Volume II: Clinical Practice Reports

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Overview

This work was completed as part of a three year Doctorate in Clinical Psychology at the University of Birmingham, UK. This thesis is in two volumes. Volume one consists of the research component and the second represents the clinical work conducted on placements within the NHS.

Volume I consists of three papers. Paper one is a critical review of the current literature regarding instruments used to measure relationship quality between a spousal couple when one of the couple has a diagnosis of dementia. Paper two presents the construction and validation of a new measure: The Birmingham Relationship Continuity Measure (BRCM). The final paper of Volume I is an executive summary of the main research findings.

Volume II includes five clinical practice reports. The first report presents the case of ‘Mia’, who was experiencing low mood. Mia’s problems were formulated from both a cognitive and psychodynamic framework. The second report is a single case experimental design, investigating the effectiveness of Cognitive Behavioral Therapy used with a 35 year old man experiencing Obsessive Compulsive Disorder. Report three is an evaluation of a Child and Adolescents Mental Health Services use of outcome measures. The service was evaluated inline with government policy and recommendations made as to how the service could improve the completion of the necessary outcome measures. The final written report is a case study of the work conducted with ‘Kate’ an older person with anxiety. The fifth clinical practice report is presented here in the form of an abstract, and describes the presentation of a commissioning report for a new service supporting parents with Learning Disabilities.
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This paper considers the case of Mia\(^1\). She is a 44-year-old woman who was referred to psychological services via the Community Mental Health Team (CMHT)’s Consultant Psychiatrist. Her presenting problems were labelled as anxiety and depression. The client’s background information is presented as well as her current difficulties. The type of assessment conducted is discussed as well as the formulation of Mia’s problems from both a Psychodynamic (Malan, 1979) and Cognitive Behavioural perspective (Beck, 1967, 1976). Reasons for the development and maintenance of her problems are also explored from both perspectives and formulations are reflected upon.

\(^1\) In the interest of confidentiality the name of the client and those of related persons have been changed
Presenting Difficulty

The referral was received via the CMHT’s Psychiatrist. He felt that Mia was presenting with an ‘adjustment disorder of a depressive nature’ due to her marital difficulties. She was taking an anti depressant and the referrer thought it would be beneficial for her to talk through her difficulties. On meeting with Mia she described her main difficulties as depression and an inconsistency in her mood. Her main aim in therapy was to work at making her mood stable. She felt that the marital difficulties were a catalyst for seeking help but she had been experiencing depression for the majority of her adult life.

Mia is a 44-year-old married woman with two children. At the time of the referral her marriage of 25 years had broken down and her husband had filed for divorce. Mia found this difficult to understand as it had been her husband who had been unfaithful. Her husband’s family were also becoming less supportive and blamed her mental health difficulties for the relationship breakdown. She also felt abandoned by her son (James) who had recently had a baby whom her son’s partner would not allow her to see. Mia believed that this was due to an earlier dispute between her son’s partner and Mia’s estranged husband. This had left Mia and her 18-year-old daughter, Lucy, as the only members of the family living in the family home.
Background Information

Family

*Figure 1. Geneogram of Mia’s family: illustrating family relationships.*

Employment History

Due to her mental health difficulties Mia has found it difficult holding down a full-time job. During her marriage her husband was also earning enough to cover the family’s finances without Mia working. Thus Mia described herself as a housewife. She is currently receiving incapacity benefit and had a high level of anxiety about going back to work, as she believes she would not fit in. Mia had previously worked in a local supermarket before her children were born.
Assessment

For the purpose of assessment the psychology and counselling service offers an outpatient screening appointment from a clinical psychologist to assess potential clients. This typically takes the form of a clinical interview. Following this screening appointment if a client is thought to be suitable for psychological therapy, they are placed on a waiting list for treatment; at the time that Mia was screened the waiting list was two months long.

I had observed Mia’s screening assessment and, therefore, knew that she was likely to be “robust” enough to deal with psychological therapy. She was able to talk about her problems with relative ease, and began to make links between her past and current life through interpretations made by the therapist (Orlinsky & Howard, 1986). As she had been waiting for two months for one-to-one therapy I began our session together as a first encounter. I thought that this approach would give us the opportunity to build rapport. The assessment of Mia’s presenting difficulties was conducted over four sessions.

As this is a predominately psychodynamic placement the assessment method I used was a clinical interview, which has less structure than a behavioural interview (Bateman & Holmes, 1995). Winnicott (1965) describes this process as an ‘extended history taking’. Hinshelwood (1991) suggests that the aim of the psychodynamic assessment interview is to develop a formulation that can be used in the early stages of treatment. I thought that this method of assessment would be beneficial to Mia as it would give her freedom to express her feelings about her presenting problem and hopefully allow her to feel understood as an individual. The advantage of this method
of assessment is that you can ‘make interpretation’ and this can remove resistance in the therapeutic relationship, if the correct interpretation is made (Malan, 1979). The disadvantage is however that making the wrong interpretation could result in lack of engagement from the client. Using an interview as an assessment tool also allows the therapist to be “active” and “encouraging” which can help the client disclose information (Menninger, 1958).

This method of assessment worked for Mia as it allowed her to move away from giving defensive answers. Mia had reported being a passive easily-led person and, therefore, I wanted her to lead the initial sessions and set her own agenda. Menninger (1958) suggests that the therapist needs to get the “ball rolling” in therapy due to the client’s initial anxiety of coming to therapy. However the initiative should be given back to the client once this anxiety has reduced.

Risk

Mia had talked about suicide in the past and had made plans, however, has never attempted to kill herself. Her risk was assessed in each session and was measured using clinical judgement. She reported no substance or alcohol misuse.

Clinical Interview

Family and background history

Mia is the eldest of two sisters. She lived with her sister, mother and father up to the age of 12 when her father passed away. Mia described this as a shock as she had not known that her father was ill, as her mother had kept his terminal cancer from her, and she was subsequently unprepared for his death. Mia described her relationship with
her father as a close one. Mia also described her mother as not coping with the death of her father at the time and since then the house became a “time warp” to his memory. Mia’s mother had also lost her mother and father a year prior to the death of Mia’s father and is to this day, according to Mia, suffering with unresolved grief.

Mia described her current relationship with her mother as difficult as her mother will not accept professional help in the home and Mia has the responsibility of caring for her mother due to a recent hip replaced. Mia described feeling frustrated that she responds to her mother’s demands and feels “pathetic” for not being able to be more assertive. She also expressed feelings of guilt for not being a “good enough” daughter. Mia gave the example of her mother being advised to have a mole checked at hospital for possible cancer; however, she refused to go as she wanted to die so she can be with Mia’s Dad again. This made Mia feel unloved and isolated which are feelings she remembers experiencing at the death of her father. Mia reported an unloving relationship with her mother and Mia had to look after herself and her sister. Mia’s sister never had this responsibility as she has been physically unwell for the majority of her adult life. Mia stated that she had to be the “peace keeper” to protect her sister from getting stressed, as she has recently had a third heart attack and suffers with Lupus.

**Schooling**

While Mia was at 6th form College she described herself as shy with a small number of close friends. It was at college that she met her now estranged husband “Thomas”. She described their relationship as “moving quickly” as Mia wanted to get out of the family home and she saw marrying Thomas as “her chance” to do this. She reported
that prior to them getting married she had discovered that Thomas was having an affair with a woman the same age as his mother. She decided to forgive him and married him regardless of this. Mia changed her feeling about this decision; she sometimes thinks she was right to marry him and other time thinks it was the biggest mistake of her life. She finds her changeability difficult to understand and the lack of control distresses her, especially in sessions when Mia would become tearful. Initial hypotheses for Mia feeling ambiguity regarding her marriage could be due to her feeling that she could have prevented the strong negative feeling she was experiencing in the here-and-now if she had not married Thomas.

Development of presenting problem

Mia discussed a long history of depression and how this really began to affect her after the birth of her children. She reported symptoms of increased pain, poor concentration, inconsistent sleep, irritability and low mood. She reported being overwhelmed by motherhood and feeling ‘not good enough’. She was able to find support in Thomas’ Grandad and enjoyed a close father - daughter like relationship with him. Thus when he died ten years ago she felt as if she would not be able to go on without him and has been taking anti-depressant medication ever since.

Mia reported constantly feeling not “good enough”. She feels that if she had been a “better wife” her family would still be together. There is, however, ambiguity here as she believed it was her husband’s intimidating behaviour that prevented her from seeing her granddaughter “Katie”. Mia reported that Thomas had threatened their son, James’ partner “Emma”. As a result Emma and James have distanced themselves from the family and moved to another town nearby. Mia wants to see Katie and bring
the family back together. She feels that her son has abandoned her and chosen a new life over her. Recently Mia has begun a new relationship with a man “Ben” whom she met over the Internet and she reported that this gives her much joy. However she expressed concern that if he really got to know her that he would leave her, as she is a person that people always see the worst in.

Current factors
Mia’s husband is filing for divorce due to her “lack of psychological and financial support in the marriage”. Mia finds this difficult to understand as her husband had always been very dismissive and unsupportive of her depression. He has also started a new relationship with a work colleague and Mia is convinced this is why he left her. She also forgave his affairs in the past as she “wanted things to be right”. She feels that she was obviously “not a good enough wife”.

Presentation in sessions
Mia has attended all of the sessions offered to her, which was four in total. She exhibited a tendency to change the way she presents and is defined by what has gone on for her that week. She was tearful through the initial assessment especially when talking about her estranged husband, but this moved into humour and making light of her problems as the sessions progressed. She would regularly say ‘I’m stupid for thinking this’, ‘God I’m pathetic’ or ‘I’m not good enough’. She also made reference to needing to be a stronger person.

Death and losses
Mia has experienced a lot of loss and death in her life. Her father died when she was 12, closely followed by the death of her mother’s parents. Mia had also formed a close relationship with her husband’s Grandad who also died. Mia also perceives her divorce to be a significant loss and believes she has lost her family.

Formulations

The following sections delineate Mia’s difficulties from two therapeutic perspectives—Psychoanalytic and Cognitive Behavioural approaches. In accordance with optimum clinical practice, the formulations are provisional and may be altered to accommodate new information.
Psychodynamic Formulation

Psychodynamic theory suggests that individuals have strategies called defences that they knowingly or unknowingly use in order to avoid intense negative emotions (Jacobs, 1998). When defences work they protect the individual from the potential ‘core conflict’ of negative emotion in the conscious self. Feeling the negative emotions would be unbearable for the individual, and, there may be multiple defences defending against the same negative emotion. Due to the uncomfortable nature of negative emotions, individuals suppress them into the unconscious, thus they become hidden from the individual’s awareness. When defences break down, due to a critical event, individuals begin to experience the anxiety and hidden feelings they were defending against, therefore, the defences, becomes maladaptive. This is usually when an individual would present to services for “help” (Menninger, 1958).

Malan (1979) suggested that defences can be tracked back to childhood; therefore, it maybe possible to construct a timeline of an individual’s defences and core conflict. It is also in childhood that a child discovers the nature of “triangular relationships”: you, me and other and develops an understanding of relationships between themselves, mother and father. Malan (1979) used the idea of the triangular relationship as a way to aid psychodynamic formulations. A working hypothesis of Mia’s core conflict is described in more detail below.

In Malan’s (1979) model he conceptualised defences and anxieties in a “triangle of conflict”. This triangle hypothesised the defence, the conflict or unbearable anxiety and the feelings that are hidden from the individual (Figure 2).
In the case of Mia, it can be hypothesised that she uses the defence of being passive and a people pleaser (nice to everyone) to defend against her fear of rejection and abandonment by people, she may also defend against anger at being rejected. i.e. if Mia expressed her hidden feelings of anger, she could potentially experience further rejection and abandonment. Mia’s defences broke down following her husband filing for divorce, as her defence of being passive and “nice” by turning a blind eye to his multiple affairs did not work as he rejected her regardless. Thus the defence of being the nice person who pleases people is actually maintaining her depression.

It could also be suggested that Mia uses guilt to defend against anger; Malan (1979) called this a ‘depressive self reproach’ where anger is directed at the self and guilt is manifested consciously. Mia reported that she cannot remember every showing the emotion of anger, as she was fearful of the negative consequences and does not like upsetting people. Malan (1979) suggests that when an individual experiences a depressive self reproach they become high risk for suicide. Mia has never attempted
suicide but after she received a divorce letter from her husband, she had made plans to kill herself. She reported her love for her daughter prevented her from carrying it out. Bateman, Brown and Pedder (2000) suggested that if an individual such as Mia reports never getting angry it is an indication of anger being repressed and, therefore, remaining hidden. Furthermore Mia denied any hostile feelings towards others especially her husband but informed the author of others being hostile towards her and reinforced herself in the victim role. The pattern illustrated in Figure 2, suggested that Mia is defending against rejection, loss and abandonment. This can be seen throughout Mia’s life and in her interactions in therapy.

Malan (1979) encapsulates this in a second “triangle of person”. Bateman and Holmes (1995) explained that the two triangles are linked via hidden feelings in the Triangle of Conflict (Figure 3). It is the role of the therapist to make interpretations of the possible links between both triangles. This process is known as the ‘resistance or defence interpretation’ (Malan 1979).

![Figure 3. Mia's Triangle of Person.](image-url)
In the case of Mia it is possible to track back her defence of rejection and abandonment from others (current and recent past), parents (distant past) and in the transference at therapy sessions (here-and-now). As previously stated, Mia’s “passive” defence broke down following her divorce proceedings, which had come as a surprise to Mia as she had not felt that there were any irremediable problems in the marriage. Subsequently Mia was unprepared for the relationship breakdown and the rejection from her husband. This pattern is also seen in her distance past regarding her father’s death. Mia had not been told of his terminal illness and was again unprepared for the loss. Ultimately Mia may have perceived this as rejection from her father. It may also be hypothesised that Mia felt rejected by her mother who was unable to support Mia to grieve. The connection between Mia feeling unprepared for rejection and subsequently abandonment in her distant and recent past forms the O/P link in the triangle of person. Given the suggestion that Mia defends against rejection and that the O/P link highlights being unprepared for it, it can be hypothesised that Mia may have difficulty in therapy, as our sessions, at some point, have to come to an end. Mia may feel that I will reject her, thus, it is of importance that I prepare Mia for the end of the sessions and this forms the T/P link.

In this model there is emphasis placed on the occurrence of transference. Bateman and Holmes (1995) defined transference as a representation of the attachments that the individual experienced with their parents, being experienced in the here-and-now via the therapeutic relationship (T/P Link). Malan (1979) suggested that transference also provides information about the person’s relationship with significant others (O/T Link). During our sessions Mia appeared to be dependent on the therapist. She wanted to be given answers to her problems and wanted to be rescued. Jacobs (1998) termed
this as “Paternal Transference”. Her dependent presentation could be a representation of her dependency as a child on her parents being shown in the here-and-now; however, she was unable to experience this as a child due to the loss of her father (T/P link of the triangle of person). Mia also had a strong willingness to agree with every tentative interpretation made. Her dependency and lack of disagreement could be hypothesised as relating to her core conflict of rejection. Mia could have been defending against my possible reject of her by being passive and agreeing. Winnicott (1965) suggested that as a child if you receive “good enough” care your true personality emerges, however, if you do not receive this level of care a false self emerges. Therefore, Mia may have been being nice and passive as a result of not receiving ‘good enough’ care as a child following the death of her father. A possible defence interpretation could therefore be “I wonder if you feel I will reject you if you disagree with me?” Mia’s passiveness and agreement in therapy also demonstrates her presentation in the external world and her relationship with others in her recent past (O/T link).

Mia’s dependency on me as a therapist began to make me feel anger towards her, I felt that she was acting the martyr and was unprepared to make changes to her life. Through supervision I was able to understand that the feelings that I was experiencing were actually a result of countertransference. This type of transference is feelings that arise in the therapists that actually belong to the individual client and can reflect relationships that both the client and the therapist have experienced. Hinshelwood, (1987) considers countertransference as important in understanding the state of mind of the patient. Therefore it could be hypothesised that the feelings of anger that I was
experiencing towards Mia were actually her own feelings of anger that she is unable to express, hence them being hidden in the triangle of conflict.
Cognitive Behavioural Formulation

Beck (1976) highlighted the role of a person as an active agent who interacts with the world. This notion added a dimension of learning to the dynamic model of behaviour. Through learning and interaction with the world it is suggested that individuals develop “core beliefs”. According to Beck (1976) these core beliefs can be anchored back to early childhood experiences and serve as a primitive understanding of the self, others and the world. The understanding of the self, other and the world is referred to as the “cognitive triad” (Beck, 1967). Beck (1967) suggested that depressed negative thinking about the self, world and the future such as low self-esteem, helplessness and hopelessness for the future predisposes people to depression.

Robins and Hayes (1993) referred to core beliefs as fixed internal models of aspects of the self, which are utilised in the process of coding and recalling information. Clinically, core beliefs are presented as absolute terms such as ‘I am not good enough’ (Willis & Saunders 1997). Padesky (1994) also suggested that core beliefs are “self-prejudice”. Core beliefs are usually difficult to access as they are usually non-verbal. From core beliefs, assumptions develop, the function of which is to help the person live with his/her particular beliefs. These are often manifested through “rules for living”.

Fennel (1999) suggested that “rules for living” are strategies for getting by in the world given the “truth of your core beliefs” Examples of rules for living for a core belief of “I am not good enough’ would be ‘unless I always get it right, I will never get anywhere in life”. It is only when these assumption or rules for living become dysfunctional in a situational trigger that negative emotions could arise (Fennell,
1999). For example, if you held the assumption above, a failure could be a critical incident to predispose negative emotions. Once activated, a dysfunctional assumption leads to Negative Automatic Thoughts which in turn produce more negative emotions. The cognitive formulation based on Beck’s (1767, 1976) model of depression is outlined diagrammatically in figure 4. As I have not been working with Mia from a cognitive perspective some of the information has had to be hypothesised. This is especially true with reference to Mia’s early childhood experience as she had difficulty recalling facts.

The early life experiences that Mia could recall were centred around death and dying. She had difficulty remembering happy memories as a child. This maybe an example of a thinking error such as ‘filtering’ this is when negatives are magnified and positives are filtered out of a situation (Hawton, Salkovskis, Kirk & Clark, 1989). Another thinking error that Mia maybe employing could be ‘overgeneralising’ that her childhood was bad, due to the focusing on the one event of her father dying.

Although Mia was unable to remember details of her childhood experiences she was able to talk about her mother as always being unloving and critical. Mia described her mother as a cold person who never offered support even if she had fallen over or had a bad day. Padesky (1994) suggests that lifelong depression can develop in individuals that experience “life stresses” such as childhood abuse or familiar deaths, which can be identified in Mia. It is these childhood experiences that potentially developed Mia’s core beliefs of “I’m not good enough”. It can be hypothesised that Mia felt that if she had been a “better daughter” her mother may have showed her love and supported her to grieve for her father. The themes of loss and abandonment are also
central to Mia’s childhood and therefore it can be hypothesised that this could also have developed her negative core beliefs of not being “I’m not good enough”.

Beck, Freeman, Pretzer, Davis, Fleming, Ottavani, Beck, Simon, Padesky, Mayer and Trexier (1990) suggest that a core belief of I’m not good enough can lead to “conditional beliefs”, such as “if people got close enough to me, they would discover the real me and would reject me (p43). This could be true in the case of Mia, as she reported being wary of her new relationship. She believed that if “Ben” got to know her then he would leave her. Mia’s distrust of Ben leaving her could also highlight a core belief of not being able to rely on others. This lack of relying or trusting others could mirror a parallel between her early experiences, for example when her father died and left her.

Having the core belief of having to be “good enough” could lead Mia to the assumption that she has to be perfect and if she is not than she has failed and is unlovable. Mia, therefore, has for the majority of her life been a passive person, not disagreeing with people and trying to keep everyone happy for fear of rejection and negative evaluation. She avoids situations where she sees potential for failure, such as employment and forming close relationships with friends. Padesky (1994) hypothesised a cognitive triad for an individual such as Mia, with a core belief of “I’m not good enough”. Padesky (1994) suggests that the negative view of the self is the core belief of “I’m not good enough”. Mia may have the view of others are not to be trusted and see the world as a place where her efforts do not pay off.
Fennell (1999) suggests that dysfunctional assumptions alone do not account for clinical depression. Thus, when her assumption was activated by her husband filing for divorce, the increased negative emotions were expressed in form of negative automatic thoughts (“I’m pathetic” & “I’m stupid). A further critical event for her depression could be her sister terminal illness. Mia may have interpreted this as another potential loss. These negative automatic thoughts connect with assumptions that she already held about herself and other people. Mia lived by her “rules for living” to be good and always get things right, however her husband still rejected her.

**Early Experiences**
Mother is over critical and unloving
Father dies

**Core Beliefs**
I’m not good enough
I can’t rely on others

**Formation of Dysfunctional Assumptions**
Unless I always get it right, I will never get anywhere in life; if someone points out mistakes of mine it means I have failed and I’m unloved and rejected by people.

If I get close to others they will leave me and abandon me.

**Critical Incident**
- Divorce
- Sister is terminally ill

**Assumptions Activated**

**Negative Automatic Thoughts**
I’m stupid
I’m pathetic
I’m not good enough as a mother, wife or daughter.
If people really get to known me they will not like.

**Symptoms**
- **Behavioural** – Avoidant for people
- **Affective**- Low, guilt, low self worth
- **Motivational** – Loss of interest
- **Somatic**- Loss of sleep and increased pain
- **Cognitive**- Poor concentration and memory

Figure 4. Cognitive Formulation of Mia’s presenting problem
As well as developing a formulation of the cognitions highlighting individual’s difficulties, the cognitive model formulates in the here-and-now and suggests how the current symptoms are maintained. Greenberger and Padesky (1995) discussed a model that can explain the maintenance of Mia’s symptoms of depression, as illustrated in figure 5.

A situation, in which the maintenance cycle (presented in figure 5) could lead into the thoughts and feelings, could be when her mother criticises Mia’s abilities to care for her. The criticism could provoke negative thoughts in Mia such as “not being good enough”. This could make her behave in an avoidant passive manner, to avoid future criticism, which could increase her negative feelings and physical symptoms associated with depression.

**Situation:** Mothers Criticism

**Thoughts**
- I’m not good enough
- I’m pathetic
- I’m stupid

**Behaviour**
- Passive and avoidant of confrontation (avoid future criticism).

**Somatic/Physical**
- Increased pain
- Lack of sleep
- Tiredness/fatigue

**Affect/Feelings**
- Increase in low mood
- Low self worth
- Guilt

Figure 5. Maintenance cycle of Mia’s depression.

It is illustrates in Figure 5 that Mia’s depression is maintained through her negative thinking, which has a knock on effect to her feelings, behavioural and her physical
self. In therapy Mia would be encouraged to notice her negative thoughts and develop more balance positive thoughts. Potentially this could be achieved by capturing her thoughts in a diary and conducting behavioural experiments. Mooney and Padesky (2000) describe this as “chipping away” at the negative thoughts and core beliefs.
Reflections

Mia’s problems have been formulated from two different psychological perspectives; psychodynamic using Malan triangles (1979), and cognitive behavioural using Becks (1976, 1967) model. On reflection both theoretical perspectives have strengths and weaknesses and these are explored below.

The psychodynamic formulation sets Mia’s problems within a context of her interpersonal world and seeks to explain her difficulties in terms of repeating dysfunctional relationship patterns. This offers both intervention and explanation of why Mia experienced her difficulties in life and how she might adopt a more adaptive approach to the future. Within the psychodynamic formulation there is also emphasis placed on transference and the interaction during the sessions.

In the case of Mia her passive defence emerged during the sessions and this was offered as a tentative transference interpretation. According to Malan (1979) the response to an interpretation can assess the suitability and psychological mindedness of the client. The use of countertransference is also beneficial in the psychodynamic process. Through supervision I was able to understand that the anger I was feeling towards Mia was actually a result of countertransference. Furthermore I was able to notice that I did not feel angry towards my other clients suggesting that the anger was unique to the therapeutic relationship with Mia. This subjective information provides important evidence for identifying maladaptive attitudes and behaviours in both cognitive and psychodynamic formulations (Strupp & Binder, 1984).
Feeling the emotions that Mia invoked developed the therapeutic relationship and gave a greater interpersonal perception of her problems. I found that this process was useful for Mia as it allowed difficult emotions to be named and discussed during sessions. The disadvantage to this process is that the clients may evoke negative emotions in the therapist that could be misinterpreted as the clients. Therefore the role of supervision is very important.

The main area of interest in the psychodynamic model is emotions and impulses (hidden feelings) which are located in the clients unconscious. It potentially could be distressing for the client when trying to get in touch with their hidden feelings. A client has to have good ego strength to be able to experience their hidden feelings and therefore a psychodynamic approach may not be suitable for every client. Mia demonstrated good ego strength during the assessment and was able to reduce her symptoms of depression using therapy from the psychodynamic perspective. The psychodynamic model was however unable to explain the role of physical symptoms of depression.

In the cognitive behavioural model outline by Beck (1967, 1976) greater emphasis is placed on non-repressed thoughts. The advantage of this is that the thoughts especially negative thoughts are usually accessible to the client. Even thought the assessment of Mia was conducted from a psychodynamic perspective, she verbalised many negative thoughts such as “I’m pathetic” and I’m not good enough”.

The cognitive formulation further suggests that cognitions about the self, others and the future develop as a result of childhood experiences. However, less emphasis is actually placed on the past and childhood experiences and more on the here-and-now.

A feature of Mia’s difficulties less evident in both formulations was the issue of historic ill health within her family. It is conceivable that these problems could be linked to her suggested core belief of not being able to rely on people. It is also possible that Mia construes the experience of people getting ill as an indication that they could die and that things may change for her in a negative way. A way to enhance both formulations and respective interventions would be to explore her relationship with illness, loss and how she manages loss in the family.

Even though there are slight differences in the process of psychodynamic and cognitive behavioural models, both have the same goal. They aim to understand individual’s problems and aid in the application of intervention. As both models focus on the individual’s problems maybe a systemic approach may have been beneficial, given that lots of Mia’s problems were linked to her family and significant others.
References


Abstract

This paper considers the case of William, a 38-year-old man who was referred to Psychological Services by his General Practitioner with a diagnosis of Obsessive Compulsive Disorder (OCD). An AB design was used to monitor and evaluate a cognitive behavioural intervention. A self monitor tally was used to measure the occurrence of these behaviours, focusing in particular on his intrusive thoughts regarding food contamination. The clinician rated Y-BOCS severity scale was used for every session to monitor the severity of his OCD on a global scale. The results suggest that the cognitive behavioural intervention significantly reduced his “neutralising behaviours” regarding fear of food and the occurrence of intrusive thoughts he noticed. There was also a reduction in the Y-BOCS scores, suggesting that the intervention had a global effect on Williams’s overall symptoms.

2 In the interest of confidentiality the name of the client and those of related persons have been changed
Introduction

This single case experimental design examines the effectiveness of a cognitive behavioural intervention with a 38 year old man affected by Obsessive Compulsive Disorder (OCD). It focuses in particular on the use of cognitive behavioural approaches in the reduction of intrusive thoughts regarding fear of food contamination.

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder is characterised by the presence of either an obsession or compulsion but not commonly both (NICE, 2006). An obsession is intrusive and persistent in nature, and can take the form of thoughts, impulses or images. According to Wells and Morrison (1994), the most common obsession is that of intrusive thoughts about contamination and intrusive thoughts regarding self doubt. Experiencing an obsession such as thinking that one is contaminated, results in increased anxiety, thus an individual attempts to reduce the anxiety by executing compulsions, such as compulsive washing. From a cognitive perspective, this is seen as “neutralising behaviour” to prevent the fear outcome, in this case contamination (Wells, 1997). Another way of reducing the anxiety associated with obsessions is avoiding situations that are perceived as “risky” (Wells, 1997).

It is important to highlight that obsessional thoughts experienced by individuals with OCD are not indistinguishable from a non-clinical sample (Rachman and Silva, 1978). Salkovskis (1999) suggests that the difference between a normal intrusive thought and an obsessional thought is the meaning that the person with OCD attaches to the occurrence, together with the content of the intrusions, which are often interpreted as
dangerous or immoral. Some intrusions may also be interpreted as causing harm to other unless certain behaviours are completed. Thus, the person with OCD believes that they are able to prevent harm occurring either to their self or a vulnerable person.
Case Summary

Reason for Referral

William was referred to Psychology by his General Practitioner who felt that he might benefit from Cognitive Behavioural Therapy (CBT) for his diagnosis of OCD. He had declined the use of pharmacological treatment for fear of the side effects.

Assessment

William believed his thoughts were centred on fear and a sense of increased responsibility for his family. He described his problems as thoughts about members of his family being hurt if he did not carry out certain behaviours. He was also having thoughts about being contaminated if he ate food he did not know the origin of. The appraisal of the thoughts had become increasingly distressing and anxiety provoking for William. He felt compelled to respond to reduce his anxiety by behaviours such as: checking his work over and over again, repositioning objects that were pointing towards him and compulsive washing. He had also found that seeking reassurance from his wife for his thoughts regarding contaminated food had helped reduce his anxiety. William was also avoiding things that he believed trigged the intrusive thoughts by employing safety behaviours such as storing his lunch in a locked container at work so that he knew his food had not been contaminated. At the time of the assessment, William estimated that he was spending half the day having intrusive thoughts and reducing his anxiety about them by conducting compulsions and neutralizing behaviours.
William reported having certain obsessive and compulsive behaviours of an intrusive nature as a child. He believed that he had learnt these behaviours from his mother who he described as having OCD traits (but who had not been diagnosed). He reported coping with his symptoms while living with his parents but said the thoughts became harder to handle after he moved in with his wife. He also reported a greater increase in his symptoms following IVF treatment for the birth of his much wanted twin boys. William reported being aware that his OCD symptoms increased if he was under a large amount of stress.

**Background information**

![Geneogram of William’s family; illustrating family relationships.](image)

**Family history**

William was a 38-year-old married man; the eldest of two sons. He reported a close relationship with all of his family, and suggested that he had many male and female friends. He said his family were all aware of his OCD symptoms and were supportive. William lived with his mother and father until he was 30. He said that living with his parents was ‘easy’ but later divulged that it was in fact his fear of living somewhere that may not be clean enough that kept him in the family home. He
also trusted the food that his mother prepared and was less fearful at home. William left home to move in with his girlfriend whom he married three years later. At the time of the assessment he had been married for six years and his wife had given birth to twin boys who had just turned two. William found the period of conceiving the twins stressful, as he and his wife had to go through IVF as she had a medical problem that made it difficult to conceive naturally. William found that his OCD symptoms increased following the birth of the twins. He said he believed that this was because he had more to lose, and was having thoughts about the twins getting ill from germs or dying himself due to being contaminated. He reported seeking professional help at the time of his referral, as he believed that his symptoms were increasing. He was also concerned that his sons might copy his behaviour.

During the assessment, William described his presenting problems as beginning from the age of eight. William had first become concerned about food and contamination when he was at school. During an assembly, the head master had told all the children that if they had oranges in their lunch boxes they were not to eat them, as they had been poisoned. William described becoming deeply distressed about this and even when he later found out that it had been an April fool’s joke, he could not forget about the possibility of becoming ill if he ever ate something poisoned. He also remembered feeling a great sense of vulnerability. He reported that when he was nine he had suffered from mild food poisoning, and that his mother had become very emotional and blamed the school canteen and prevented him from eating there again.
Employment

William left school at the age of 16 and had been employed as a pipe fabricator since then. His reported that his OCD symptoms were beginning to affect his work in that he checked his work four times, as he did not trust himself. He was also afraid that he might of cause a road traffic accident on his way to work and would therefore recheck his journey, making him late for work. William reported that the most distressing problem he had at work regarding his OCD was his worry over his food being tampered with. He would therefore lock his lunch away and keep it in his bag next to his workstation. If he needed to leave the workstation, he would always take his bag with him.

Presentation

William was very motivated to change his behaviours and the way he reacted to his intrusive thoughts. He engaged well with all eight sessions and was appropriate throughout. During more challenging sessions, his level of anxiety noticeably increased, however he was still able to participate in the negotiated tasks. William did not miss any appointments and was always on time.

Formulation

Rationale

From the assessment it was apparent that the extent of Williams OCD was wide-ranging. He was experiencing intrusive thoughts, rituals and checking behaviours and the most debilitating behaviour was his preoccupation with intrusive thoughts regarding food contamination. In particular he was also locking his food away while at work for fear of it being contaminated by work colleagues. He was reluctant to eat food he had not prepared himself or that had not come from a particular supermarket.
He was also locking his food away at work for fear of it being contaminated by colleagues. This was causing him distress and impacting on his home and work life.

William wanted to undertake a treatment plan to reduce his compulsive behaviours regarding fear of food contamination, especially at work. He also agreed to monitor his other intrusive thoughts using a thought diary and self monitoring his compulsive behaviours. However the self reported results presented here are centred on the reduction of compulsions concerning food contamination at work.

Formulation

Williams’s difficulties were formulated within a cognitive behavioural framework, using the conceptualisation from Salkovskis (1985, 1989), due to the emphasis placed on responsibility during the assessment, it was felt that Salkovskis (1985, 1989) conceptualisation would be a best fit explain Williams symptoms. (Rachman, 1976).

The Salkovskis model is also based within Beck’s cognitive theory (Beck, 1976).
Events

It was hypothesised that a number of different events had contributed to William’s concerns about being contaminated, including his mother’s OCD behaviours, suspected food poisoning when he was nine and the April fools joke regarding oranges, as a result William developed general assumptions about his world. Given these events, William was also compelled to adopt strategies to prevent him becoming contaminated and to protect other people from harm, thus reducing his increased anxiety. Over time, control strategies such as avoiding eating out and locking his
lunch away at work were encouraging an attention biases, increasing his fear of food contamination in an attempt to control his environment.

**Cognitive and Maintaining Factors**

According to the models set out by Salkovskis (1985, 1989), William was giving significant meaning to his intrusive thoughts regarding contamination. He considered himself as being responsible for harm that may occur to himself and others (mainly his family). His increased sense of responsibility was having an adverse effect on his mood, resulting in depression and anxiety. The adverse lower mood led William to complete more “neutralising behaviours” in an attempt to improve his mood. The neutralising behaviour further increased the intrusive thoughts and his perception of responsibility led to a maintaining cycle of negative thoughts and neutralising behaviour. This maintaining cycle can be seen in Figure 2.

**Intervention** (the intervention was conducted over eight sessions)

According to the National Institute for Clinical Excellence (NICE, 1996), the main evidence-based psychological treatment for OCD is cognitive behavioural therapy (CBT) combined with SSRI medication. The NICE guidelines also suggest including exposure and response prevention (ERP) as a way of “exposing” a client to the feared stimulus and finding a way of resisting the urge to carry out any rituals in these circumstances. Salkovskis (1985) suggests that cognitive behavioural interventions should be concentrated concerned with modifying automatic negative thoughts and reducing the client’s belief that they are responsible for causing harm to themselves and/or others.
The general aim of the intervention offered to William incorporated the elements suggested by NICE (1996) and Salkovskis (1985). The intervention was therefore planned to adjust his unhelpful appraisals and beliefs concerning intrusions and to reduce the counterproductive responses that maintained mistaken beliefs and increased intrusive thoughts. In addition, other approaches were used such as: development of the formulation to help William understand the process of his OCD and maintenance of it; thought diaries; psychoeducation; behavioural experiments; Socratic questioning; probability statements and relapse prevention. The aim of the intervention was not to prevent intrusions per se but to enable William to “detach acceptance of intrusive thoughts as irrelevant for further action or processing” (Wells, 1997 p. 249).

Firstly psychoeducation was used to aid William’s understanding of OCD and to “normalise” some of the intrusions that William was experiencing. This process also helped in socialising the CBT model. Thought diaries were introduced to “tap into” the automatic negative thoughts that William experienced and to explore the content and occurrence of his intrusions. The negative thoughts that William commonly experienced were centred around responsibility for his children “what if I get sick and die…what would happen to the kids?” Using this information, the formulation seen in Figure 2 was constructed in collaboration with William.

The formulation was used as a possible suggestion for development and maintenance of William’s OCD symptoms. As well as highlighting that intrusions themselves are common to everyone (Rachman & Silvia, 1978), it was made clear to William that it is the misinterpretation of their meaning that can cause distress (Salkovskis, 1999).
Using the formulation and thought diaries, specific appraisals were challenged, forming the introduction to behavioural experiments incorporating ERP, in accordance with Wells (1997) and NICE (1996). The purpose of the experiments was to help William to test his beliefs associated with food and contamination and to reduce the associated anxiety. Prior to the behavioural experiments, William made specific hypotheses about the outcome.

**Design**

Single case experimental designs are used for the purpose of testing the effectiveness of a specific intervention. In William’s case, an AB design was employed to measure the effectiveness of a CBT based intervention on the reduction of his fear of contamination centred on food. The AB design involves the introduction of an intervention (B) following a baseline (A) monitoring phase (Barlow & Hersen, 1984). It has been suggested by Barlow and Hersen (1984) that a major shortcoming of this design lies in its poor ability to attribute change to the intervention. A way of overcoming this difficulty could have been to use an ABA design, in which the intervention (B) is removed and the baseline monitored for a second time. This could have strengthened the interpretation of the intervention having a bigger effect if William’s OCD needed continuing intervention. If continuing intervention were needed, this would suggest that no learning had taken place. Given the nature of the CBT intervention, it would have been difficult for the intervention not to affect the second baseline measure. The ABA design has also been criticised for being unethical, as the client is left without a second treatment phase (Cook & Campbell, 1979), therefore the AB design was chosen.
Measures

To gain a wider impression of the intervention and William’s progress, data was obtained from two different sources: the therapist’s perspective, using the Y-BOCS severity section to monitor global symptoms, and the client’s continuous self monitoring of the occurrence of food neutralising behaviours via a daily tally. William’s self monitoring was used to form the statistical basis of this report.

*Yale-Brown Obsessive Compulsive Scale (Y-BOCS) - severity section*

This measure can be used across all ages and allows the clinician to rate the severity of the client’s obsessions and compulsions. Goodman at al (1989) suggest that it is particular sensitive to monitoring improvement during treatment without being biased towards the type of obsessions or compulsions present. The severity section is completed by the clinician and scores time spent on obsessions and compulsions, interference, distress, resistance and control of compulsions and obsessions. At the first session, William’s severity was 22 out of a possible 40, thus placing him in the *moderate range.*

*Self Monitoring Tally*

Morley (1994) suggests that self monitoring can be reported more frequently than standardised measures, such as the Y-BOCS. As William had wanted to see a reduction in his compulsive behaviour regarding food contamination, he was asked to keep a tally of the times he neutralised an intrusive thought or conducted a compulsion in order to relieve his anxiety, for example, locking his lunch away at work, keeping his lunch with him at all times or making sure the zip on his bag was in the same place so that he could be sure that nobody had been in his bag. Although this
was completed daily over the six sessions, during the last two sessions, William asked if he could stop self monitoring. At this point it was felt that if William was asked to continue monitoring his behaviours, his engagement could be affected and the therapeutic relationship could be damaged. The self monitoring was therefore discontinued at this point.

*Baseline* (Data was collected daily for two weeks, generating 14 data intervals)

The aim of the baseline was to obtain a typical record of the number of times that William was conducting obsessive behaviours regarding food contamination prior to the intervention. Also during this stage, two Y-BOCS were collected to monitor the global severity of his OCD symptoms.

*Intervention* (data was collected for four weeks, therefore giving a total of 28 data intervals). The cognitive behavioural intervention began in week three (data point 15). William continued to complete thought diaries during this time and six Y-BOCS clinical rated severity scales were completed.

**Hypothesis 1:** That the intervention would reduce William’s self reported checking of his food.

**Hypothesis 2:** That the intervention would have a decreasing effect on the total Y-BOCS during the eight weeks.
Results

The self monitoring data collected during the baseline and intervention phases can be seen in Figure 3.

![Figure 3. Graph representing self monitored data from William: baseline and intervention](image)

The descriptive statistics show that the mean score for the baseline intervention is $M = 4.5$, with a $SD = 1.6$, compared to $M = 2.0$, $SD = 1.4$ in the intervention. This could suggest that there is a difference between the baseline and the intervention, as the total percentage change is 25%. The standard deviation has stayed consistent however, suggesting that the scores are similarly distributed in both the intervention and the baseline phases. The linear trendline in the baseline shows that the baseline was slightly decreasing; however it can be seen for the intervention trendline that the reporting of food contamination compulsion had become extinct.

Kazdin (1982) suggests that using a graph (as presented in Figure 3) to represent the data visually could be a sufficient process to identify reliable intervention effects. However Wampold and Furlong (1981) found significant differences in the interpretation of graphically presented data alone. Pearson and Bear (1992) suggest
that this can occur due to the bias of the examiner of the data and a potentially over-optimistic interpretation, especially if they were clinically involved with the single case design. Kazdin (1982) also suggests that judgements regarding change using visual analysis alone are hindered by unstable baselines. It can be seen in Figure 3 that on data interval 6 there was a sharp rise in the occurrence of William’s food contamination behaviours. William explained that on this day, both of his sons had a tummy bug, causing him to become more vigilant about his food, as he did not want to become ill.

The use of a statistical approach can also be criticised when applied to single case data (Pearson & Bear, 1992). Huitema and McKean (1991) suggest that problems can occur due to potentially small sample sizes. Johnston (1984) defines a small sample size as below 50 and suggests that performing a statistical analysis on this small number (N = < 50) can increase the chance of a type 1 error. Other difficulties in completing parametric tests with single case data are associated with the basic assumptions that the data must meet.

The basic assumptions for parametric tests are that the data is normally distributed, that the observations are independent and that the two groups have variance. As the single case data had unequal points and the data was not independent, having been collected by William, the data did not meet the assumptions for a parametric test. Completing a parametric test with this data would increase the chance of a type II error (Howell 1997).
The data also has the potential to be serially dependent, suggesting that the previous data point will affect the next data point. Therefore if the residuals of the data in a regression analysis autocorrelate and the data is shown to have serial dependency, a time series analysis, known as the double bootstrap method, will be conducted (McKnight, Huitema & McKean, 2000). McKnight, Huitema and McKea (2000) suggested this new model to explore data when it has been shown to have serial dependency because the data does not have to meet the parametric assumptions and the method can be conducted with a small sample size. Thus, the bootstrap method estimates and removes autocorrelation and then uses the adjusted scores to produce a regression.

The results of the regression analysis completed using the residuals, to account for any treatment trend, suggested that there was a significant serial dependency in the data at lag 1 the “first order influence”. The significant autocorrelation coefficient of the regression residuals was $r = .613 \ p < 0.0)\).

As a positive autocorrelation had been detected, the new time series model suggested by Mc Knight at al (2000) was completed. The bootstrap method was applied to the data using an online computer programme (McKean, 2000). The result suggested that the standardised $\beta (3) = -0.05 < p 0.95$ was significant. The slope of the baseline and the intervention were thus significantly different to each other, suggesting that the intervention had an effect on William’s self reporting of food contamination behaviours. Hypotheses 1 can therefore be accepted. The standardised beta $\beta (4) = -0.82 < p 0.41$ also suggests that the slope of the intervention has a significant change compared to the baseline slope.
Results from the Y-BOCS, which is an overall measure of OCD severity (not specific to Williams’s food contamination), are presented in Figure 4.

![Figure 4. Total score of Y-BOCS severity scale.](image)

As can be seen from Figure 4, the slope for the Y-BOCS shows a steady decline in the severity of William’s overall symptoms ($M = 17$, $SD = 4.9$). William’s overall symptoms placed him in the “Moderate” ($n = 22$) category in week one and by week eight he was in the “Subclinical” ($n = 9$) range. Using visually analysis techniques it can be seen that there is a decrease. Clinically this is relevant as, coupled with William’s self report of “feeling better” and being “more in control”, it suggests that the intervention was effective. This finding appears to support hypothesis 2, that the intervention had a decreasing effect on the global symptoms of OCD.

**Discussion**

The results suggest that both hypotheses can be supported. The intervention can be described as effective, as there was a significant reduction in William’s obsessive behaviours regarding food contamination. The results from the Y-BOCS also suggest
that the CBT intervention had a global effect on the severity of William’s OCD. This may have been due to certain aspects of the intervention such as the psychoeducation and cognitive elements being more general to William’s OCD symptoms. William also reported that he believed he was able to transfer findings from the behavioural experiments regarding food contamination to other OCD symptoms, such as compulsive washing.

In the final session, as well as a reduction in the Y-BOCS severity section, William also reported that he had found the intervention beneficial. He reported an improvement in his mood as well as his symptoms. William believed that the aspects of the intervention that made a difference to him were: being challenged regarding his intrusive thoughts and conducting behavioural experiments. William also found that learning more about OCD had helped him to understand that intrusive thoughts were common to lots of people and this “normalised” his symptoms and enabled him to stop attributing significant meaning to his intrusions. It is difficult to tell which aspect of the intervention made the biggest improvement. Eick and Kofoed (1994) suggest that a solution to this is to test one treatment per client. However, given the time constraints of placement and service demands, this would not have been possible.

Nevertheless there are other factors that could have been accountable for the change and it is difficult to attribute the reduction purely to the intervention. One of the main weaknesses of an A-B design is that environmental influences cannot be controlled. Therefore the improvement that William experienced may have been down to spontaneous recovery or an environmental reason such as reduced stress at work.
There is also the rationale that the therapeutic relationship alone, rather than the intervention, could have facilitated change for William.

An ABA design may have been helpful in determining the effectiveness of the intervention but as suggested previously, this design can be described as unethical and the CBT intervention would have been difficult to withdraw, due to the educational nature of the intervention. A limitation to the design used for this single case study was that there were unequal data points in the A and B phase, making visual interpretation and statistical analysis difficult. A more effective design could be to have an equal number of data intervals, during baseline and intervention, and then visual analysis could have been completed to supplement the statistical analysis. However this would still have been complicated by serial dependency. Another limitation is that of the validity of the raw self report data, as the ratings could not be independently verified.

The baseline was also unstable prior to the introduction of the intervention, making it difficult to conclude that the intervention was successful. Morley (1989) suggests that a baseline needs to be stable to make this claim. However statistical analysis did show that the intervention could have been successful in elevating William’s symptoms.

To improve the design, it may have been beneficial to conduct a follow-up session with William to see if the improvements were upheld. A Y-BOCS and self report could have been conducted.
Reflections

The author has found the process of completing the single case experimental design to be a beneficial as a means of evaluating clinical work. It has also drawn attention to the importance of offering interventions that the client wishes to pursue and not merely those on the clinician’s agenda. The process has also highlighted the difficulty of determining whether the intervention offered to William would have been equally beneficial to other clients experiencing symptoms of OCD.
References


Appendix

Food contamination

### Descriptive Statistics

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Autocorrelation lag 1

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<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
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<tr>
<td>N</td>
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</table>

| Unstandardized Residual | Pearson Correlation | .613** | 1.000 |
| Sig. (2-tailed)         | .000 |       |
| N                       | 41 | 42.000 |

**. Correlation is significant at the 0.01 level (2-tailed).

### Parameter Estimates and Test that parameter is zero (boot strap)

Food Contamination

<table>
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<th>Parameter</th>
<th>Estimate</th>
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<td>Beta 3</td>
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<tr>
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Descriptive Statistic of Y-BOCS

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Abstract
The following service evaluation was conducted in a Child and Family Service (CAFS) to explore reasons why outcome data were not being produced by mental health professions, in particular data generated by the Strengths and Difficulties Questionnaire (SDQ), which is delivered pre and post intervention. The CAF Service noticed that post intervention data was not being completed in accordance with government guidelines set out in the National Service Framework for children, young people and maternity services (NSF, 2004) and Public Service Agreement (12) (HMSO, 2007). Six mental health professionals were interviewed and the data were analysed using thematic analyses. The results highlighted various themes pertaining to the non collection of SDQ data, including poor utility of the SDQ and practical barriers making it difficult to complete. On the basis of these results, recommendations are made that may increase SDQ completion. Limitations of the service evaluation are also discussed.

*The names of the service and other identifying features’ have been altered to maintain confidentiality.*
Introduction

Description of the Child and Family Service

The current service on which this audit of clinical practice is based comes under the umbrella of Child and Adolescent Mental Health Services (CAMHS) but is known as Child and Family Services (CAFS). The CAFS is part of a Primary Care Trust serving a large city. Parts of the city are relatively affluent, where other areas are among the top 10% most deprived areas in the UK (City Primary Care Trust and City Council, 2007). The trust serves a population of 236,573 according to the 2001 census (National Statistics Online, 2001). The area is made up of a mix of ethnic groups, including 78% white and 14% Asian, including British Pakistani and Bangladeshi. There is a high level of religious diversity within the city; it has the fourth highest Sikh community in the UK.

The service offers a multi disciplinary approach for a range of mental health problems. Assessment, diagnosis and treatment are offered for any child or adolescent up to the age of 16 and the service will see young people up the age of 18 if they are in full time education. CAFS accept referrals from a range of services, including education, social care and health.

Following an initial screening appointment, clients and families are offered the most suitable form of intervention to meet their needs; on some occasions this may be the initial screening appointment only. CAFS covers all types of provision and intervention from mental health promotion, primary prevention and specialist community based services. Interventions may be indirect (e.g. consultative advice to
another agency) or direct (e.g. direct therapeutic work with an individual child or family).

**National Service Framework**

The evaluation of CAMHS has become common practice in recent years (Williams & Kerfoot, 2005; Kazdin, 2003 & Wolpert et al, 2007). The focus on evaluating services has become even more popular due to the development of The National Service Framework for children, young people and maternity services (NSF, 2004).

The NSF (2004) is a government document for the National Health Service (NHS), social services and educational authorities to follow. The document sets out standards that should be adhered to in order to ensure the best possible care for young people and expecting mothers. The NSF has 11 standards to be implemented in services in three phases. Phase 1 of the NSF consists of standards 1-5, which are the responsibility of every service offering provision to children and young people. The standards are based on the government’s white paper “Every Child Matters” (2003). Standard 9 of the NSF (2004) refers to all children and young people between the ages of 0-18 who have mental health problems and is thus relevant to CAMHS. Specifically, the standard outlines: “timely, integrated, high quality, multi disciplinary mental health services” to ensure effective assessment and treatment. In particular sections 9.19 and 9.20 refer to measuring outcomes to make sure the service is delivering high quality and effective treatments.

Measuring clinical intervention should be common practice among CAMHS (Wolpert et al 2007). This is for many reasons, such as informing direct clinical work,
developing services by highlighting where further resources maybe needed and informing commissioners that services are effective (NSF, 2004; Ford Tingay, Wolpert, 2006). The Government’s white paper “Every Child Matters” (2003) also states that “service equity improvements” should be achieved by addressing the gaps in the service by measuring outcomes. Measuring outcomes is becoming integral to CAMHS as moves are made towards “Payment by Results” (HMSO, 2007). The government has set figures in the Public Service Agreement (12) (HMSO, 2007) that an aspect of the measure known as the Strengths and Difficulties Questionnaire (SDQ) should be used to evaluate the effectiveness of CAMHS across the UK by 2009 (HMSO, 2007).

Measuring clinical outcomes is not a straightforward process (NSF, 2004). A young person accessing CAMHS usually has a network of people around them, including parents/carers, educational professionals and sometimes social services (Every Child Matters, 2003). Thus a common problem with measuring outcomes in CAMHS is whose perspective to use; the young person’s experiences of their mental health problem or the family and professionals around them. The government’s policy for Mental Health (1999) emphasised that all services should be deveopled in the interest of service users. Perkins (2001) inferred that this means that service users’ perspectives on services should be collected and used. This is also supported by the NSF for children, young people and maternity services (2004) where service users’ views should be “systematically sought and incorporated” (p.13). There are also issues surrounding what should be measured, such as the general adaptation, rating of the actual problem or a more general measure of feelings such as anxiety. A
nationwide steering group was developed to help answer the above issues; the CAMHS Outcomes Research Consortium (CORC) was established in 2002.

CORC suggested three questionnaires that CAMHS could use across the UK to evaluate clinical outcomes. The questionnaires aim to measure three areas: the child and parent perspective (Strengths and Difficulties Questionnaire); the service user’s satisfaction with the service (Commission for Health Improvements, CHI) and the perspective of the practitioner (Health of the Nation Outcome Scales- Child and adolescent, HoNOSCA). The CAFS that this service evaluation is based on currently use the SDQ and the HoNOSCA, however this service evaluation will focus on the SDQ, as the service has been experiencing problems with the collection of this particular measure. As previously stated, an aspect of the SDQ is now being used to evaluate the effectiveness of CAMH services (HMSO, 2007). Currently the CAFS service is collecting on average 9% of SDQ’s completed after intervention. The government guidelines suggest that this should be at least 30%. Therefore this raises issues for CAFS submitting data to demonstrate its effectiveness to fundholders. CAFS is potentially also not meeting NSF (2004) and Public Service Agreement standards (HMSO, 2007).

**The Strengths and Difficulties Questionnaire (SDQ)**

The SDQ has several variants depending on who is asked to complete it and the age of the young person to whom the questionnaire refers. Parents/carers complete the SDQ, together with adolescents aged between 11-17 years of age. For each of these SDQs there is a follow-up SDQ questionnaire that asks the same questions about the past
month, with the addition of two questions asking if the intervention has reduced the problem and if it has been helpful in other ways.

The SDQ requires the respondent to rate whether 25 psychological attributes about the young person are “not true”, “somewhat true” or “certainly true”. The 25 items are distributed across five scales; Emotional Symptoms, Conduct Problems, Inattention-Hyperactivity, Peer Problems, and Prosocial Behaviour. The Total Difficulties score is the sum of all scales apart from the Prosocial Behaviour score. The maximum score on each of the five scales is 10, and 40 on the Total Difficulties score. The higher the score on these scales, the more severe the problem, except for the Prosocial scale, where the reverse is true. For this reason the Prosocial Behaviour scale is not included in the Total Difficulties score.

CORC suggests that the SDQ should be administered at two points. Firstly it should be completed by the parents and child before they are seen, and secondly completed by the parents and child after the intervention or after six months following the initial meeting, whichever comes first. The SDQ should not be completed less than four months after the initial screening or more than eight months after. Using the measure twice offers a baseline with a repeated measures design suggesting whether the intervention has been effective (Ford, Tingay, Wolpert, 2006).

Why use the Strengths and Difficulties Questionnaire (SDQ)?
Goodman (1997) reported that the SDQ was a good overall measure of a child’s presenting problem. The SDQ has also been proved to be good at measuring positive change six months after the intervention, using the “Total Difficulties” score completed by parents (Goodman, 1997). The Total Difficulties score was also related
to a significant reduction in the HoNOSCA scores completed by clinicians involved. Goodman concluded that the HoNOSCA and the SDQ “complement” each other, as data from clinicians, children and parents can be collected. Therefore if the CAFS service is not completing the post SDQ, a biased view of the outcome may be generated. This could also be construed as a lack of validity of the data being collected.

The SDQ version for children/adolescents between the ages of 11 and 17 allows CAFS to meet the NSF guidelines that young people should be asked to give feedback where the opportunity arises (Perkins, 2001). Goodman, Renfrew and Mullick (2000) used a computer programme to predict psychiatric diagnoses from the raw scores of the SDQ when completed by parents, teachers and young people. They found that the SDQ could be used to aid in the assessment and diagnosis of new referrals to CAMHS. Muris, Meesters, Eijkelboom and Vincken (2004) also suggest that the SDQ could provide useful self reports about the mental health symptoms of children as young as eight. This evidence suggests that the SDQ is a reliable and useful tool for CAMHS. Ford, Tingay and Wolpert (2006) suggest that the “Added Value” score of the SDQ is also a useful pre and post intervention measure to present to commissioners. It is this score that will be used as a measure of effectiveness of CAMHS in accordance with the NFS (2004) and (HMSO, 2007).

The SDQ has been shown to be effective at measuring positive change over time (Goodman, 1997), aiding assessment (Goodman, Renfrew & Mullick, 2000) and giving a valid parent’s/carer’s view of their child’s problems (Goodman, 1997). The SDQ has also been correlated against more lengthy questionnaires such as the Child
Behaviour Checklist (CBCL) and has shown to be less time consuming and equally as good at reporting young people’s difficulties (Goodman & Scott, 1997). Goodman and Scott (1997) also suggest that the SDQ was “significantly better” at detecting inattention and hyperactivity than the CBCL. The SDQ could therefore be used as a practical tool to help clinicians adapt their interventions during therapy (Hatfield and Ogles, 2007).

The SDQ has been described as being a good overall measure, as it focuses on strengths as well as difficulties (Goodman, 1999). Goodman and Scott, (1999) found that mothers of low risk children were twice as likely to prefer the SDQ to the CBCL and were therefore more likely to complete the measure. However, this research did not evaluate the SDQ in the type of geographical area covered by CAFS in which a high proportion of the children are high risk. Another reason for using the SDQ is that other services across the UK use it, therefore allowing services to be compared and join figures to be presented at government level.

**Why do clinicians not complete outcome measures?**

Little research has been carried out into why clinical staff do not complete outcome data, however with services now becoming measured on outcome, more emphasis seems to be placed on understanding the reasons why outcome data are not used (Wolpert et al, 2007). Hatfield and Ogles (2004) suggest that the majority of clinicians use outcome measures for clinical reasons and not as a result of institutional requirements, such as commissioning. Hatfield and Ogles (2007) later explain that clinicians also give practical reasons, such as additional paperwork and time constraints, for not completing outcome measures. For Hatfield and Ogles (2004,
2007) therefore, it would appear that if measures are not deemed to be helpful to practical clinical work, they are less likely to be prioritised and completed.

Bickman et al (2000) discovered that 23% of clinicians who worked in CAMHS used standardised outcome measures. Although this percentage is low, they found that many other clinicians were interested in formalised feedback about the intervention. Hatfield and Ogles (2004) were able to ascertain that 37% of their participants gathered outcome data. The authors also found that clinicians working for organisations such as the NHS were more likely to gather outcome data than those in private practice. Hatfield and Ogles (2007) also determined that psychologists with a clear theoretical orientation such as Cognitive Behavioural Therapy (CBT) were more likely to complete outcome data than psychologists identifying themselves as eclectic. However, they also discovered that regardless of theoretical orientation, practical issues were rated as the most significant reason for not completing outcome data.

Currently in CAFS an administrator sends out a SDQ with an initial appointment letter. The administrator ensures that the SDQ has been completed before the initial appointment takes place. It is the clinician who is responsible for collecting SDQ data from the parents/carer and young person, if appropriate, following the intervention.
Method

Rationale and aims behind the service evaluation.

Direct interventions offered by CAFS are measured using the HoNOSCA and the SDQ at initial assessment and following the intervention. By using both of these measures, the child’s, parent’s and clinician’s perspectives are covered. As a service, CAFS has noticed a problem with gathering post intervention SDQs. This may have implications for demonstrating the service’s effectiveness for commissioning purposes (NSF, 2004; HMSO, 2007). The service is also potentially not meeting guidelines outlined by the NSF (2004), Every Child Matters (2003) and Public Service Agreement 12 (HMSO, 2007).

The following aims were agreed with the manager of the CAFS service.

1. To determine the attitude of clinicians towards the use of the SDQ.
2. To identify factors that could increase the completion of SDQs.

The following hypotheses were generated by, reading through the background literature on why outcome data is not completed and discussing this in supervision. The researcher’s supervisor had been working in the service for five years.

1. Clinicians do not like the SDQ as a measure.
2. Young people and their families do not attend appointments and are discharged by the service before the SDQ can be completed or do not return the SDQ if it is sent out.
3. Clinicians may have anxiety about what is being done with the data and be reluctant to send out the SDQ for completion.

Design

A semi-structured interview using open and closed questions was conducted with six professionals based at the CAFS (appendix 1). A semi structured interview was used
to potentially allow participants to talk more freely about outcome data and the completion of the SDQ. Semi-structured interviews have also been described as “less intrusive to those being interviewed” (Fylan, 2005). Fylan (2005) also suggests that conducting interviews can be more explorative. A thematic analysis was used as suggested by Braun and Clarke (2006) to analyse the interview data.

**Participants**

Six clinicians were asked if they would be willing to take part in the research. Participants were all working in the CAF Service and were using the SDQ as part of their clinical work. Participants were recruited by explaining the research and asking staff members to contact the researcher if they were interested in participating, this occurred during a weekly team meeting. The total sample pool was 48 and out of these six offered to participate.

**Developing questions for the semi-structured interviews**

The literature was reviewed by the researcher and used to draw up questions that could fulfil the aims set out by senior management. The questions were then appraised by the researchers supervisor and questions amended accordingly. Six questions were asked in total (appendix 1).

**Procedure**

Participants were asked if they would be willing to take part in the service evaluation. They were then asked to read and complete a consent form (appendix 2). The interviews lasted no longer than 60 minutes, and took place in a clinical room on NHS property. Each participant was asked six questions and the answers were recorded and then transcribed. Following the analysis the transcripts were destroyed. The finding of the service evaluation were fed back to CAFS service via a team meeting.
Table 1: *Percentage of the participants’ disciplines.*

<table>
<thead>
<tr>
<th>Discipline</th>
<th>% Represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>33</td>
</tr>
<tr>
<td>Psychologist</td>
<td>33</td>
</tr>
<tr>
<td>Social Worker</td>
<td>17</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>17</td>
</tr>
</tbody>
</table>

A mix of professionals were interviewed as seen in Table 7.

**Results**

The main themes from the six interviews are presented in Tables 1-7. The data from the interviews were analysed using thematic analysis in accordance with Braun and Clarke (2006). The aim of the analysis was to report themes within the data. The analysis was carried out in a series of steps. The first step was for the researcher to become familiar with the depth and breadth of the content of the six interviews by transcribing the interview into written form. Initial codes were then generated by highlighting features that appeared to be of interest, thus organizing the data into meaningful groups (Tuckett, 2005). The third phase was to search for the themes from the initial codes. The construction of the themes from the initial codes can be found in appendix 3. Some of the themes were collapsed to form grouped themes for example “negative effect on therapeutic relationship” and “No time” were both placed in the theme of “Practical Issues”. To increase the credibility of the results in accordance with Robson (1993) the themes were presented to a clinical psychologist who supervised the researcher. Changes were then made to the themes titles for example “Dislike” was changed to “Poor Utility”. One of the participants was also
asked to give feedback on the themes generated as a form of “member checking” the themes were upheld Robson, (1993).

Table 2: Question 1 How important is the use of outcome data in CAFS?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotes from Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measures are useful.</td>
<td>“It’s a good way of showing our effectiveness”</td>
</tr>
<tr>
<td></td>
<td>“I think it’s really important that we show we do a good job”</td>
</tr>
</tbody>
</table>

Table 3: Question 2: What do you think about the SDQ? Is it useful to you?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotes from Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Utility</td>
<td>“Data produced is unhelpful…SDQ is not specific to disorders such as ASD”</td>
</tr>
<tr>
<td>Not a specific measure</td>
<td>“The questionnaire is too general, things can change a lot with children and I don’t think you get the full picture, just the behaviours depending on the mood of the parent”</td>
</tr>
<tr>
<td></td>
<td>“A child can be in distress and need psychological intervention and the SDQ score can be normal… how is that useful?”</td>
</tr>
<tr>
<td>Not culturally friendly</td>
<td>I don’t find that the SDQ takes into account the cultural diversity of our client group</td>
</tr>
</tbody>
</table>

Table 4: Question 3: Are you concerned by the potential misuse of the outcome data?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotes form Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Utility</td>
<td></td>
</tr>
</tbody>
</table>
SDQ does not show the whole picture. “Yes as some children’s problems are not getting the classification they need…their problems are much worse than the SDQ suggests” “If we just use the SDQ to show our effectives we will be in trouble… SDQ is just part of the story”

**Table 5: Question 4: Do you believe that outcome data, specifically the SDQ has an effect on service development and delivery?**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotes form Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ll worry about it tomorrow</td>
<td>“it’s getting more important to commissioners, so I think that the SDQ will matter more in the future”</td>
</tr>
<tr>
<td>Increasingly Important</td>
<td></td>
</tr>
<tr>
<td>Data in a black hole</td>
<td>“We never hear about the outcome of completing any of the outcome measures…I never hear anyone talking about it”</td>
</tr>
</tbody>
</table>

**Table 6: Question 5: Do you have problems completing the SDQ post data, if so why?**

<table>
<thead>
<tr>
<th>Theme</th>
<th>“Quotes form Clinicians”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical Issues</td>
<td></td>
</tr>
<tr>
<td>Time.</td>
<td>“SDQ is the last thing from my mind when I discharge a client”</td>
</tr>
<tr>
<td></td>
<td>“I don’t have the time to chase people… and they don’t fill it in”</td>
</tr>
<tr>
<td>Discharge pathway</td>
<td>“Parents just stop coming once the problem has gone away. I mean even if you post it to them they don’t send it back”</td>
</tr>
<tr>
<td>Effect on relationship</td>
<td>“outcome measures can sometimes intrude on the therapeutic relationship… I mean if they complete it and you’re still doing therapy”</td>
</tr>
</tbody>
</table>

**Table 7: Question 6: What could help you complete the post SDQ?**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Quotes from Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>“Admin support”</td>
</tr>
</tbody>
</table>
“It worked best in the past when we had a designated person to be in charge of the SDQ”
Discussion

Summary of findings

There were three aims of this service evaluation:

1) to determine why staff were not completing the post SDQ;
2) what the clinician’s attitudes were towards the SDQ and
3) to identify what could increase the completion of the post SDQ.

When interpreting the results there appears to be agreement among mental health practitioners in CAFS that using outcome measures is a good idea, with equal agreement that the SDQ is not a good example of such a measure. The themes that emerged seem to suggest that clinical staff are concerned that the SDQ is not robust enough to capture their clients’ problems or the effectiveness of the intervention. There was also concern that completing the SDQ at six months could affect the therapeutic relationship if an intervention had not finished.

Given that clinicians expressed frustration with the time spent on chasing SDQs, it is not surprising that there are negative feelings surrounding SDQ completion. All the clinicians interviewed suggested that having administrative support for collecting post SDQs would be beneficial.

The three hypotheses that were generated:

1) Clinicians disliking the SDQ;
2) the way families cancel their service provision by not attending further appointments and
3) clinicians having anxiety about the service’s use of the SDQ data have all been shown to be real concerns of the clinicians working in the CAF service. The hypotheses can therefore be supported. Based on the findings of the interviews, possible recommendations for the CAF service will be explored alongside the limitations of this service evaluation.

**Recommendations:**

Below are proposed recommendations from the service evaluation. Some of these recommendations may be easier to implement compared to others. This is based on staffing availability, time, resources and available funding. The aims of the following recommendations are to increase the frequency of the SDQ completed by parent/carers following intervention. As suggested by Wolpert et al (2007), 100% completion of the outcome data may never be achieved, however CAFS should set a goal of achieving 30% return rate in accordance with government guidelines (HMSO, 2007).

- **Highlighting the Importance of the SDQ.**

The theme of the SDQ as having a poor clinical utility may be the first issue that needs to be addressed to facilitate change and improve the collection of SDQ post data. The NSF (2004) suggests that services will be monitored by the SDQ “Added Value Score”. It is therefore important for the service to educate staff about the importance of the SDQ. This may be achieved through having a slot at the team meeting. The importance of the SDQ could also be modelled and emphasised by having a dedicated feedback slot across the year. The psychometric properties of the SDQ could be explored with clinicians using it and relevant research highlighting the good qualities of the SDQ compared to other questionnaires (Goodman & Scott, 1997;
Goodman, Renfrew & Mullick, 2000). If the SDQ could be shown to be effective and efficient, it could lighten the burden of practical barriers (Hatfield and Ogles, 2007).

- **Training of New Staff**

Hatfield and Ogles (2007) suggest that to maximise the clinical benefit from outcome measures, clinicians need to be trained in how to use the measures effectively. It may be beneficial for CAFS to offer training to new staff in their induction to the service. This would enable appropriate use of the measure, as well as increasing the importance of it. Research by Hannon et al (2005) suggests that explaining how to interpret outcome data to make it practically significant can also improve rates of completion, therefore staff could be trained in the analysis and application of the data to clinical cases.

- **Giving Adequate Information**.

It has been highlighted that parents do not complete the SDQ and return it. This may be improved by giving the parents adequate information about the SDQ; why they are being asked to complete it and what happens to the data. This could be added to the initial appointment form (face to face) to remind clinicians. Improving training and emphasising the importance of the SDQ at a staff level may also ensure that adequate information is passed to service users.

- **Administrative Support**.

The interview data suggested that clinicians felt that dedicated administrative support would help with the collection of completed post intervention SDQs. However, there could be issues surrounding finding administration time to complete this role. A way round this barrier could be to have a nominated “clinical champion”. This could be a person who takes responsibility to educate and encourage clinicians to complete outcome data. As this person would already be working in CAFS, staffing would not
be a barrier for change. Staff could potentially take turns to perform this role, thus easing the time constraints being placed on one person.

- **Learning from Other Services.**

CORC has published advice to help services reach government standards concerning outcome measures. As well as this advice, CORC has a website which offers clinicians working in CAMHS across the country the opportunity to get in touch with one another. Increasing the communication between other services maybe helpful for CAFS, as they could build on other services’ successes and learn from their mistakes (Wolpert et al, 2007).

- **Document data**

Hatfield and Ogles (2004) suggest that making outcome data meaningful can help clinicians complete it. It may therefore be helpful to include pre and post SDQ scores in discharge letters to referrers and parents/carers. This could improve the status and usefulness of the SDQ, as well as making other agencies aware that the SDQ is an outcome measure being used by CAFS (Hannon et al, 2005). It may be beneficial for CAFS to supplement SDQ data with another measure that has been shown to be valid and is preferred by clinicians. For example, the HoNOSCA has been shown to have similar outcomes to the SDQ (Goodman, 1997) and is currently being completed by clinical staff in CAFS.

- **Caseloads and time available**

Using the theme of practical barriers, it may be beneficial to keep a track of individual caseloads and have a maximum caseload for each team member. The optimum caseload could be defined by the number of hours worked and the needs of the service
user and his/her family. Time for paperwork and completion of outcome measures could also be included in the maximum caseload.

**Barriers**

One of the biggest barriers for CAFS to break down before change can occur must be the clinicians’ dislike of the SDQ. Obviously, if clinicians feel that the SDQ is not relevant to their clients, they will not put much effort into overcoming this barrier (Lambert 2001). However it is not as simple as just changing the outcome measure, as the government has set targets using the SDQ. The first step for CAFS to begin to complete post intervention data must therefore be to make staff aware of the importance of the SDQ. Sharing the responsibility may empower team members to begin to prioritise SDQ collection.

Practical barriers such as time for completing the SDQ may also be overcome by ring fencing a set amount of time per week for each clinician to dedicate to outcome measure collection.

**Stages of Change**

Prochaska and DiClemente (1986) described a model of behavioural change that had five stages which individuals move through in a spiral. These stages include pre-contemplation, contemplation, preparation, action and maintenance. It may be helpful to think about the CAFS at the pre-contemplations stage where there is no intent to change behaviour. By highlighting the importance of the SDQ clinicians may move into a contemplation stage, where an awareness of the problem exists. CAFS may also benefit from preparing for the change by being informed of developments and how change will come about. To move into the action phase training could be offered to equip clinicians with new skills to bring about the change. The change can be
maintained by continued training of new staff and safeguarding time for clinicians to complete the data.

**Limitations and conclusions of the service evaluation**

The service evaluation is limited, as only six clinicians were asked to give their opinions. Some opinions may have been missed, which may have influenced the themes that were developed through thematic analysis. On reflection, it may have been more useful to supplement the qualitative data with a questionnaire that could have been fully anonymous. Confidential data collection may also have allowed the clinicians to talk more freely about the SDQ. As the author is currently a member of the CAF service, it may have been difficult for the clinicians to talk honestly due to fear of breach of confidentiality. On hindsight some of the questions asked may have been leading and may have influenced the results. If I was to complete the service evaluation again, having a pilot interview would have been beneficial. Unfortunately due to time restraints and lack of participants this was not able to take place.

The service evaluation may have also benefited from data being collected from a management perspective, as the results could show a bias due to managers not being included. The author may also have approached people that she felt would participate and may have obtained different results if a different recruitment procedure had been used.
References


City Primary Care Trust and City Council (2007) Child and Adolescent Mental Health Draft Strategy 2007-2010, City Council: UK.


Appendix 1 – Questions Asked to Participants.

Question 1: How important is the use of outcome data in CAFS?

Question 2: What do you think about the SDQ? Is it useful to you?

Question 3: Are you concerned by the potential misuse of the outcome data?

Question 4: Do you believe that outcome data, specifically the SDQ has an effect on service development and delivery?

Question 5: Do you have problems completing the SDQ post data, if so why?

Question 6: What could help you complete the post SDQ?
Consent Form

Please tick the boxes

I confirm that I have understood that my participation in this service evaluation is confidential and have had the opportunity to ask questions. □

I understand that participation in the study is voluntary and that I am free to end my involvement at any time, or request that the data collected in the study be destroyed, without giving reason. □

I agree to my participation in the above study □

Participant’s name ……………………………………………………………………………………………

Participants signature ……………………… Date………………

FOR OFFICE USE ONLY

Signature of researcher ……………………………… Date………………
### Appendix 3

<table>
<thead>
<tr>
<th>Theme</th>
<th>Initial Codes</th>
<th>Endorsed by Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outcome measures are useful.</td>
<td>a. Easy to use</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b. Tangible</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>c. Supportive</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>d. Added knowledge</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>e. Good assessment tool</td>
<td>1</td>
</tr>
<tr>
<td>2. Poor Utility</td>
<td>a. Cultural issue with SDQ</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b. Specifics of SDQ</td>
<td>4</td>
</tr>
<tr>
<td>3. I’ll worry about it tomorrow</td>
<td>a. Awareness of SDQ being increasingly important</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>b. Data not used in service</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>c. Not my responsibility</td>
<td>5</td>
</tr>
<tr>
<td>4. Practical Issues</td>
<td>a. No time</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>b. Clients discharge</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>c. Negative effect on therapeutic relationship</td>
<td>2</td>
</tr>
<tr>
<td>5. Support</td>
<td>a. Admin</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>b. Data base</td>
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</table>
Abstract

This case study describes the use of couple based solution-focused brief therapy (SFBT) with an 81 year old lady with anxiety and her husband. The assessment is presented, together with a systemic formulation based on Cronen and Pearce’s (1985) coordinated management of meaning model. An outline of the brief solution focused intervention conducted is provided, along with the rationale for selecting it. The effectiveness of the intervention is discussed with the use of outcome measures.

The process of using SFBT with couples is reflected upon and the limitations discussed.

NB All names have been changed to ensure anonymity.
CPR 4 - Case Study

Working with a 81 year old client who has anxiety using a solution focused couples approach

Referral information (from referral letter)
Kate was referred to clinical psychology from the Community Mental Health Team (CMHT). The referral described an 81-year old woman who had been seeing the team’s consultant psychiatrist, community psychiatric nurse (CPN) and occupational therapist (OT) for the past 12 months. The referral requested a psychological perspective of Kate problems, as members of the CMHT felt that they were having difficulties moving Kate forward. She had been suffering with anxiety for the last 18 months.

Background
Onset/duration
Kate reported that her current anxiety and depression had resulted from her husband receiving some bad news about his physical health. He had been diagnosed with kidney problems and cancer of the prostate. Kate found this news difficult to deal with and began to experience feelings of anxiety and low mood.

Intervention used prior to psychological intervention
The OT had eight sessions with Kate using anxiety management techniques and relaxation. The OT had also put together an activity plan to encourage Kate to fill her day with meaningful activities. Kate did not feel that this approach had helped and she had reported little gain from the relaxation techniques. Kate was also being seen twice a month by a CPN and every three months by the consultant psychiatrist. The CPN reported that her main role had been reassuring Kate that her symptoms were
associated with anxiety and encouraging Kate to increase her activities. The consultant psychiatrist had less contact with Kate. However, she felt that Kate was having difficulty accepting that she was getting older.

**Assessment sessions 1-3**

A clinical interview was selected for the assessment session, which took place at Kate’s home. This is standard practice for the older adult service in which the trainee was on placement. A benefit of using a clinical interview is that the clinician can ask open ended questions to obtain information about the client and his/her problems. Wells (1997) suggests that a clinical interview is most frequently used as an assessment method due to its flexibility. However, it is important for the clinician to be reflective in this process and to be aware of potential bias. Supervision was used as a means of identifying possible bias and being aware of this in subsequent sessions. During the sessions, the nature of the presenting problem, the onset and maintaining factors were assessed with the aim of determining specific therapy goals (Wells, 1997).

**Psychometrics**

Kate was not keen to complete questionnaires independently. However, she did agree to rate her anxiety from session to session using a scale from 1-10 rating her feeling of anxiety.
**Presenting difficulties**

Kate presented as anxious and low in mood. She found it difficult to leave the house. She was also finding it hard to cope with the physical sensations of her anxiety. She described feeling unreal and apprehensive. She reported finding it hard to relax and complained of feeling tired from the slightest activity. Kate believed these feelings were a side effect of the medication prescribed for her anxiety.

Kate described a good sleeping pattern but said she woke with a feeling of dread which lasted until around eleven am. She expressed no suicidal thoughts, however she reported that sometimes she wished that she would not wake up. Kate had lost three stones in weight in the last 12 months and described a poor appetite.

**Carer’s perspective**

During the assessment, Kate’s husband Thomas was present at her request. He described Kate as having changed into a person he did not recognise. He described her as previously being an independent, sociable person and said he now believed her to be anxious, frightened and dependent.

**Previous mental health**

Kate reported that she had also “been a worrier”. She described a low mood following the birth of her daughter in her early 30s, which she said had been successfully treated with anti depressants. She reported that following this period of low mood, her husband took over the running of the household bills and Kate was able to concentrate on looking after their two children.
Family
Kate lives with Thomas, her husband of 65 years. They have two children, a son and a younger daughter. They have a lot of contact with their daughter who has a son and lives locally but Kate reported not seeing as much of her son, as he lives abroad (appendix 2).

Coping strategies
Kate initially informed the trainee that she was not coping with her anxiety. However, during the assessment she described not coping without the use of medication. She said she believed that taking medication was a “sign of weakness” and described feeling humiliated by her current problem. Kate reported that she felt better in the afternoons when she could watch quiz shows on television.

Further assessment
Further assessment was conducted over two sessions using clinical interviews, during which time Kate expressed frustration that Thomas did not understand what it was like to feel the way she did and that he just thought she should “snap out of it”. Kate also described the debilitating nature of her anxiety. She found it difficult to leave the house, for fear of what people might think of her but said she liked to get out of the house. Kate described pushing herself to leave the house for the sake of her husband and said she would like to do more with him. Kate found it difficult to think of the person she used to be and said she did not know who she was any more.
**Therapeutic relationship**

A good therapeutic relationship was developed with Kate. Knight (1996) asserts that a good way of strengthening the therapeutic relationship with older adults is to let them talk about the problem. Lipchik (2002) found that this is helpful as long as the therapist listens with a constructive ear, and employs the information given by the client in the development of questions, aimed at eliciting resources. Kate was encouraged to do more of the talking during the assessment. A therapeutic relationship was developed, where the author was more of a collaborator than the leader.

**Goals**

From the assessment, Kate was able to generate goals that she wanted to achieve. These are presented in Table 1.

**Table 1. Collaboratively generated intervention goals.**

<table>
<thead>
<tr>
<th>Intervention Goals</th>
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<tbody>
<tr>
<td>1. For Thomas to understand Kate’s anxiety.</td>
</tr>
<tr>
<td>2. For Kate to see a spark of her old self i.e to have “spontaneity”</td>
</tr>
<tr>
<td>3. For Thomas and Kate to have a different topic of conversation, other than Kate’s anxiety.</td>
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</tbody>
</table>

Thomas was also asked what he would like to achieve from the sessions and he agreed that a different topic of conversation and going out with Kate would be of benefit to him.
From spending three assessment sessions with Kate and her husband, it was hypothesised that Kate and Thomas were having difficulty communicating their feelings to one another. This was reflected to Thomas and Kate who agreed that communication had become a problem for them. The outline suggested by Vetere and Dallos (2003) was therefore used to assess the appropriateness of using a systemic approach to Kate’s presenting problems.

Vetere and Dallos (2003) highlight three ways of assessing the suitability of a systemic approach. They suggest that there must be a trauma to the family system; that the system is showing signs of relationship problems and that the family system is aware of some connection between the relationship problem and the presenting problem. Kate’s presenting problems indicated that a systemic approach would be appropriate, as Thomas’ illness had been a traumatic event in the family; Kate thought that Thomas did not understand how she felt; she had experienced difficulty telling him how she felt and believed that she would be able to talk to him if he understood her feelings.

**Formulation**

Vetere and Dallos (2003) indicate that distress is a complex process, the origins of which can be due to relationship influences. They point out that a major event that directly affects one person will have an impact on all relationships which are within that system. A problem is therefore not merely an intra-psychic process, but is influenced by different relationships throughout the system. It can be helpful to think of problems from a systemic perspective, as the very nature of systemic thinking moves away from focusing on the person and the problem, and shifts to thinking about the person in relation to a system (Campbell, 1999).
Systemic theory is fundamentally different to other schools of psychological thought as causation is described as circular rather than linear. This would suggest that Kate’s anxiety is not a direct result of Thomas’ ill health but rather a pattern of events which leads to anxiety and its maintenance (Altschuler et al, 1997). Altschuler et al, (1997) described the change of belief/or behaviour at one part of the system can have a ripple effects to other parts of the system, suggesting a circular pattern.

Many scholars have referred to schools of systemic thinking including Milan, narrative, structural and solution focused (Donovon, Mastroynannopoulall & Cobner, 2002). The formulation of Kate’s presenting problem was developed using Cronen and Pearce’s (1985) coordinated management of meaning model, which suggests multiple levels of context (the diagram of the formulation can be seen in Figure 1).

A genogram was constructed during the assessment (see appendix 1). The purpose of constructing a genogram was to enable an understanding of the system that Kate was in and “map the problem” to significant relationships with other members of the system (Anderson et al 1986). Mcgoldrick and Gerso (1999) suggest that a genogram also acts as a way of understanding the context of the problem. The formulation presented concentrated on Kate’s relationship with her husband, as according to Burnham (1986), a systemic formulation should be constructed in a context of importance to the client. At the time of the assessment, Kate’s marital relationship was of great importance to her.
CULTURAL/SOCIETAL
Western ideas about getting old.
Ideas about what later life should mean.
When people are old and dependent they are a burden on society.

FAMILY STORY/SCRIPT
You should just get on with it.
You should not talk about how you feel.

PERSONAL STORY/SCRIPT
I have to take control.
I should be able to sort this out by myself.

DEFINITIONS OF RELATIONSHIPS
Relationship is suffering because of the problem
Communication has broken down.

EPISODES
Transition from being cared for to caring
Realisation of mortality

SPEECH ACT – BEHAVIOUR
Anxiety
Avoidance

Figure 1. Formulation of Kate’s presenting problems in the context of her relationship with Thomas. Adapted from Cronen & Pearce (1985).

Carter and McGoldrick (1989) suggest that individuals pass through transition points at different points in their lives. Kate and Thomas may be currently passing through a
transition as a result of Thomas’ ill health and diagnosis of cancer. Asen et al (2004) suggest that stress and tension are usually familiar emotions around times of transition. As Kate described feelings of stress and tension, it may be fair to hypothesise that a transition is occurring as a result of Thomas’ ill health. Kate and Thomas described having good physical health for the majority of their adult lives and that Thomas had also looked after Kate and the family both financially and emotionally. Kate may have found that there was a transition from being cared for by Thomas to having to care for him (cared for to the carer).

Kate said that her daughter believed that Kate’s anxiety was putting increased pressure on her father; Kate reported that her daughter thought she was being selfish and that she should just “pull herself together”. It may be hypothesised that Kate’s daughter believes her mother’s illness is increasing the levels of anxiety and tension in the family system. The lack of input from Kate and Thomas’ son may also be increasing negative emotions, as Kate and Thomas perceive this as him not caring.

Personal scripts in families are also very important (Byng-Hall, 1995). Kate described a “you just have to get on with it” motto, which seems to be reflected in Thomas’ and his daughter’s view of ill health. This may be a strongly held family script. Kate not being able to just “get on with it” and get over her anxiety could be causing her more distress, as this goes against the family script.

Thomas and Kate also seem to have different views on life. Thomas describes “you’re born, you live, you die” personal script when Kate found talking about death and illness as a negative and taboo. Thomas’ ill health may have led Kate to a realisation
that she was getting older and the difference in her personal script to Thomas’ may be causing the system distress. The stressful transition may be affecting the couple, as Kate and Thomas describe not communicating and showing feelings like they used to.

During the assessment it emerged that Kate had become “problem saturated”. She described a personal script of wanting to sort her anxiety out by herself and to be in control of the problem. This personal script of control could be having an overwhelming effect on Kate. The problem had become “all consuming” and Kate had reduced her daily activities. George, Iverson and Ratner (2007) describe how clients can become problem saturated by spending large amounts of time thinking and talking about the problem. Furthermore, they suggest that the problem can become bigger than the client who may feel that his or her only identity is the problem (George, Iverson & Ratner, 2007).

Western ideas about getting older may also have influenced Kate and Thomas. Woods and Clare (2008) asserts that society can have mixed views about the meaning of getting older. Reed, Stanley and Clarke (2004) suggest that older people can be perceived as a “burden” and “unproductive” by the wider society. This idea of ageing can have a negative effect on relationships and the family system, particularly as Kate and Thomas move towards a new phase in their lives where they may see ill health as the theme.

Communication between Kate and Thomas had become difficult following Thomas Cancer diagnosis, as Kate struggles to keep her anxiety about dependency, aging and death to herself. However, Kate also finds that anxiety dominates her conversation
with Thomas. Thus, working as a couple could allow Kate and Thomas to overcome
Kate’s anxiety and their communication problems. Using Solution-focused brief
therapy (SFBT) could also allow Kate to feel more spontaneous as the sessions would
be less structured. Using this approach could address Kate’s goals presented in Table
1.

Rationale for intervention

During the assessment Kate’s successes and resources were discussed and this seemed
to fit well with the couple. As successes were discussed there was a noticeable
positive change in Kate’s facial expression and Thomas became more relaxed. As a
couple, they appeared more hopeful, suggesting that working together as a couple to
unite against the problem could be successful.

Solution-focused brief therapy (SFBT) was used to work with Kate and Thomas. It
was thought that this approach would be helpful as Kate had become focused on her
problem and they were unable to move forward as a couple. Kate’s increased focus on
the problem was minimising her conversations with Thomas, as she did not want to
discuss how she was feeling for fear of distressing her husband while he was ill.
As Kate’s goals were centred on herself and Thomas it was again thought that a
couples approach would be appropriate.

Kate’s goals suggested that she wanted to see a spark of her old self and improve
communication, she indicated that working as a couple could be beneficial as any
successes could be highlighted and talked about in therapy. Kate also reported
wanting to control her anxiety on her own. It was therefore decided that a solution a
solution focused approach could encourage Kate to focus on her own current coping strategies and enable her to feel independent in managing her anxiety.

The formulation was used as an overarching framework which presented a ‘snapshot’ of Kate’s presenting problems at assessment. Although a SFBT approach does not require a specific formulation to be effective (de Shazer, 1985), the formulation was used as for reference throughout the intervention As O’Connell (2005) asserts solution focused approaches do not need to understand the underlying reasons for a presenting problem, just to understand the solutions.

Brief solution focused therapy was first developed in the 1980s by de Shazer and falls under the umbrella of systemic thinking according to Dallos and Draper (2000). According to Dallos and Draper (2000) the foundations of a solution focused way of working are to focus on the positive strengths and successes that the client has had (de Shazer, 1985). De Jong and Berg (2008) suggest that there is always a time when the problem is not present and this can be used as a foundation to form solutions.

It has been suggested that a brief solution focused approach can be beneficial with older adults, as the process of clients developing their own solutions to problems can be empowering (Iveson, 2001). Research has also suggested that solution focused therapy (SFT) is effective with older people with a range of presenting difficulties (Dahl, Bathel & Carreon, 2000; Iveson, 2001). Gingerich and Eisengart (2000) conducted a systemic review of the use of SFT and found that in 15 papers reviewed that 67% of cases showed a significant improvement. Knekt and Lindfors (2004) reported improvement in the functioning of individuals with anxiety and depression.
by 43% when using SFT and Beyebach and Carranza (1997) found that following SFT, clients felt more able to manage their problems. Seidel and Hedley (2008) also described positive results, as clients reported a higher level of confidence following SFT.

Lasoki and Thelen (1987) conclude that older adults are less likely to identify problems as psychological in nature, and it was therefore decided that focusing on solutions rather than pathology may be helpful to Kate. There is currently a dearth of research literature focusing on the effectiveness of a solution focused way of working with couples. However, given Kate’s presenting problems and the potential effect that her relationship with Thomas may have been having on them, it was thought that this way of working would be of benefit. Kate and Thomas were also willing to work together as a couple.

**Intervention**

Kate and Thomas were offered six sessions. The sessions were time limited due to the timescale of the placement. However, Kate could continue to receive CMHT input form the CPN and consultant psychiatrist following the end of therapy. The intervention followed the scheme suggested by George, Iveson and Ratner (2007) which has the outline of *Opening, Future Focus, Past and Present focus, Highlighting Progress* and *Closing*.

McGee, Del Vento and Bavelas (2005) highlight the importance of questioning in SFBT. During the intervention sessions, questioning was based on using words and phrases that Kate and Thomas had used and incorporating them into subsequent questions. McGee et al (2005) suggest that therapists should listen, absorb the client’s
use of language and connect the language to positively framed questions aimed at eliciting solutions from the client.

**Session 4- (Brief outline of the 1st intervention session)**

Before formally opening the session, practical arrangements were discussed. Following this in accordance with de Shazer (1985) the session was opened with a question that was deemed to explore the non-problematic side of Kate and Thomas’ life. Kate and Thomas were asked “What are your best hopes from this meeting?” Following this the couple were asked a “miracle question”. George, Iveson and Ratner (2007) suggest that good outcomes in therapy have been associated with asking clients a “miracle question”. According to Connell (2003) the miracle question gives the client a reference to the desired future and suggests a positive future focus. The question used in the session was “If you woke up tomorrow and your hopes had been realised what’s the first thing you might notice different?”

Berg and Dolan (2001) suggested that it is beneficial to use a Past and Present focus in SFT as a way of focusing on what is already working for the client. De Shazer (1985) also suggested the use of scaling questions to monitor the achievements of a client and evaluate progress. Thus, Kate was asked to rate her anxiety during each session. “Where is your problem now, say on a scale of 1 to 10? 1 having little anxiety and 10 being completely paralysed by our anxiety”. Thomas was also asked to rate his perception of Kate’s anxiety this was used to highlight progress. George, Iveson and Ratner (2007) also suggest that highlighting progress that the client makes can be a positive step and can encourage and empower the client to continue. Kate was asked to name for herself what progression would look like for her in relation to
her intervention goal of seeing a spark of her old self. “How would you know when you have made a step towards your goal of seeing a spark of your old self? Kate and Thomas were also asked to think back over the week and try and think of a time when they noticed something positive “When in the past couple of weeks have you seen something, even in a small way, of what you are hoping to see in the future” Berg and Dolan (2001) suggest that the purpose of this is to minimise the failing of the past and emphasise previous successes. SFBT is working towards finding ways that the client uses their own natural protective mechanism (de Shazer et al, 2006).

All the sessions with Kate and Thomas were closed in accordance with George, Iveson and Ratner (2007) by reflecting back the positive progress of that session with a significant statement. A statement such as the one presented below was used at the end of the first intervention session with Kate and Thomas. This statement has the main elements suggested by Iveson (2001) validation and acknowledgement, resources and what’s right and these have been highlighted in the statement.

“We have discussed lots of things today and it seems that you have been through a lot recently, it’s not surprising you feel the way that you do (validation and acknowledgement) but you have been able to tell me about times when your anxiety has not been such a problem to you, like when you were at the garden centre (Resources). It seems that having a reason to go out can really help you (what’s right).

George, Iveson and Ratner (2007) suggest, every SFBT session should be treated as if it were the only session. Following the session, Kate and Thomas were asked if they
would like another appointment and as they agreed, they were asked to notice things happening in their lives that they would like to see continue, no matter how small, and to report on these in the following session. This noticing task, taken from Berg and Dolan (2001), is suggested as a way for the client to shift from a problem to a solution.

At the end of the session, Kate and Thomas seemed more light-hearted than before. They were making jokes and the atmosphere felt more positive.

The following five sessions followed the same format as session 1. However, more emphasis was placed on exploring change, and highlighting the progress and signs of change. The second intervention session took place one week after the first and thereafter the sessions were held at two then three week intervals.

**CMHT (Multi disciplinary working)**

The systemic formulation (Figure 1) was presented to the consultant and the CPN during a meeting arranged by the trainee. The aim of this meeting was for the team to see Kate’s presenting problems from another perspective and to agree on the best way to support Kate in moving towards her goals. Effective communication between all of the professionals involved in Kate’s care enabled them to support Kate in finding her own solutions to her problems. This also allowed the consultant and the CPN to carry on working with Kate after one to one work with the trainee came to an end.
Outcome

Following the nine sessions in total, Kate’s anxiety reduced slightly (see Graph 1). Practically Kate had been able to go out for a bar meal with Thomas and they had reported enjoying going to the garden centre. Kate had also begun to go to her hairdressers once a week and walk to her friend’s house for a coffee. Kate expressed some disappointment for not making speedier progress but felt that she was on the “right track”. Thomas and Kate appeared to be working together as a couple and seemed to be more relaxed in each other’s company. They were also able to comment on activities that they had done in the time between sessions and make jokes about arguments they had had, which to them was a reported sign of “being normal”. Kate still reported feeling anxious most of the time, but she said she was trying not to let it stop her from enjoying her life. Interestingly, Thomas perceived Kate’s anxiety to be lower than she did. This was used in sessions to highlight progress and successes.

The self rating data taken during sessions 4 to 9 demonstrate a downward trend over the intervention and this can be seen in Graph 3.

Graph 1. Illustrating the self rating form 1 to 10 “Where is your problem now, say on a scale of 1 to 10? 1 being having little anxiety and 10 being completely paralysed by your anxiety.”
Although the outcome data demonstrated a slight improvement in Kate’s reported level of anxiety, it did not reflect the practical steps that Kate was able to achieve. This may be that the outcome measures used were too general to take slight improvements into account. However, this could also be that Kate was able to complete tasks while still experiencing a perceived high level of anxiety. Using self-reporting scales may be seen as an accurate way of measuring anxiety. However, Kate may have been under-reporting her anxiety in order to maintain the therapeutic relationship or over-reporting as she felt overwhelmed by her anxious feelings. The timing of the scaling question may also have affected the outcome data. The question was asked when deemed appropriate during the session, however, on reflection, it may have been more accurate to ask the question at the beginning of every session.

**Other models of therapy**

Although a systemic overarching formulation was presented and a SFBT intervention implemented it may have been helpful to think of Kate’s anxiety from a cognitive perspective. Using a model such as Wells’ (1997) cognitive model of Generalised Anxiety Disorder (GAD) may have helped Kate to understand her anxiety and “normalise” her physical feelings. However, this may have led Kate to internalise her problem and become self-blaming. Using SFBT, Kate was able to look at a different future and to use her own natural protective mechanisms.

There is also an evidence base for Interpersonal Therapy (IPT) as a successful intervention for older adult’s experiencing anxiety (Wetherell, 1998). Kate may have benefited from IPT as the emphasis is placed on interpersonal relationships and the “interplay between the individual and their environment” (Hinrichson, 1999, p950). The IPT intervention could have focused on Kate’s conflict and reduction in her
communication with Thomas. Furthermore, there could have been a focus on the significant changes to their relationship as a result of Thomas ill health and Kate’s role transition from wife to caregiver (Hinrichson, 1999).

**Reflections**

Working with Kate and Thomas has highlighted the importance of not forgetting that an individual is part of a greater system and that in some instances it can be helpful to work with the system and not just the individual. Kate was able to benefit from having Thomas present at the sessions, as they were able to work together to form new ways of moving towards solutions and away from their problems. However, it is difficult to determine whether the intervention was solely responsible for the decrease in Kate’s anxiety. There could be other factors that reduced her anxiety such as just being listened to (Knight, 1996) or that the anxiety may have decreased on its own.

The lasting effects of the intervention cannot be measured as a follow-up appointment with Kate and Thomas was not possible. It has been suggested by Berg and Dolan (2001) that SFT does not explore underlying reasons for anxiety and therefore cannot maintain positive results over time. However, O’Connell (2005) suggests that it is not necessary to explore underlying reasons to make and maintain changes. Macdonald (2005) conducted a follow-up study and discovered that improvements were maintained in 75% of cases where SFT was used with individuals.

During the intervention sessions there were times when it was difficult not to be drawn back into talking about the problem. Supervision became crucial for identifying when this was occurring. The effect of the author’s gender and age on the system was
also explored during supervision. However, as the position of collaborator, as opposed to leader, was taken during the sessions, the difference in age and gender did not appear to affect the therapeutic relationship.

The use of scaling questions as suggested by Berg and Dolan (2001) were helpful to aid in the motoring of Kate’s anxiety. However, this also felt paradoxical as the couple were being asked to focus on the problem. Therefore during the sessions the author was aware to highlight the progress made during that particular session and try not to be drawn into the “problem talk”.

This case study suggests that taking a solution focused approach with a couple can facilitate change. However, more research is needed to improve the evidence base for working with an older adult population.
References


Appendix 2. Copy of Genogram- illustrating Kate’s significant relationships.
Abstract

The presentation was based on an evaluation of current services available to parents with Learning Disabilities (LD) in Wolverhampton.

Government guidelines suggest the importance of supporting parents with LD to have relationships, become parents and to be supported to continue to be parents. Good practice guidelines for working with parents with LD (2007) also featured heavily in the presentation.

The findings of the evaluation demonstrated that there were gaps in the services that Parents with LD received. There was also no clear identification of parents with LD and no clear pathway for parents to access services they may need.

A new service was outlined that was underpinned by government guidelines (Every Child Matter, 2004 & Valuing People, 2001). The service was suggested to be funded by the pooling budgets from Mental Health, Social Care and the Acute Trust. The possible outcomes of the new service were presented and the importance of measuring the services effectiveness.

Barriers to the development of the new service were highlighted.