on the capacity within black and minority ethnic communities and in the voluntary sector for dealing with mental health and mental ill health.

One of the proposals for developing a culturally capable service was ensuring language access for people who prefer a language other than English. The Positive Steps guide (Department of Health, 2007) was produced with the help of mental health care staff and community workers and offers advice and support for better responding to the needs of BME patients. The guide – which highlights good practice that already exists in the mental healthcare system - is part of the Government’s five-year action plan (Delivering Race Equality in Mental Health Care) to further improve services for these patients. The guide also incorporates key mental health issues, religious, and cultural needs for different ethnic groups, using needs for South Asian, African and Caribbean groups as examples. One of the recommendations for providing inclusive and effective mental health services to South Asian Communities is to use specially trained bilingual mental health care interpreters.

Staff from Health and Social Care and Child and Adolescent Mental Health Services (CAMHS), Primary Care, Education, Voluntary Sector, Sure Start, and Children’s Centres have all been trained in the Triple P model of parenting training. A
variety of disciplines, including Clinical Psychologists, Teachers, Health & Family Support Workers, Link Workers, and Sure Start Librarians, have been delivering the programme across Birmingham City often across agencies, with different populations at different levels of difficulty/complexity of problem.

Triple P has translated its materials into eight community languages, including Arabic, Chinese, Cambodian, Macedonian, Spanish, Somali, Turkish, and Vietnamese. However, there is a need to provide a service to children and families in Birmingham City from Black and Minority Ethnic groups (BME), whose first language is not one of the above. At Triple P steering groups across Birmingham, an increased demand for resources to be translated in South Asian languages has been highlighted. This would allow families from South Asian communities who have a language barrier, to access Triple P. In response to this need, some bilingual facilitators have translated the material themselves to carry out groups and individual work for parents who speak South Asian community languages, but this has not yet been evaluated.

Due to the fact that the interpreting element of delivering Triple P Groups in South Asian Community languages has not been assessed, a qualitative methodology was chosen in order to explore the facilitator’s experiences so far.

The aims of this project are to address the following questions:

1) What are the experiences of practitioners delivering this program in South Asian community languages?

2) Which aspects of interpreting the material were helpful and which aspects can be improved?
METHOD

Structure of the Triple P Group

It is an 8-week programme, which includes 4 group meetings; a 3-week break where parents can practise strategies at home with telephone support from facilitators and 1 more group meeting to feedback and plan for the future. The groups have around 6-8 parents in them and parents are welcome to bring someone along for support or who spends a lot of time with their child e.g. partner, other parent, friend or other family member. Each session lasts 2 hours and takes place during school time.

Sample

Seven Triple P practitioners, with experience in delivering the programme in South Asian Community languages, were interviewed. The participants were from a range of services and geographical areas around the City. The sample consisted of two Sure Start Librarians, two Link Workers, two Health and Family Support Workers and a Family Support Manager.

Design

A qualitative design was used to explore the experiences of the practitioners around interpreting the group. Nelson, Splaine, Batalden and Plume (1998) imply that although measurement is essential if changes are to be made in order to improve the quality of care, the measurements themselves must be defined pragmatically. They suggest that usefulness rather than perfection is the determining factor, and that the measurement must fit the work environment, time limitations and cost restraints. With the small number of staff involved and the time constraints of the placement, evaluation of the group in terms of client benefit or measurable changes in practice, would not have been viable.
Measures
A semi-structured interview was used to assess the practitioners’ thoughts about interpreting the group. A copy of the interview guide can be found in Appendix 3.

Procedure
Triple P Steering Groups across Birmingham City were emailed information about the project, and applicable practitioners were approached by telephone to be invited for interview. If they consented, an appointment was made to visit them at a time and place that was convenient to them. They were informed that the interview would be audiotaped and would last approximately thirty minutes. Practitioners were interviewed individually in a quiet room. Ethical implications of the project were discussed and written consent was obtained (Appendix 3). Practitioners were informed that a copy of the report would be made available to them upon completion.

Ethical considerations
Practitioners were informed that their participation in this project was entirely voluntary. Confidentiality procedures were explained. They were informed that the tape would be transcribed, and that short, anonymised, extracts would be used to demonstrate key points in the written report. It was explained that no one else would have access to the tapes, and that they would be destroyed after transcription. Participants were informed that a copy of the final report would be sent to them.
Data Analysis

The transcribed data was read and re-read to ensure familiarity with the text. Notes and initial interpretations were recorded, and then possible themes were identified. Broad themes began to emerge, and sub-themes within these themes were identified and recorded. The “strength” of the themes and sub-themes was established by recording the frequency of the particular theme within the text (Dey, 1993, p202). This was recorded as the number of individual interviews that contained the theme, and also the total frequency of the theme across all transcripts. The practitioners’ comments were also included in the analysis.

RESULTS

Theme 1: Helpful

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Frequency the sub-theme occurred across all texts</th>
<th>Number of interviews containing the sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of materials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For parents</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>• For practitioners</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Generalising from other experiences</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Preparing before the groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rehearsing scripts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>• Pre-empting difficult concepts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Using culturally sensitive examples</strong></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Simplifying the language</strong></td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 1: Sub-themes within the theme of “Helpful”
Use of Materials

Three of the practitioners explained how various materials (provided as part of the programme) were helpful for both the parents, “the tip sheets are fantastic, nice to give to parents” and themselves, “You’ve got your planned routines, for example the shopping scenario. You’ve got that, it’s all laid out. So basically you just work your way down it, explaining it in the language you’re translating it in. I think because it’s so rigidly set out, it’s quite easy to translate that”

Generalising from other experiences

One practitioner commented on how her and her colleagues use the same approach to translating for the groups as they would in their general practice, ”We just speak to them (parents) on a level that we would normally do and that seems to have worked”

Preparing before the groups

One of the practitioners explained how they found it helpful to prepare before each session, “I sort of like rehearsed what I was going to say before the parents make it in”. The same practitioner found it useful to pre-empt which words parents may find difficult to understand, “So there are a few things that I think the parents are going to ask what does that mean, so I have a word already written to say to them”.

Using culturally sensitive examples

Three of the practitioners had found it helpful to use more culturally sensitive examples in order that parents would understand the concepts better, “you’ve got to tailor it to your client, you know a lot of examples I will tailor it to the audience. It’s
still Triple P, but some of the words that I use, some of the children’s names, I make sure they’re culturally sensitive.

**Simplifying the language**

Most of the practitioners reported that, when interpreting the material, they had simplified the language to help parents understand, “sometimes you have to make it easier for the parents. There’s a tip sheet, but you still have to make it simpler, so that they can understand”. One practitioner explained how they had used pictures and symbols to help parents remember the information, “we do go through all the tip sheets, we go through all the information with them, but then, we try to whatever we leave with them, is we try to make it user-friendly. So, if they can’t read it might be picture formats or symbols or that kind of thing”

**Theme 2: Practical difficulties**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Frequency the sub-theme occurred across all texts</th>
<th>Number of interviews containing the sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers for parents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalising strategies to home</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Lack of reading/writing skills</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional explaining</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Translating the questionnaires</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Practitioners’ language skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No direct translation</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Concepts difficult to explain</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 2: Sub-themes within the theme of “practical difficulties”
**Barriers for parents**

Six of the practitioners reported that some of the strategies were difficult for parents to carry out as they were living with extended family members, who were heavily involved with the parenting, “so you’ve got aunties, uncles and grandparents in the same house and they’re doing something completely different and the parents are trying to discipline them & you get that clash. That’s a classic situation in an Asian family.” However, one of the practitioners felt that this barrier could be broken down by involving extended families in the programme, “it’s about getting the other mums in the family on board rather than saying it’s a cultural issue. It happens, so break down those barriers”.

The same practitioner suggested that culture should be taken into consideration when delivering Triple P, but that the same concepts can be applied across cultures.” There are no differences, in that it doesn’t matter which country you are from. If the child is behaving in a certain way that is unacceptable, then that needs to be addressed.”

It was a common experience that parents could speak the language, but lacked reading and writing skills, “a lot of parents can speak the language, but not all of them can write them”. Majority of the practitioners implied that they had needed to simplify the language as they were interpreting to parents due to the parents’ limited language skills, “I think it’s because of the parents’ educational background because they can speak in Urdu but they have like a limited language”

**Time**

Time was a problem for all seven practitioners as they explained how they had to spend longer explaining the material, “obviously we found it took much longer, you have to go around the bush and come back to the point again”
One practitioner described an experience of running a group with some parents who spoke English and some who only spoke a South Asian Community language, “it was too long & the other parents were getting involved, you could see them trying to cut me off, talking and saying she means this and I’d say hang on no it’s not quite that, it’s this as well as this.” Interpreting the questionnaires was something that one practitioner commented on, “it gets very time consuming, I remember my first time doing Triple P, and I spent 3 hours just adapting the questionnaire into Urdu.”

**Practitioners’ language skills**

Four practitioners explained how they couldn’t translate the material precisely, “I think it’s when you try too hard to translate as the book speaks – you can’t do that”. They also reported how they found it difficult to interpret specific terms and struggled to find the right words, “I’m very fluent in Urdu, that’s my first language, but Triple P I found a bit difficult especially specific terms. Some of the words I couldn’t find exactly In Urdu”. Three of the practitioners expressed their concerns about diverting from the manual, the thing is, we don’t want to change the main concept of Triple P, so when we are interpreting we are very careful, very conscious of this. We don’t want to give the wrong message to parents.”

The concepts of Triple P were reported by a couple of the practitioners to be too complex to explain at their level of speaking Communities languages, “I think the concepts are a little bit tricky, even though I speak Urdu and Punjabi I think to kind of grasp the concepts properly and if you want to teach it properly, you have to go to a higher level”
Theme 3: Suggestions for the future

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Frequency the sub-theme occurred across all texts</th>
<th>Number of interviews containing the sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal translations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• To help parents</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>• To help facilitators</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td><strong>Multimodal communication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Translations on audio cassettes for parents</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>• Alternatives to a written translations for practitioners</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 3: Sub-themes within the theme of “Suggestions for the future”

**Formal translations**

It was suggested by two of the practitioners that formal translations of the material would improve parents’ understanding, “the booklets are great, driving mum & dad crazy was good. It needs to be in other languages”. All seven of the practitioners reported that formal translations would help them in delivering the programme, “having translations in South Asian Community languages, I think that would help us a lot, instead of us translating every single time with the family”

**Multimodal Communication**

Producing formal translations of the programme on audiocassettes was suggested by six of the practitioners, “If the parents are not able to read, then we should have audio-cassettes in different languages”. However, three of the practitioners identified the issue of not being able to read or write South Asian Community languages, “I don’t know how the training would work for that (formal translations) because, for example, myself I can translate verbally those languages but I don’t read or write them”
DISCUSSION

The purpose of this study was to hear from practitioners interpreting Triple P groups into South Asian Community languages how they have experienced delivering these groups and how they feel the service could be improved. By carrying out thematic analysis on the interview data, three main themes were identified: what has been helpful for the practitioners, the practical difficulties they have experienced, and their suggestions for the future to improve the quality of the service. The results showed that some of these practitioners have found the Triple P tip sheets, videos and booklets helpful when interpreting, but all of them have simplified the language and used more culturally sensitive examples to help parents understand the material better. Some of the challenges these practitioners faced were around their inability to translate some of the specific terminology, and the common experience of being unable to read or write the language posed difficulties for them in delivering and for parents in understanding the material. Requiring additional time was an issue for all of the practitioners when delivering the groups, mainly resulting from the need to provide parents with more detailed explanations to support their understanding of the material. All of the practitioners felt that having formal translations in South Asian Community languages would improve the service and majority suggested that audiocassettes would be useful for those unable to read or write the language.

However, qualitative analysis has its limitations. It is important to understand and acknowledge the origins of the data i.e. the process by which the data was generated. Some researchers argue that data are not discovered, but reflect interactions with participants and judgements made by researchers (Gergen & Gergen, 1991; Guba & Lincoln, 1989; Schwandt, 1994). Brody (1992) states that researchers should disclose any preconceptions and assumptions that may have influenced the
data gathering and processing as an inherent part of the enquiry. Qualitative researchers are more likely to see bias not as something to avoid, but rather as a researcher's greatest asset. As Greene (1994) explains, "it is precisely the individual qualities of the human inquirer that are valued as indispensable to meaning construction" (p. 539).

It is important to note that I am of different ethnic and cultural origin to the practitioners in this study, and my previous experience of facilitating a Triple P group with English-speaking parents means that I had certain assumptions and expectations prior to carrying out this evaluation.

Mays & Pope (1995) claim that the analysis of qualitative data can be enhanced by organising an independent assessment of transcripts by additional skilled qualitative researchers and comparing agreement between raters. Unfortunately, involving additional researchers to assist with the analysis was not within the scope of this small-scale project. With less time restrictions, it would also have been useful to validate my findings by discussing the themes with the practitioners and ensuring that they agreed with my analysis before writing up this report.

Greenhalgh & Taylor (1997) suggest that the conclusions of qualitative studies, like those of all research, should be "grounded in evidence". Usually, this takes the form of quotations from interviews, which were included in this report. The aim of this service evaluation is to generate information upon which to base practical service delivery decisions. Berwick (1998) suggests that “in trying to improve the process of care wisdom often lies not in accumulating all of the information but in acquiring only that amount of information necessary to support taking the next step”
By interpreting Triple P groups into South Asian Community languages in order to offer this service to the families in the City of Birmingham, these practitioners are adhering to the standards set in 2006 by NICE and SCIE, recommending that parenting programmes should be provided for children with conduct behaviour. They are also working towards achieving some of the objectives of Inside Outside (Department of Health, 2003), which recognise the need to improve the service experience and service outcomes for people from black and ethnic minorities. However, this report has identified some of the challenges around interpreting Triple P into South Asian Community languages, and these need to be addressed in order to provide equality in service provision.

Conclusions

This evaluation indicates that practitioners are facing the challenges of interpreting Triple P groups with limited language skills amongst themselves and the parents. They have found the process very time consuming, but suggest that the material is best delivered to these parents using simpler language and more culturally sensitive examples. The results of this evaluation suggest that consideration of the following recommendations may assist service provision and development;

- To produce formal translations of the programme in South Asian Community languages
- To simplify the language when interpreting into South Asian Community languages
- To produce audiocassettes in South Asian languages for people who do not read or write the languages and to help pass the information on to extended family.
• To use culturally sensitive examples in the scripts
• Not to facilitate group programmes with a mixture of parents who speak fluent English and those who require interpretation.
• Further research using different methodology and including parents’ perspectives would be useful in gaining additional information around the quality of service provision.

REFERENCES


Title: A behavioural approach to challenging behaviour displayed by a client with learning disabilities

Word Count: 4,744
ABSTRACT

Tim is a 7-year-old boy with a severe learning disability and a diagnosis of autism who was referred to the community clinical psychology service for challenging behaviour at school. These behaviours consisted of hitting, head butting, pinching, and kicking others, kicking furniture and throwing himself to the floor. After carrying out an initial assessment, it was decided that the target behaviours would be hitting and kicking others, as these occurred much more frequently than the other behaviours. A behavioural intervention was implemented as a short-term management strategy. The effectiveness of the intervention upon the frequency of the target behaviours was evaluated using an A-B single case experimental design. Graphical presentation of the frequency of behaviours suggests that the intervention reduced the occurrence of these behaviours at school. Finally, the results are discussed highlighting limitations and identifying ways of improving the study.
INTRODUCTION

Background

Referral

Tim is a 7-year-old boy who was referred to the learning disability psychology service by his schoolteacher, Sarah. The referral stated that Tim had a diagnosis of autism and his behaviour was becoming increasingly aggressive at school. His teacher stated that his aggressive behaviour was difficult to manage in the classroom environment and she was hoping that psychological support would help. It also described how Tim displayed aggressive behaviour at home, but that his parents did not require any input at the moment.

Presenting problems

A psychological assessment was conducted in which Tim’s teacher, Sarah, was interviewed in order to obtain information about Tim and the difficulties he was experiencing. Sarah described a number of challenging behaviours, which Tim displayed at school. These included hitting, head butting, pinching and kicking others, kicking furniture, and throwing himself to the floor. In addition, she reported being extremely worried and stressed by these behaviours and the disruptive influence Tim’s behaviour was having at school. Tim’s behaviour is described as “challenging” to reflect the fact that such behaviour is not intrinsic to him but should be viewed as a response to environmental, social, individual and historical characteristics (Emerson, 2001). Emerson (1998) suggests that between 12-17% of those administratively defined as having an intellectual disability will display challenging behaviour.

Developmental History

Previous case notes written several months prior to this referral indicated that Tim was not toilet trained at home and wore nappies at all times. However, the head
teacher stated that Tim stayed dry at school and appeared to enjoy using the toilet, singing and clapping whilst sat on it. Parents reported that they have tried to toilet train Tim at home, but that he refused to use the toilet. It was reported in the notes that Tim had always slept approximately 6 hours and currently went to bed around 10:30pm. His health was unremarkable.

Tim’s parents stated that his first words were “all gone” at 12 months old when the toilet flushed. He has not used speech since and currently uses limited PECS and objects of reference to communicate.

Tim has a diagnosis of Autism. Previous observations in the notes indicated that he does not show interest in interacting with other children, but interacts with adults mainly to get his needs met. Tim prefers to watch DVD’s or play on the computer on his own and shows signs of being irritated if too many people are around e.g. gently pushing them away.

Clinical Interview with Teacher

Although Tim’s parents did not feel that they required input at the time of carrying out this report, they were aware of my involvement at school and gave permission for me to access information from Tim’s school files and communication book from school to home. Tim attends a school for children with learning disabilities. He does not have any siblings and currently lives at home with his mother (Kim) and his father (Frank). He has a good relationship with his grandparents, who usually see him every weekend, but contact has increased to daily since Tim’s father had a back injury 2 months previously and Tim’s mother required additional support around caring for Tim. During this time, Tim’s mother has reported to Sarah that Tim
has been spending extended periods of time on the computer while she cares for his father.

Sarah reported that the Tim had displayed some of the behaviour described above in the past, but this had increased in severity and frequency in the last 2 months. During this time, Tim had developed an “obsession” around using the computer at school and would display the behaviours mentioned above mainly after being refused access to the computer. Sarah described Tim’s behaviour partly as “attention seeking” due to the fact that his grandparents have been giving him more attention than usual at home. She also explained how she felt that Tim could not understand why he could not have access to the computer all day at school when this was currently his main activity at home. Sarah stated that Tim’s learning needs could not be met if he was allowed to sit on the computer all day and this was also not possible within the structure of the school day.

“If the behaviour is constructing a barrier to learning then we must adopt a rigorous approach to removing the barrier, so that the teacher can focus upon the learning need, rather than the behaviour difficulty.” (O’Brien 1998, P.75)

Sarah’s strategy was to allow Tim access to the computer for 10 minutes after the first activity in the morning, 10 minutes before lunch, and 10 minutes at the end of the day. Sarah also felt that sometimes Tim displayed these behaviours when he was anxious due to his routine being changed. When Tim displayed any of the above behaviours, staff removed him from the classroom and walked with him around the school corridors to calm down. Sarah stated that Tim would typically continue the behaviours for approximately 10 minutes, before crying and calming down. At this point, Tim would return to the classroom. Sarah explained how Tim’s behaviour was
extremely difficult to manage and very disruptive for the rest of the class. She also
described Tim as the most “difficult” child she has come across in her teaching career.

**ASSESSMENT**

*Functional Analysis*

Functional analysis is an assessment tool for identifying the functions served
by a particular set of behaviours for a given individual in a given set of circumstances
(Sturmey, 1996).

“…our goal must change from the elimination of problem behaviours to
understanding their function so that we can craft an intervention designed to teach a
new form of behaviour that is at least as successful in achieving the identified function
as the old, more coercive form.” (Halle, 1994)

There is evidence that good functional analysis is associated with successful
interventions for people with a learning disability challenging behaviour
(Emerson, 2001, Toogood & Timlin, 1996). Data for functional analysis may be
gathered by interview, by observation and by setting up analogue assessments to test
specific behaviour and environmental relationships (O’Neill, Horner, Albin et al.

There are some limitations of the approach. Toogood and Timlin (1996)
looked at the three approaches to functional analysis described above. There appeared
in their study to be a poor level of agreement between each of the different
approaches in relation to their understanding of the function served by the behaviour
for the person. Reliability and validity is likely to be improved by the use of multiple
The first stage in conducting a functional analysis is to clearly identify and define the behaviour to be treated (Emerson, 2001). In this case it was the behaviours reported by the teacher, which included hitting, head butting, pinching and kicking others, kicking furniture, and throwing himself to the floor. The next phase is to assess the behaviour by drawing upon measures that determine frequency, duration, setting, and possible functions the behaviour may serve. This information is then used to devise hypotheses with the final stage being to implement the intervention and assess its efficacy (Repp & Horner, 1999).

A number of methods were used to assist in the formulation of Tim’s behaviours. These included interviews with staff, Incident Reports, Behaviour Frequency Charts, Scatter plot charts and general observations. A-B-C charts are the most frequently used observational approach for challenging behaviour. The methodology involves the informant recording occurrences of a defined behaviour and describing these. Such a description would include antecedents, the behaviour itself and the consequences (Desrochers, Hile & Williams-Moseley, 1997). The school already had a system in place for Tim, which involved completing an Incident Report Form (see Appendix 1.) each time staff intervened or someone was injured when Tim displayed challenging behaviour. This included recording possible triggers, details of the incident and what happened afterwards. As the staff were familiar with this form, it was used to collect the data instead of an A-B-C chart. The results are summarised in table 1.
Table 1: Summary of results from Incident Report Forms

<table>
<thead>
<tr>
<th>Triggers (antecedents/events that trigger Tim’s challenging behaviour)</th>
<th>Details of incident (description of behaviour)</th>
<th>Following the Incident (Consequent events of Tim’s behaviour)</th>
</tr>
</thead>
</table>
| • Tim wants the computer  
• Not clear enough routine  
• Tim not wanting to participate in activity | • Incidents occur more frequently in the afternoon  
• Hitting staff/other pupils  
• Kicking staff/other pupils  
• Pinching staff  
• Kicking furniture in classroom  
• Head butting staff  
• Tim dropping himself to the floor | • Staff try to distract Tim  
• Staff talk calmly to Tim  
• Staff walk with Tim around corridors until he is calm |

Due to the frequency of Tim’s behaviour and the demands on staff, it would have been impractical for the teachers to complete an Incident Report Form for every incident. Therefore, it was felt that Behaviour Frequency charts would be useful to show the frequency of Tim’s behaviours and whether they occurred in the morning or the afternoon. The Behaviour Frequency Charts (see Appendix 3.) were completed by staff at school each time Tim displayed challenging behaviour. Baseline data was collected from Monday to Friday over two weeks.

The average number of incidents each day was 58, the most frequent behaviours were hitting and kicking others, and the frequency of the behaviours increased in the afternoons (see figure 1.)
Based on the information from the Behaviour Frequency charts, the Clinical Psychologist in Training carried out some general observations of Tim in the classroom over several afternoons.

“Observation provides us with an insight into the child, the teacher, the learning environment and the intricate and complex interaction between all three.”

(O’Brien 1998 p.76.)

After carrying out these observations, and looking for patterns in the Incident Report Forms, it appeared that Tim mainly displayed challenging behaviour when denied
access to the computer. Changes to his usual routine or not understanding what was happening next also appeared to be significant. A joint decision was made with Tim’s teacher that the target behaviours would be kicking and hitting others as these were the most frequent and therefore most disruptive to Tim’s learning.

**BEHAVIOURAL FORMULATION**

When working with people who have a learning disability and challenging behaviour, a behavioural approach is considered the most appropriate (Didden, Duker, & Korzilius, 1997). Due to Tim’s limited communication skills, a cognitive approach would have been inappropriate (Carr, 1999). Durand (1990) suggests that challenging behaviours are simply adaptive behaviours given the limitations of the environment, the unusual learning history and skills of the person. He implies that by displaying challenging behaviour, individuals are telling us that we are not meeting their needs. From the assessment information, it seemed that this was the case for Tim, so a behavioural approach was used.

The behavioural approach is based on the assumption that challenging behaviour is learned and maintained as a consequence of reinforcing responses. The fact that behaviour can be learned has been proven by early behavioural psychologists, such as Pavlov (1927 cited in Glassman, 1995). Principals of learning theories are often used to explain challenging behaviour displayed by children with autism (Richman, 2001). To explain how behaviour is learned, theorists have developed what has become known as the antecedent, behaviour, consequence sequential triad, which is used below to explain Tim’s behaviour:

**Antecedent** – Tim does not have the appropriate communication skills to get what he wants, and his favourite activity is playing on the computer.
**Behaviour** – Tim hits and kicks others.

**Consequence** – others give attention to Tim by trying to stop the behaviour and when at home, Tim is allowed on the computer. It is likely this behaviour will be repeated because it was reinforced.

This scenario demonstrates how Tim’s challenging behaviour may have developed in order to get what he wants. It appears that due to Tim’s learning disability and autism, he has not developed appropriate communication skills and has been compelled to seek what he wants in challenging ways. It is likely that this behaviour had increased in the last 2 months since Tim’s father had a back injury and Tim was allowed to spend most of his time on the computer when at home. It was not possible for Tim to have access to the computer all day at school and despite staff not giving in to him, it appeared that Tim did not have another way to communicate what he wanted. Theorists also postulate that even if the response to challenging behaviour appears to have a negative outcome for the individual, it is still reinforcing, as any attention is more reinforcing than none (McCue, 2000).

**Maintenance**

Tim’s teacher felt that his challenging behaviour was sometimes encouraged by the positive reinforcement he gained from staff engagement with him. Skinner (1950, cited in Glassman 1995) uses the theory of operant Conditioning to explain the maintenance of a particular behaviour. This theory proposes that the probability of a behaviour occurring again is directly determined by its consequences. When behaviour is followed by a favourable consequence such as attention there is an increased chance that the behaviour will occur again. This is referred to as positive reinforcement.
Relevance of Autism

Wing (1996) describes Autism as triad of impairments: impaired social interaction, lack of imaginative play, and verbal communication problems. Certain risk factors increase the likelihood of challenging behaviours. These include children with a more severe intellectual disability and additional disabilities such as autism and communication disorders (Borthwick-Duffy, 1994, Emerson, 1998). Many of these behaviours are thought to be a functional response to a challenging situation and represent the child's attempt to interact with and to control the behaviour of others (Joyce 2003; pp. 17-20).

Having difficulties in communicating and interacting with others means that school brings particular challenges for children diagnosed with an Autistic Spectrum Disorder (ASD). Make school make sense (2006), a report by the NAS, highlighted many of the difficulties faced by pupils with ASDs.

“Difficult or challenging behaviour is not a part of an autistic spectrum disorder, but it is a common reaction of pupils with these disorders, faced with a confusing world and with limited abilities to communicate their frustrations or control other people.” (Jordan and Jones, 1998)

Challenging behaviour may serve more than one function (McCue, 2000). In Tim’s case, his challenging behaviour also appeared to be triggered by changes in his routine or uncertainty around what was happening. Clements & Zarkowska (2000) explain how people classified as having Autism have difficulties understanding language, which might make the world a very unpredictable place. They state that this is likely to lead to dependence on routines, and that changes in routine, or misunderstandings of language may cause them to feel upset and display difficult behaviour. Clements & Zarkowska (2000) also suggest that problems with
understanding social information and language may lead to difficulties understanding time lapse and sequence. They report how this causes difficulties for children with an ASD in predicting what will happen when, which may lead to feelings of agitation. The A-B-C model can be used to explain this in relation to Tim’s behaviour;

Antecedent – Tim’s routine is changed or he is uncertain of what is going to happen.

Behaviour – Tim hits and kicks others

Consequence – Others try to stop the behaviour and Tim avoids dealing with something new or unexpected.

This scenario demonstrates how Tim’s challenging behaviour may have developed in avoid a difficult situation

INTERVENTION

As Tim’s parents did not wish to be involved, and Tim lacked the capacity to give consent, the importance of gaining parental consent for carrying out the intervention at school was considered. Telephone contact was made with Tim’s parents to explain the intervention and obtain their consent. Tim’s case was also discussed in clinical supervision where it was determined that the following approach would be most useful.

Time out

As part of an intervention programme, “time out” can be an effective way of reducing challenging behaviour; based on the assumption that the behaviour is maintained by the reinforcement it receives, and therefore by removing the reinforcement the behaviour will be reduced (McCue, 2000). In Tim’s case, the reinforcement appeared to be the attention of staff. Time-out appears to be a particularly effective intervention for the reduction of disruptive classroom
behaviours with male students below the age of 7, with verbal and physical aggression being the most appropriate target behaviours (Jenson, Kircher, & Vegas, 2007).

The ethical issues around using time out as part of the intervention were considered, as despite its wide acceptance as a therapeutic procedure, it has generated much controversy as an aversive procedure (Wolf, McLaughlin, & Williams, 2006). However, there is a continuum of ascending restrictiveness involved with using timeout and Harris (1985) outlined three major types: exclusionary, non-exclusionary and isolation time-out. The exclusionary and isolation types of time-out are regarded as more restrictive forms of punishment (Mayerson, 2003). Planned ignoring, which is regarded as the least restrictive technique, was chosen for Tim. This involves withholding social attention contingent upon appropriate behaviour without removing the child from the situation (Turner & Watson, 1999).

If Tim displayed either of the target behaviours (kicking or hitting others), the member of staff involved with Tim must walk away and ignore him for 3 minutes. After 3 minutes, they should approach Tim and continue with the activity.

**Positive Reinforcement**

One way of diminishing a challenging behaviour is to build up other behaviours, by deliberately reinforcing them, to compete with the target one (Carr, 1995). Carr & Collins (1992) suggest that one of the best ways of intervening with individuals with a learning disability is by using positive reinforcement. This is defined as: anything which, when it follows a behaviour, increases the likelihood of that behaviour occurring again. Used to increase appropriate skills and to teach new behaviours, it works best when given after every occurrence of the behaviour, at least at first. In addition to reducing Tim’s challenging behaviour, it was important to increase the amount of time spent focused on activities in his school timetable, other
than playing on the computer. It was decided that time on the computer would be used as a positive reinforcement for completing other tasks. Initially, Tim would be allowed access to the computer after completing each task within his timetable and the time spent doing other activities would be increased over time.

**Communication**

Sometimes a challenging behaviour appears to function in people with a learning disability as a way of 'asking' for something (Clements and Zarkowska, 2000). The introduction of the Picture Exchange Communication System (PECS) or the Treatment and Education of Autistic and related Communication Handicapped Children (TEACCH) programme for a non-verbal or verbal child with an ASD can assist communication and help alleviate some of the possible frustrations associated with challenging behaviour (Clements and Zarkowska 2000, Cumine at al 2000, Jordan and Jones 1999, Jordan and Powell 1998, Powell and Jordan 1997).

From the assessment information, it appeared that one of the functions of Tim’s behaviour was to ask for access to the computer. In such cases an effective treatment may be to teach the person to use a word or sign to ask appropriately for what they want (Durand, 1990). So if Tim is misbehaving in order to gain access to the computer, teaching him to use PECS to ask for the computer should result in a reduction of the misbehaviour. As part of the school timetable, Tim had seven slots in the day where he could choose a leisure activity of his choice. Part of the behaviour intervention was to construct a leisure board for Tim, with picture symbols for him to choose an activity during leisure time. Tim was allowed 5 symbols for the computer and once these were used, he must choose a different activity.
Providing structure and visual cues

From the assessment information, it appeared that Tim’s challenging behaviour increased when routines were changed or there was a lack of structure around activities. Clements & Zarkowska (2000) explain how providing routines, structuring and presenting information in a way that makes it easier for individuals with autism to understand will help to make the world a more predictable place. They suggest that once confusion and misunderstanding is reduced, anxiety and distress is greatly alleviated and challenging behaviours reduce.

Clements & Zarkowska (2000) also state that most people with autism work better in the visual channel. One of the main concepts of the TEACCH system is to show visually important day-to-day information, forthcoming events, behavioural and social expectations. Using a visual medium is appropriate for individuals like Tim, whose visual processing capacities may be superior to his verbal processing capacities. Visual information is also more concrete and reduces the need to hold items in memory whilst taking on more items (Clements & Zarkowska, 2000). As part of the intervention, each activity on Tim’s timetable was split into three tasks, and to inform Tim which activity was about to take place, picture symbols were used as cues. In order to help Tim understand start and end points of activities, these were removed in front of Tim after each activity had been completed and a new symbol shown to indicate the activity that was replacing it.

Finally, to help with Tim’s difficulties understanding time lapse and sequence, a sand-timer was also used as a visual cue to show how long he had for each activity.

Ensuring safety

It was agreed that if Tim’s challenging behaviour threatened to be harmful to other children he should be withdrawn to a designated area in class or if really bad
removed to another room to work 1 to 1. It was important that Tim did not see this as a reward for his behaviour; therefore as soon as he calmed down he would be returned to the classroom.

**OUTCOME EVALUATION**

Whilst the intervention was being implemented, staff at school continued to record Tim’s hitting and kicking behaviours from Monday to Friday over two weeks. The frequency of the target behaviours in both the baseline and the intervention phase are described in table 2. and shown graphically in figure 2.

<table>
<thead>
<tr>
<th>Day</th>
<th>Phase</th>
<th>Behaviours</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Hitting</td>
<td>Kicking Others</td>
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<tr>
<td>1</td>
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<td>20</td>
<td>Intervention</td>
<td>10</td>
<td>5</td>
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**Table 2. Frequency of challenging behaviours in baseline and intervention phase**
Figure 2 suggests that the target behaviours (kicking and hitting others) varied from one day to the next during the baseline stage of the A-B design. When the intervention was implemented, there was a dramatic increase in the frequency of challenging behaviour during the first week of this phase and then a reduction in the second week. In the baseline stage, the mean number of times Tim hit others was 17.5 (SD = 13.93) and the mean number of times Tim kicked others was 16.6 (SD = 12.32). In the
intervention stage the mean number of hits was 33.9 (SD = 29.43) and the mean number of kicks was 12.0 (SD = 11.92).

Due to the fact that the baseline was not stable, and Tim’s challenging behaviour dramatically increased when the intervention was initially applied, it was difficult to conclude if the reduction in the second week was an effect of the intervention or simply a random fluctuation. However, Tim’s teacher reported that his challenging behaviour had reduced enough that she felt better able to manage it. She also reported that Tim was able to focus more on activities within his school timetable and appeared to be accepting the limited number of computer sessions during leisure time. These reports imply a clinical significance, which is just as important.

Statistical analysis

In order to draw any worthwhile conclusions by carrying out statistical analysis, most statisticians recommend having between 50 and 100 data points (Glass, Wilson, & Gottman, 1974). Due to time restraints, only 20 data points were recorded in this case and therefore statistical analysis was not used. If more data had been collected, the following statistical analysis would have been appropriate. Firstly, it would be important to check for serial dependency, using a statistical procedure known as autocorrelation (see Barlow & Henderson, 1984). This analyses the data to find out if successive observations are related to one another so that proceeding observations can be used to predict succeeding ones. Once the possibility of a serial dependency in the data has been excluded, a t-test can be used to analyse the data from an A-B design. In single case research, independent t-tests can be used to compare scores from a particular measure taken in the baseline phase with scores from that same measure taken during the treatment phase. If there were serial
dependency in the data, Time Series Analysis would be appropriate, also described in Barlow & Henderson (1984). This adjusts to the specific dependency relationships among data points, and provides separate analyses for level and slope changes depending on the characteristics of the data.

**DISCUSSION**

This assessment has provided a greater understanding of Tim’s challenging behaviour. However, behavioural approaches have been criticised for being too simplistic and mechanical, inconsistently applied, too controlling and unethical, and not understood by those applying it (Lovett, 1996). The assessment information mainly consisted of Interviews with the teacher and tick charts completed by staff. This method is reliant on the knowledge base of staff, their skills in completing charts, and their skills in observation. The reasons individuals behave in certain ways in often complex and a more holistic, systematic approach may have mitigated some of these criticisms as they incorporate quality of life issues and system changes (McCue, 2000).

A weakness of the A-B design is that it does not provide a strong enough outline to prove that the intervention caused a reduction in the challenging behaviour. This weakness could have been resolved by using an A-B-A strategy in which following the baseline treatment (A) the intervention could be introduced (B) and then withdrawn (A). If after the baseline measurement the intervention led to improvement and results deteriorated once withdrawn, it could be logically concluded that the intervention was responsible for the positive change. However, the A-B-A method, which involves withdrawal of treatment, would have been unethical. In addition, it was not viable due to time constraints.
To some children with autism, the simplest way to convey their wants or needs is to scream or shout, hit out at others, throw things, bite themselves or others etc. to get attention.

“Even practitioners and researchers who do not speculate on primary causes often refer to the direct correlation between communication and language difficulties and other inappropriate behaviours, such as aggression, self-stimulation, and self injury. This emphasizes the importance of communication intervention as a primary goal in the habilitation process and suggests that many untreated aberrant behaviours are likely to show concomitant positive changes as communication improves.” (Koegel & Koegel, 1998 p.17)

Tim’s challenging behaviour invariably resulted in him achieving his needs i.e. gaining attention from staff, in attempt to gain access to the computer or to avoid situations when changes were made to his routine. Due to Tim’s limited communication skills, hitting and kicking others appeared to be a way he had learnt to get what he wanted, “Communication is a two way thing” (Waterhouse, 2000).

It is also the responsibility of others to use a common “language” when communicating with children with autism, whatever media form this may take and to have specific strategies to deal with challenging behaviour. The intervention package designed for Tim included positive reinforcement of desired behaviour, time-out to reduce the frequency of hitting and kicking, and TEACCH and PECS to provide structure and better ways of communicating. During the first week of the intervention, Tim’s target behaviours increased. This is often explained as an “extinction burst”. The person finds that the expected reinforcement is not forthcoming, so tries a repeat of the behaviour. If still there is no reinforcement the person may raise the level of the behaviour. If the reinforcement is rigorously withheld, no matter how much worse the
behaviour becomes, the behaviour should then begin to lessen, slowly at first and then more rapidly (Carr, 1995).

Tim’s teacher reported a significant reduction in Tim’s behaviour, after the initial increase, as he began to respond to the intervention package put in place. Changing behaviour is usually a long-term prospect, particularly challenging behaviour displayed by individuals with a learning disability (Mansell, 1993). Collecting more data points and carrying out statistical analysis may have drawn stronger conclusions drawn from this study. However, clinical significance should not be underestimated and it is the start of Tim’s challenging behaviour being addressed, enabling him to improve his learning and interaction with others.

REFERENCES


Title: A Cognitive Behavioural approach with a client diagnosed with Persistent Paranoid Delusional Disorder

Word Count: 4,996
ABSTRACT

Steve is a 43-year-old man with a diagnosis of Persistent Paranoid Delusional Disorder who was referred to the Clinical and Counselling Psychology Service to explore his childhood experiences in relation to his current difficulties. After carrying out an initial assessment, it was decided that the goals for treatment would be around increasing Steve’s feelings of control around his paranoid thoughts, in addition to linking childhood experiences with his current beliefs and cognitions. A Cognitive behavioural intervention was implemented alongside relapse prevention work. The effectiveness of the intervention is discussed and reflections on the work carried out.

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

Background

Referral

Steve is a 43-year-old man who was referred to the Clinical and Counselling Psychology Service by his Consultant Psychiatrist. The referral stated that Steve had a diagnosis of Persistent Paranoid Delusional Disorder and that his delusions were around people wanting to kill him. His psychiatrist reported that Steve had variable childhood experiences and felt that he would benefit from psychology input to explore these. The referral also stated that Steve had relapsed once a year in the past five years, three of which resulted in inpatient admissions to a psychiatric hospital.

Presenting problems

A psychological assessment was conducted in which Steve was interviewed in order to obtain information about the difficulties he was experiencing. Steve reported that five years ago, around the time of the onset of his “illness”, his parents died within a few months of each other along with his father-in-law. The main incident that Steve reported and linked to his illness also occurred around the same time, when a friend from his local rugby club was murdered in his sleep. According to Steve, the police arrested the man who committed the crime, and he was later found hung to death in his prison cell. Steve explained that he believed the person who instructed the murder had not been found, after hearing rumours to this effect. He reported that this was always on the back of his mind, and that he sometimes felt anxious about it. Steve explained that when he was unwell, he had paranoid thoughts around people at his local rugby club being involved with the murder and believed that these people must
be thinking the same about him. Each time Steve had been unwell, he believed that these people wanted him dead too and were a threat to him and his family.

Steve explained how he had lost his confidence and felt a completely different person to the one he was five years ago. He described himself as quite an “aggressive” person, who didn’t care what others thought. However, he currently felt unable to show any aggression and feared confrontation with others due to his concerns around raising suspicions about him amongst people at his rugby club. Steve described how he felt powerless and unable to protect his family, fearing for their safety and feeling to blame for bringing potential harm upon them by his involvement with the rugby club.

Steve reported that he had experienced an “attack” of illness every summer in the last five years and how he felt these were sudden and seemed to come out of nowhere. However, he reported feeling more “aroused” during the summer months. Steve described being withdrawn and avoiding certain situations. He described how he spent his whole time waiting for the next “attack” and that he wanted to feel more in control. He explained that his grandfather, mother, and siblings all had mental health difficulties and that he consequently believed the cause of his illness to be genetic. Steve stated that he wanted to explore his childhood to find out if it was having an impact on his current difficulties, but he felt ambiguous about whether a psychological intervention would be beneficial.

**Personal History**

Steve has two sisters and one brother, all of whom had experienced psychotic episodes as adults. Steve reported that he had a difficult childhood, due to witnessing his father physically and verbally abuse his mother from five years of age. He
reported that his father used to hit his mother repeatedly, and that he used to be kept awake at night with the sound of them arguing. Steve stated that his father worked away a lot of the time, but when he was home, it was like “walking on egg shells”, waiting for him to explode. Steve explained how he often felt humiliated by his father, and that both of his parents were very critical. He described an incident at age sixteen, when he intervened to defend his mother from his father by hitting his father in the face. After this incident, Steve reported that his father left home and his parents divorced. His mother suffered with mental health difficulties and Steve had to care for his younger brother.

At aged sixteen, Steve started playing rugby and has spent every weekend and all of the summer months each year doing fitness training. Steve described being academic at school and he worked for thirteen years as a technician and chemist for testing materials and chemicals. He also worked as a teacher in engineering. Steve currently works as a voluntary Events Organiser for charity, so that he doesn’t feel the pressure of being employed.

Steve reported that he was not having any problems sleeping; he was taking regular exercise and eating healthily. He reported no history of alcohol or substance misuse and has been taking an anti-psychotic drug (Sulpiride) on a daily basis for the last four years.

Steve explained that his main social support system consisted of his wife of twenty-two years, mother-in-law, younger sister and some close friends. His younger sister lives locally, but his other sister and brother live away. He has a 19-year-old son and a 20-year-old daughter living away at university. Steve’s parents died five years ago, his father died at the age of sixty from stomach cancer and his mother at the age of fifty-nine from coronary heart disease.
Risk assessment

Regarding risk assessment, Steve reported no suicidal ideation and has good insight into his illness when well. During past episodes of illness Steve’s paranoid persecutory delusions that people are out to kill him and his family have led to thoughts around harming these individuals. However, he has never acted on these thoughts and explained that during previous episodes of being unwell, if these people were to approach or confront him, he has been ready and willing to hurt them. During one episode, Steve has asked his wife and children to stay out of the house while he waited for these people, but has never actively sought them out.

Mental health history

Steve described how his difficulties started at age 15, when he had a “fear of something bad happening” and reported having health anxiety, frequently visiting his GP for reassurance and requesting medical investigations. Steve stated that he had two further periods of health anxiety at age 23 and age 26. He reported no further mental health difficulties until his current illness, which was diagnosed 5 years ago.

ASSESSMENT

A standard assessment was used to gain an objective measure of Steve’s difficulties, which may assist in developing a formulation and appropriate intervention. For the measurement of general psychological distress, the Symptom Checklist (SCL-90-R was used  (Derogatis, 1994). The SCL-90-R is a 90-item self-reported symptom inventory that is designed to screen for a broad range of psychological complaints (Derogatis, Lipman, & Covi, 1973). It takes 15-20 minutes to complete. Each of the 90 items is rated on a five-point Likert-type scale, ranging
from "not at all" (1) to "extremely" (5) for indication of the severity of symptoms over the past week.

Although the SCL-90-R was originally developed for psychiatric outpatients, it has been used in several settings (e.g. primary care, general population and chronic pain patients), and has proved to have good-to-excellent psychometric properties (Schmitz, Hartkamp, Kiuse, Franke, Reister, & Tress, 2000). It is also frequently used as a progress or outcome measure across clinical and research contexts (Derogatis, 1994).

The SCL-90-R instrument helps measure 9 primary symptom dimensions. The sum of all 9 subscales is the Global Severity Index (GSI), which can be used as a summary of the test, reflecting overall psychological distress at a specific point in time. It is also useful in measuring patient progress or treatment outcomes.

The raw scores are converted to standard (normalised) T scores using the norm group that is appropriate for the individual being assessed. The SCL-90-R has been successfully used as a screening measure for psychiatric disorders in a variety of non-psychiatric populations (Derogatis & DellaPietra, 1994; Derogatis & Lazarus, 1994; Dohrenwend & Dohrenwend, 1982) The operational definition for “caseness” states that if an individual has a GSI score greater than or equal to a T score of 63, or if any two primary dimension scores are greater than or equal to a T score of 63, then the individual is considered a positive risk or a case (Derogatis, 1994). This means they are at risk of having one or several of the psychiatric disorders measured within the primary symptom dimensions.
Table 1: SCL-90-R Pre-assessment Results

<table>
<thead>
<tr>
<th>Symptom Scales</th>
<th>SOM</th>
<th>O-C</th>
<th>I-S</th>
<th>DEP</th>
<th>ANX</th>
<th>HOS</th>
<th>PHOB</th>
<th>PAR</th>
<th>PSY</th>
<th>GSI</th>
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<tr>
<td>Raw</td>
<td>0.58</td>
<td>0.90</td>
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<td>0.80</td>
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<td>Caseness Criterion</td>
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**SOM** - Somatization  
**O-C** - Obsessive-Compulsive  
**I-S** - Interpersonal Sensitivity  
**DEP** - Depression  
**ANX** - Anxiety  
**HOS** - Hostility  
**PHOB** - Phobic Anxiety  
**PAR** - Paranoid Ideation  
**PSY** – Psychoticism  
**GSI** - Global Severity Index
As shown in the graph, Steve scored 63 and above on the symptom scales for Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Phobic Anxiety, and Paranoid Ideation. Based on his GSI score of 63, Steve was considered a positive risk.
CBT Model of Paranoid & Suspicious thoughts (adapted from Freeman & Garety’s model, 2006)

**EARLY EXPERIENCES**
Witnessing father physically abuse mother. Parents divorced after Steve hit father to protect mother. Critical parents. Frequently humiliated by father

**DYSFUNCTIONAL SCHEMAS FORMED**
“I am weak/powerless” “I am worthless” “I am bad” “Others can’t be trusted” “If I stand up to others, they won’t inflict harm” “Others are unpredictable”

**CRITICAL INCIDENTS**
Deaths of parents & father-in-law
Friend being murdered & uncertainty around who was involved

**ACTIVATES SCHEMAS**

- **Believing suspicions are true**
  Noticing the things that seem to confirm our suspicions and failing to notice those that don’t: the Belief confirmation bias. Failing to consider alternative explanations for events

- **Behaving as if suspicions are true**
  Adopting safety behaviours (e.g. avoiding situations) Acting differently around other people (e.g. hypervigilant) Quiet/withdrawn Questioning & analysing others verbal & non-verbal communication

- **Suspicious/paranoid thoughts**
  “Others are watching/talking about me” “Something bad is going to happen to me or my family” “Others think I’m to blame”

- **Physical symptoms**
  Disturbed sleep
  Changes in appetite
  Aches & pains
  Headaches
  Loss of sexual interest

- **Feelings**
  Anxious/scared
  Paranoid
  Depressed
  Guilty
  Low self-esteem
Importance of Early Experiences

Freeman, Freeman & Garety (2006) suggest that early experiences have a profound impact on the development of anxiety, paranoia, depression etc. and in particular, on beliefs of self-worth. Many theorists believe that early interpersonal experiences have a direct and powerful impact on the development of self-schemata (Beck, 1987, Beck & Young, 1985). Beck (1967, 1976) suggests that if early interpersonal experiences are marked by either real or imaginary losses or threats, then negative and dysfunctional schemas regarding the self, the world and the future are likely to develop.

Blatt and Zuroff (1992) suggest that dysfunctional assumptions and person-evaluations are developed in childhood, depending on the amount of attachment and autonomy the child has. They imply that children of caregivers, similar to Steve’s descriptions of his parents, who are intrusive, controlling, judgemental and punitive, seem to be critical of others and themselves and are prone to feelings of worthlessness (Blatt & Zuroff, 1992).

Steve described being frequently humiliated by his father throughout his childhood, and humiliation has been associated with numerous psychosocial problems including low self-esteem (Stamm, 1978), anxiety, (Beck & Emery, 1985), depression (Brown, Harris, & Hepworth, 1995), and paranoia (Klein, 1991b).

Critical Incidents

One way of understanding of paranoia is that such thoughts are individuals’ attempts to explain their experiences, that is, to make sense of events (Maher, 1988). The sorts of experiences that are the proximal source of evidence for persecutory delusions are external events and internal feelings. Freeman & Garety (2006) explain
how suspicious thoughts often arise in the context of emotional distress and are often preceded by stressful events mainly stress caused by deprivation, rejection, or threat. In addition, the stresses may happen against a background of previous experiences that have led to beliefs about the self (e.g. as vulnerable), others (e.g. as potentially dangerous) and the world (e.g. as bad) that make suspicious thoughts more likely (Fowler, Freeman, Smith, Kuipers, Bebbington, Bashforth, Coker, Hodgekins, Gracie, Dunn, Garety, 2006). Chadwick, Birchwood and Trower (1996) suggest that individuals are made sensitive to certain events, triggering existing negative self-evaluative beliefs and associated emotions and behaviour.

John had relapsed in the summer time every year and explained how he felt more “aroused” during these months. Freeman & Garety (2006) suggest that unusual or anomalous internal feelings often lead to delusional ideation; for example, the individual might be in a heightened state or aroused.

**Maintaining Factors**

Wells and Giannetti (1990) describe how individuals do not question the validity of their interpretations and are unaware of their errors or biases in information processing because the operation of schemata during processing is automatic and may be triggered without awareness or intent.

Beck maintains that activation of negative schemata displaces more appropriate cognitive processes and disrupts processes involved in reality testing and attaining self-objectivity. Consequently, the processing of self-relevant information is likely to be biased or inaccurate. Freeman & Garety (2006) indicate that ambiguous social information is a particularly important external factor, and is likely to be both non-verbal (e.g. facial expressions, people’s eyes, hand gestures, laughter/smiling) and verbal (e.g. snatches of conversation, shouting)
Freeman & Garety (2006) also suggest that anxiety is particularly important in the initiation of persecutory ideation due to anxiety and suspiciousness having the same cognitive theme of the anticipation of danger. They imply that anxiety is central in the interpretation of internal and external events and provides the threat theme of paranoia. During sessions, Steve found it difficult to recognise and label his emotions and showed signs of not being able to recognise physical symptoms of psychological distress.

Chadwick, Birchwood and Trower (1996) imply that people who believe they are being persecuted often take their fear and anxiety as evidence of an actual threat, rather than being part of what it is to perceive a threat. Freeman, Freeman, and Garety (2006) explain how thoughts, feelings and behaviour affect each other, maintaining vicious cycles in relation to suspicious thoughts.

Freeman, Freeman & Garety (2006), explain how, at an immediate level, attention is focused on bodily events and the individual is likely to become more hyper vigilant to the behaviour of others and the environment around them. Biased thinking causes individuals to interpret these events as a threat, and see this as evidence for confirmation of their suspicious thoughts (Freeman, Freeman & Garety, 2006). They suggest that persecutory delusions are inherently a judgement and therefore reasoning processes are of central importance. Persecutory ideas are more likely to reach a delusional intensity if there are accompanying biases in reasoning such as jumping to conclusions (Garety & Freeman, 1999), failure to consider alternative explanations (Freeman, Garety, Fowler, Kuipers, Bebbington, & Dunn, 2004) and a strong belief confirmation bias (Wason, 1960). When reasoning biases are present, individuals believe their suspicions to be certainties, and thoughts around
threat held with a conviction unwarranted by the evidence may then be considered delusional.

Steve’s difficulties recognising his biased thinking, different emotions and their relational physical symptoms, meant that he had problems recognising his early warning signs of relapse. As a consequence, Steve had been unwell for some time during each relapse before it was brought to the attention of those around him. This meant that he perceived his “illness” to come out of nowhere and this led to him feeling out of control.

**INTERVENTION**

**Session 1**

**Objectives:**

- Explain the role of a clinical psychologist and confidentiality
- Build rapport and begin to develop therapeutic relationship
- Encourage Steve to tell his story, focusing on current problems and precipitating events
- Complete a cognitive-behavioural assessment of current difficulties
- Complete a Risk Assessment

A Cognitive-behavioural assessment was carried out (see background section of this report) and it was decided that reasonable rapport should be established before asking him about his traumatic early experiences. Screening for risk and needs should be part of a routine mental health assessment (Department of Health, 2007), and this was felt to be particularly important for this case due to Steve’s paranoid delusions towards others. A structured risk assessment was carried out, as part of the initial assessment.
Session 2

Objectives:

- Continue encouraging Steve to tell his story, focusing on childhood experiences
- Complete (SCL-90-R)
- Discuss and set shared goals for treatment

During the interview process, Steve found it difficult to express his emotions and was concerned about being “out of control”. Steve’s early experiences were talked through in detail in order to assess evidence around perceived threat or loss and to identify any dysfunctional schemas. The Symptom Check-List-90-R (SCL-90-R) was completed to assess Steve’s general psychological functioning, and the last part of the session was spent discussing and identifying the following goals for treatment:

1) To feel more in control of his “illness”
2) To improve his self-confidence
3) To explore possible links between his childhood and his current difficulties

Session 3

Objectives:

- Present formulation and agree intervention
- Explain principles of Cognitive-behavioural therapy (CBT)
- Discuss early warning signs and relapse prevention
- Homework – to think about early warning signs & ask others

Using the information obtained in the previous assessment sessions, a cognitive-behavioural formulation was drawn out (see formulation section of this report) and shared with Steve, who agreed that it felt like a reasonable explanation of his current difficulties. This process was used to explain the principles of CBT, which Steve
showed signs of understanding. Due to time restrictions, a maximum of seven further sessions were offered.

A cognitive-behavioural intervention was chosen due to the fact that the concepts appeared to make sense to Steve, and it was felt that the collaborative nature of the approach would help him to regain some sense of control. There have been repeated demonstrations of the efficacy of CBT for delusions (Zimmerman, Favrod, Trieu, & Pomini, 2005, O’Connor; Stip; Pélissier; Aardema; Guay; Gaudette; Van Haaster; Robillard; Grenier; Careau; Doucet; Leblanc, 2007). Furthermore, there is some evidence that some forms of CBT may reduce relapse rates (Gumley, O’Grady, McNay, Reilly, Power, & Norrie, 2003). Finally, CBT is recommended as a first intervention if deemed suitable for the individual, by the Department of Health (2001).

Stevens and Sin (2005) discuss the implementation of an evidence-based, structured model of relapse prevention into routine clinical practice, recommending Smith's (2003) Self-Management Training Manual for individuals with psychosis as a clinical tool for working with patients who have schizophrenic-form disorders. It was felt that this would help Steve to feel more in control over his illness, which was one of his goals, and would consequently improve his self-confidence. This was discussed with Steve, and for homework he agreed to think about his early warning signs with the help of his wife and close friends, based on previous experiences of relapse.

**Session 4**

**Objectives:**

- Discuss early warning signs (using card sort exercise)
- Explore delusional and evaluative thinking
- Introduce cognitive errors and link to dysfunctional schemata
- Homework – to complete thought diary
Using the card sort exercise from Smith’s (2003) early warning signs manual, Steve was able to identify his early warning signs. During this exercise, 55 cards describing non-specific and psychotic symptoms, constituting early warning signs of psychotic relapse drawn from the empirical literature, are presented to the individual, who selects any cards describing early signs that they have experienced in the process of becoming unwell, and places them in order of onset.

Birchwood & Trower (1996) describe how thought chaining works particularly well with paranoid delusions, and may help in understanding the delusion as an attempt to defend the self from threat and prevent negative self-evaluative thinking associated with despair and guilt or shame. As recommended by Birchwood and Trower (1996), Steve’s paranoid persecutory delusions were not denied, and he was reassured that his experiences were “real” and that his interpretation of them that was being questioned. Thought chaining revealed evaluative themes and related emotions around Steve’s sense of guilt and self-blame for not preventing his father abuse his mother, and negative evaluations of others being unpredictable and critical.

Beck’s theory around cognitive errors was introduced to Steve and discussed in context of his childhood experiences and dysfunctional schemata. Steve was able to understand the link in principle and agreed to complete a thought diary around some of his paranoid thoughts for homework.

**Session 5**

**Objectives:**

- Complete Early Warning Signs Questionnaire and discuss self-monitoring
- Discuss thought diary
- Challenge cognitive errors by generating helpful (rational) statements
- Homework – to practice using helpful statements
Some studies (Subotnik & Neuchterlein, 1988, Birchwood, Hogg, Prasad, Harvey, & Bering, 1989, Jorgensen, 1998) have shown that psychotic relapse can be predicted using standardised measures of symptoms if ratings are conducted at least fortnightly. The idea of monitoring early warning signs was introduced to Steve, as a way for him to feel more in control of his illness. The Early Warning Signs Questionnaire from Smith’s (2003) manual toolkit was completed and Steve agreed to complete it in the next three sessions to obtain an average score when he is well. It was explained to Steve that, should he be concerned that he may be experiencing early signs in the future, he could complete the questionnaire again to see if the score reflects a change from usual.

Steve’s thought diary was discussed (see appendix 1), which included an example of a suspicious thought that Steve had experienced whilst at the rugby club the previous week. Steve’s cognitive errors were discussed and the following replacement rational statements were jointly developed:

1) “I’m jumping to conclusions again. There’s no way I can know what they’re thinking”

2) “Even if they believe it’s true, what can they do?”

For homework, Steve agreed to practice saying these statements to himself when he experienced similar thoughts before the next session, and to be aware of any changes in how he felt.

**Session 6**

**Objectives:**

- Complete Early Warning Signs Questionnaire
- Discuss impact of helpful statements on thoughts, feelings and behaviour
- Identify sequence of changes during relapse (using Time Line Exercise)
- Identify patterns of thoughts, feelings and behaviour during unwell phase
- Homework – to think about current coping strategies and ask others
Steve described an incident over the weekend, when he experienced suspicious thoughts whilst at the rugby club, and how he successfully used his helpful statements. He reported how this reduced his distress enough for him to stay at the rugby club for a whole day, which he has not been able to do in the last five years.

There is considerable variability between individuals in the nature and timing of their early warning signs (Birchwood, Hogg, Prasad, Harvey, & Bering, 1989) and prediction of relapse is thought to be more accurate if changes in early warning scores are evaluated against individuals’ own baseline scores rather than compared with those of other patients (Subotnik & Neuchterlein, 1988, Jorgensen, 1998). For these reasons, identifying and managing an individual’s ‘relapse signature’ (Birchwood, 1995); his or her unique pattern of early warning signs is considered most likely to indicate impending psychotic relapse.

Steve was supported in constructing a time line of significant external events, proceeding backwards in time for each previous relapse. These events may include activities, special events, weather conditions and current affairs. In addition, Steve identified vicious circles of thoughts, feelings and behaviour from his previous experiences of relapse. Steve’s finalised relapse signature is presented in Figure 3. The link between stress and relapse was discussed and Steve agreed to think about his stress triggers and current coping strategies for homework.
Figure 3. Relapse Signature

My earliest signs are:

1) Feeling as if I’m being laughed at or talked about
2) Having aches and pains
3) Feeling tense, afraid, and anxious
4) Behaving oddly for no reason
5) Being quiet and withdrawn
6) Feeling tired/lacking energy

These tend to start happening weeks prior to relapse (during the summer months)

This becomes a vicious circle:

**THOUGHTS**
“People are talking about me/laughing at me”
“I can’t trust anyone”

**SYMPTOMS**
Aches & pains
Lack of energy/tired

**FEELINGS**
Tense, afraid
Anxious

**BEHAVIOUR**
Behaving oddly for no reason
Being quiet and withdrawn

This may lead to the following:

1) Lack of interest in things
2) Feeling forgetful or “far away”
3) Feeling dissatisfied with myself
4) Feeling useless and helpless
5) Feeling depressed and low
6) Restless/unsettled sleep
7) Not feeling like eating
8) Having difficulty concentrating
9) Stop being funny
Session 7

Objectives:

- Complete Early Warning Signs Questionnaire
- Present relapse signature
- Discuss stress & current coping strategies
- Discuss unhelpful coping strategies and role in maintaining problems & identify more helpful coping strategies

Steve’s relapse signature (figure 3) was shared and discussed, and Steve felt that this summarised his experience well. There is evidence that even after the onset of early warning signs, stress management skills may be helpful in preventing psychotic relapse (McCandless-Glimcher, Smith, Peterson, & Plumlee, 1986, Hogarty, Kornblith, S., Greenwald, DiBarry, Cooley, Ulrich, Carter, & Flesher, 1997).

Steve found it difficult to identify his stress triggers, so a timeline was drawn out in the session, including his significant life events and periods of mental health difficulties mentioned in the initial assessment. Steve was able to link his episodes of health anxiety to stressful events in his life such as taking over the role of his father when his parents divorced, leaving home to get married, and changing jobs. This highlighted the importance for Steve to use additional coping strategies and monitor his early warning signs around times of change. Steve also explained that he felt stressed when there was a lack of structure or when he did not have a plan of action.

Steve’s primary coping strategy was to think about one day at a time, his main motto being “tomorrow will look after itself, worry about today”, and to deal with difficulties independently in his own mind. Steve agreed to try out some additional coping strategies, including asking others for support, and monitoring stress by recognising physical symptoms e.g. headaches, disturbed sleep, loss of...
sexual interest, lower back pain. For homework, Steve agreed to try out one of his new coping strategies by sharing his relapse signature with his wife and close friends.

Session 8

Objectives:

- Complete Early Warning Signs Questionnaire & work out average score from last 4 weeks (to use as baseline for self monitoring)
- Discuss impact of changing coping strategies for stress
- Introduce helpful strategies for coping with paranoid thoughts as they occur

Reasoning biases e.g. jumping to conclusions and failure to consider alternative explanations were explained to Steve. Based on suggestions from Freeman & Garety (2006), coping strategies were discussed, such as evidence gathering, reviewing paranoid interpretations rather than just accepting them, and focusing on what he is doing, not what he is thinking. Steve agreed to practice these skills for homework, in responding to paranoid thoughts as they occurred.

Session 9

Objectives:

- Discuss impact of using coping strategies for paranoid thoughts
- Joint session with Steve’s wife to discuss relapse prevention and her role
- Discuss referral to Community Mental Health Team (CMHT)
- Complete SCL –90-R to measure outcome

Having identified an individual's relapse signature and action plan, Birchwood, Spencer and McGovern (2000) recommend that the individual and relevant involved carers are provided with their own copies of the relapse prevention sheet and monitoring is outlined as a shared responsibility between the individual, carers and mental health services. Steve’s wife attended the session and Steve’s relapse signature
and prevention plan was discussed, including roles for others, and emergency contacts. A discharge plan was finalised, including a referral to the CMHT.

Session 10

Objectives:

- Summarise sessions
- Feedback results of SCL-90-R
- Ask for general feedback on sessions

The results of the SCL-90-R, as a standard outcome measure were discussed (see Figure 4.) and Steve was happy with the significant reduction of his reported symptoms. He stated that he felt more in control of his illness and that the most helpful aspect of the sessions had been the development of a relapse plan, which he felt reduced his anxiety. Steve reported that he felt confident in using the skills and knowledge he had acquired to help him manage his suspicious thoughts.

OUTCOME EVALUATION

Table 2: SCL-90-R Post-assessment Results

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<thead>
<tr>
<th></th>
<th>SOM</th>
<th>O-C</th>
<th>I-S</th>
<th>DEP</th>
<th>ANX</th>
<th>HOS</th>
<th>PHOB</th>
<th>PAR</th>
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<td>Raw</td>
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<td>63</td>
<td>63</td>
<td>63</td>
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</tr>
</tbody>
</table>

**Symptom Scales**
- SOM - Somatization
- O-C - Obsessive-Compulsive
- I-S - Interpersonal Sensitivity
- DEP - Depression
- ANX - Anxiety
- HOS - Hostility
- PHOB - Phobic Anxiety
- PAR - Paranoid Ideation
- PSY - Psychoticism
- GSI - Global Severity Index
As shown in the graph, all of Steve’s scores declined since completing the assessment prior to treatment, and he scored below 63 (caseness criterion) on all of the symptom scales. His score for Obsessive-Compulsive behaviour decreased from 63 to 46, his scores for Interpersonal Sensitivity decreased from 68 to 53, his scores for Depression decreased from 69 to 45, his scores for Anxiety decreased from 66 to 55, his scores for Phobic Anxiety decreased from 63 to 59, and his scores for Paranoid Ideation decreased from 64 to 53. Steve’s GSI score dropped from 63 to 45, which is no longer in the clinical range.

From the work that was carried out with Steve, there were also a number of observed outcomes. Steve showed signs of being able to link his early life
experiences to his current beliefs, thinking, and behaviour in relation to his
difficulties rather than believing he had a genetic illness. In response, Steve adopted
various alternative coping strategies e.g. recognising stressful situations and reducing
activity levels around these times, monitoring his early warning signs using an Early
Warning Signs Questionnaire, challenging unhelpful and suspicious thoughts, and
asking for support from family and friends.

In the last session, Steve reported that he felt more in control over his illness,
and it was the first summer that he had not relapsed in five years. He also explained
how he felt “back to his old self”, as he “didn’t care as much what others thought”.
This implies that Steve’s self confidence had improved, which was one of his goals
for treatment. However, due to time restrictions, there was no opportunity to complete
a follow-up session with Steve to see whether his gains were maintained. Given the
frequency of Steve’s relapses to date, he was referred to the Community Mental
Health Team (CMHT) to monitor his mental state and develop a care plan as part of
his relapse prevention action plan.

**DISCUSSION**

There appears to be a consensus that delusions are explanatory accounts of
experiences, arrived at on the basis of previous childhood and adult events,
knowledge, emotional state, memories, personality and reasoning processes (Freeman
& Garety, 2006). Five years prior to the referral, Steve experienced a number of
significant life events leading up to the development of his paranoid persecutory
delusions, and had since relapsed once a year. The main problems that he identified
were around lack of control over his illness, which consequently was having a
negative impact on his behaviour, feelings, and self-confidence.
From the initial session, it was apparent that Steve attributed his current difficulties to a genetically caused illness, which was causing him to feel out of control and hopeless about his future. However, by sharing the CBT formulation, Steve showed signs of being able to link his early life experiences to his recent significant life events and current difficulties, and engaged well with understanding the rationale behind CBT. In practice, cognitive formulations are generally understandable and easy to share with clients. However, this very attribute is open to criticism for its possible oversimplification of complex psychological dynamics (Persons, Gross, Etkin, & Madan, 1996).

The previously discussed outcomes suggest that the work with Steve brought about a number of positive changes for him, including a reported reduction in symptoms on the SCL-90-R and subjective reports of feeling more in control of his illness, and an associated increase in self-confidence.

On reflection, I found the initial few sessions challenging with Steve due to his difficulty expressing emotions and the dissonance between the way he presented in sessions and his reported symptoms in the SCL-90-R. I hypothesised that Steve needed to present himself to me as a “strong” person to avoid the dysfunctional schema of himself as “weak”, but another reason may have been that he had not yet developed an emotional vocabulary to express himself. More time exploring this and helping Steve to label his emotions may have been useful. With additional time to carry out the work with Steve, I would have spread the intervention out over more sessions as I felt that there was insufficient space to check out Steve’s understanding of the material or practice some of the techniques together in sessions.

By working with Steve, I feel that I have gained insight into some of the ways that a Paranoid Delusional Disorder may develop and be maintained, and some of the
many ways it may impact on an individual’s life. This study highlighted the importance of taking individual’s subjective experiences seriously. In Steve’s case; this appeared to assist in building a good therapeutic relationship before challenging some of his beliefs, which seemed to make his paranoid experiences less threatening, less interfering and more controllable:

“The delusional belief is not being held "in the face of evidence normally sufficient to destroy it, but is being held because of evidence powerful enough to support it"” (Maher,1974, p: 99).

REFERENCES


CPR 5: CLINICAL PRESENTATION

Title: A Multiple family therapy group for adolescents with anorexia nervosa: A
Small Scale Service Related Project
ABSTRACT

This small-scale service related project evaluated the experiences of family members participating in a multiple family therapy group (MFTG). This is a multilevel family intervention program and is an increasingly popular outpatient treatment for the management of eating disorders in adolescents. A pilot programme was carried out in Birmingham CAMHS, treating five adolescents with Anorexia Nervosa. At the start of the treatment, three of the young people were inpatients, one had been previously admitted, and one was a current referral for admission. During the treatment, two of the three inpatients were discharged and the two outpatients remained in the community. Semi-structured interviews were conducted with the families to explore their experience of participating in the group so far. By carrying out thematic analysis, four main themes emerged; Shared experience, positive impact on family relationships, Conflicting feelings of young people with anorexia, Ideas for future groups. The main themes and their sub-themes are discussed. The programme has elicited a positive response overall from the families, but the patients reported conflicting experiences.
APPENDIX 1: CPR 2 – Participant Information Sheet

Title: Experiences of facilitators interpreting and delivering Triple P groups in South Asian Community languages

Triple P Positive Parenting Programme has translated its materials into eight community languages, including Chinese, Cambodian, Macedonian, Spanish, Somali, Turkish, Arabic and Vietnamese. However, there is a need to provide a service to children and families in Birmingham from Black and Minority Ethnic groups (BME), whose first language is not one of the above. In response to this need, some bilingual facilitators have translated the material themselves to carry out groups and individual work for parents who speak South Asian community languages.

The main aims of this project are:

3) to evaluate the experience of delivering this program in South Asian community languages

4) to document the relevant issues in order to improve service delivery and consider the need for formal translations of the Triple P programme into South Asian languages

The sample will consist of 5-10 Triple P practitioners who have experience in delivering the program in a South Asian community language.

Participants will be invited to be interviewed for approximately 30 minutes and will be undertaken at their place of choice. Questions will be asked around the practical experience of interpreting a Triple P intervention e.g. which parts were easy/difficult to interpret, which parts of the program were helpful/unhelpful. The interviews will be tape-recorded, made anonymous and themes from all the interviews will be collected and the results will be reported back to practitioners and managers via the Triple P steering group.

If you are interested in participating, please contact Hayley Smith at hayley.smith@bch.nhs.uk or alternatively contact Hena Sabir at hena.sabir@bch.nhs.uk (tel: 0121 465 3829)
APPENDIX 2: CPR2 Consent Form

Title of the project: Experiences of facilitators interpreting and delivering Triple P groups in South Asian Community languages

Hayley Smith (Trainee Clinical Psychologist) Clinical Psychology Department, CAMHS, Hunters Rd Centre, Hockley, B19 1DR – Tel: 0121 4653829, hayley.smith@bch.nhs.uk

Hena Sabir (Clinical Psychologist) Clinical Psychology Department, CAMHS, Hunters Rd Centre, Hockley, B19 1DR – Tel: 0121 4653829, hena.sabir@bch.nhs.uk

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

☐ I have read and understand the information sheet

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

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

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

I therefore consent to participate in this project.

Participant’s signature………………………………………………………………………………………………………….

Date……………………
APPENDIX 3: CPR 2 - Interview Guide

1. Can you tell me about other work that you have delivered directly in community languages?

2. Tell me about your experience of interpreting Triple P?

Prompt: Which parts did you find easy/difficult to interpret?

3. What were parents’ responses to the programme?

4. What was it like interpreting the concepts of Triple P?

Prompt: were the concepts culturally appropriate?

5. Can you tell me about any issues you experienced around cultural beliefs on parenting?

6. Were there any issues around needing to divert from the manual?

Prompt: Did the sessions take longer than the recommended time?

Prompt: How did you interpret language specific to the programme e.g. “positive parenting” and “descriptive praise”.

7. Which aspects of the programme did you feel were helpful/unhelpful?

8. What do you feel would help you to improve this service?
APPENDIX 4: CPR 3 – Incident Report Form

Incident Report Number:

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<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Time</td>
</tr>
<tr>
<td>Name of staff involved</td>
<td>Date</td>
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</table>

REASONS FOR INTERVENTION

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<th>Immediate danger to self</th>
<th>Assault</th>
<th>Hitting</th>
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</thead>
<tbody>
<tr>
<td>Disruption to other pupils</td>
<td>Verbal threat</td>
<td>Head butting</td>
</tr>
<tr>
<td>Immediate danger to others</td>
<td>Self-injury</td>
<td>Hair pulling</td>
</tr>
<tr>
<td>To avoid damage to property</td>
<td>Kicking</td>
<td>Spitting</td>
</tr>
<tr>
<td>To prevent absconding</td>
<td>Biting</td>
<td>Pushing</td>
</tr>
<tr>
<td>Bullying other</td>
<td>Scratching</td>
<td>Other</td>
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Triggers:

Concise details of incident:

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<th>Yes</th>
<th>No</th>
<th>Description (If injury occurred, fill out accident form)</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>Injury to another pupil</td>
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<td></td>
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</tr>
<tr>
<td>Injury to staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damage to property</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriously disruptive behaviour</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Technique</th>
<th>Duration</th>
<th>Technique</th>
<th>Duration</th>
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<tbody>
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<td></td>
<td>Single person double elbow</td>
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</tr>
<tr>
<td>Single elbow hold</td>
<td></td>
<td>Floppy dead weight</td>
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</tr>
<tr>
<td>Double elbow hold</td>
<td></td>
<td>Handling belt</td>
<td></td>
</tr>
<tr>
<td>Wrap</td>
<td></td>
<td>Turn, gather, &amp; guide</td>
<td></td>
</tr>
<tr>
<td>Hair release</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Clothes release</td>
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### DE-ESCALATION TECHNIQUES USED:

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<td>Time out directed</td>
</tr>
<tr>
<td>Calm talking</td>
<td>Distraction</td>
<td>Other staff used</td>
</tr>
<tr>
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<td>Non-verbal communication</td>
<td>Other (specify)</td>
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</table>

### FOLLOWING THE INCIDENT:

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### REPORTED TO:

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<th>No</th>
<th>Date</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/carers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Protection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other additional information/external factors

**Evaluation**

Signed by those staff involved (and present for the content of this form, for single incidents)

Signature……………………………… Printed……………………….

Date………………..

Witness ……………………………… Printed……………………….

Date………………..
### APPENDIX 5: CPR 3 – Behaviour Frequency Chart

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
</tr>
<tr>
<td>Hitting others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pinching others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kicking others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kicking furniture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head butting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dropping to the floor</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## APPENDIX 6: CPR 4 – Daily Record of Thoughts and Feelings

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20/07/08</td>
<td>Paranoid (90)</td>
<td>I was at the rugby club, socialising after a match, and some of the lads walked off to the bar and didn’t invite me over. They were talking and looking over at me, whilst laughing. I thought they were laughing at me.</td>
<td>As they didn’t invite me over, I thought they were talking about my mate’s murder and whether I was involved. I thought that they wanted something to happen to me and they were laughing because I wouldn’t know it was coming. I had images of them attacking me and my family. (90)</td>
<td>I felt anxious and didn’t want them to see, so I left the bar and went home.</td>
</tr>
</tbody>
</table>