Volume II

Clinical Practice Reports

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Thesis submitted to
The University of Birmingham
For the degree of

DOCTORATE IN CLINICAL PSYCHOLOGY
Summary

This thesis is presented in two main parts. Volume I is the research component comprising two papers: a literature review and empirical paper each concerned with the psychosocial effects of living with Coeliac Disease. There is also a separate executive summary of both pieces of work. Volume II is the clinical component, a compilation of five Clinical Practice Reports completed at the end of each clinical placement during the 3 years of the Birmingham Clinical Psychology Course.

Volume I

The literature review is a systematic critique of empirical research published within the last decade to investigate the effects of living with CD in respect of psychological well-being and Health Related Quality of Life (HRQoL). Twenty-one relevant studies were identified with attention being paid to the methodology, outcome measures, type of CD and sample characteristics. Difficulties when interpreting and comparing the results of the reviewed studies included differences in design and measures used, sample populations, country of origin, age group and duration of gluten-free diet. The reviewed data suggest that in addition to a reduced HRQoL, psychological distress, especially depressive symptoms is commonly found in patients with CD. Although anxiety is commonly experienced, this tends to decrease on a GFD. However, depression may persist even in treated patients.

The empirical paper describes a postal survey aimed to explore the illness perceptions and self-efficacy beliefs of adults with CD in the UK and reports their subjective levels of HRQoL and psychological well-being. Questionnaires were returned by 288 members of Coeliac UK and within this sample HRQoL and psychological well-being were found to be reduced, with levels being comparable to those found in previous
related studies. Those participants with weak beliefs in the serious consequences of CD and reduced emotional reactions to the condition were more likely to experience an enhanced HRQoL, improved psychological well-being and increased self-efficacy. The results suggest that perceived self-efficacy and illness perceptions could play an important role in informing psychological interventions for individuals with CD.

**Volume II**

Volume II contains the five Clinical Practice Reports (CPR’s) that focus on a combination of clinical perspectives and service issues relating to each placement. CPR 5 was presented orally so that only the abstract is included.

CPR 1 presents two psychological formulations, each from a different theoretical perspective, concerning the problems of Katrina. There are four main sections. The first includes information relating to Katrina’s referral, assessment (including history) and her presenting problems. In the second section, Katrina’s problems are formulated from a psychodynamic perspective based upon object relations theory and constructed using Malan’s triangles of conflict and person. This is followed in section three, by an alternative cognitive behavioural formulation of health anxiety. The fourth and final section is a concise critique of the two different theoretical approaches used in each formulation and includes recommendations for improvements.

CPR 2 describes a study carried out to evaluate clinical supervision groups set up for NHS nurses working in a continuing care unit for older adults. National initiatives concerning supervision for nurses within the NHS and the available evidence for the effectiveness of this are considered. The limitations of the methodology and the difficulties experienced in carrying out the evaluation are discussed and blocking factors are considered which might account for difficulties in implementing clinical group supervision for all staff. Facilitative strategies are drawn from the relevant literature and
recommendations are made for future evaluations and implementing supervision into routine clinical practice.

CPR 3 concerns Christopher, a 9 year old boy referred to a Child and Adolescent Mental Health Service by his general practitioner with a request for help with long-term sleep difficulties. Details of the referral, assessment and formulation relevant to the case are presented. These are followed by a description of the AB single-case experimental design that was employed to assess the effectiveness of a cognitive-behavioural intervention designed to increase Christopher’s total number of sleep hours per night and to reduce the time taken for him to fall asleep.

CPR 4 presents the case of Marion a 58 year old woman with learning difficulties, who was reportedly displaying extreme eating behaviour by the over consumption of large quantities of food. Background information on Marion’s personal and psychiatric history is provided. This is followed by a formulation of the development and maintenance of Marion’s behaviour using cognitive-behavioural principles and a description of the interventions employed to manage her behaviour. Finally there is an assessment of the outcome and reflections on the work with Marion and her care staff.

CPR 5 was an orally presented report describing Tasmita a client who was referred to the CMHT where the trainee was on placement. The scope of the presentation included the reasons for her referral, the assessment methods used, the rationale and theory behind the cognitive behavioural formulation of her difficulties and the evidence for and details of the proposed treatment plan. The formulation described the development and maintenance of Tasmita’s depression and obsessive compulsive behaviours and was informed by the information obtained during the assessment stage. This was followed by an evaluation of the cognitive behavioural treatment plan in terms of Tasmita’s own subjective experience.
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CLINICAL PRACTICE REPORT 1:

PSYCHOLOGICAL MODELS

The case of a 41 year old woman presenting
with health anxiety: psychodynamic and
cognitive behavioural perspectives

Word Count: 4967
ABSTRACT

This clinical report presents two psychological formulations, each from a different theoretical perspective, concerning the problems of a client to be known as Katrina. There are four main sections. The first includes information relating to Katrina’s referral, assessment (including history) and her presenting problems. In the second section, Katrina’s problems are formulated from a psychodynamic perspective based upon object relations theory (e.g. Klein, 1986; Winnicott, 1965) and constructed using Malan’s triangles of conflict and person (Malan, 1995). This is followed in section three, by an alternative formulation developed from a cognitive perspective, drawing on the model of health anxiety proposed by Warwick and Salkovskis (1990). The fourth and final section is a concise critique of the two different theoretical approaches used in each formulation and includes recommendations for improvements.

All names and other identifying features have been changed in this report to ensure client confidentiality.
SECTION 1 – PSYCHOLOGICAL ASSESSMENT

Referral

Katrina is a 41-year-old Caucasian woman referred to the psychology service by her General Practitioner. The referral letter stated that Katrina had a history of depression and anxiety since the birth of her first child 11 years ago and was also obsessive. Due to this she had been treated with Paroxetine, Cipralex and more recently Dosulepin but without much improvement.

Assessment

This took place during 4 sessions over a period of 6 weeks (Katrina was unable to attend 2 of our weekly scheduled appointments due to her mother and father-in-law being admitted to hospital within a few days of each other). The Short Health Anxiety Inventory (SHAI – see Appendix 1) was completed and the score 48/54 indicated that Katrina was suffering from a severe level of health anxiety (Salkovskis, Rimes, Warwick & Clark, 2002). There was no evidence of self-harm or suicidal intent.

Background History

Katrina was born in 1966 and has one younger brother Adam, 4 years her junior. Her mother stayed at home to look after the children whilst her father, a brass polisher, went out to work. Her parents married young, before they had reached the age of eighteen. Katrina and Adam were brought up in the local area, but Katrina’s memories of her early childhood are very vague. Her earliest memory (aged about 4 years) was of playing down by the canal with her female friend from next door and being severely reprimanded by her mother for running off to such a dangerous place. Her mother she recalls was rather anxious and overprotective and her father was generally passive, often absent from the
Katrina finds it hard to recall memories of her primary school years. One incident that does come to the fore is falling over and bumping her head in the playground. She remembers having a huge bandage put around her head, even though it wasn’t bleeding. Her mother came to collect her and took her to hospital where she was kept in overnight for observation.

Katrina attended a mixed secondary school in the local area. Her mother had wanted her to go to a single sex school, but this would have involved a lengthy journey each day. She told me that during her time at this school, there had been a period of about 3-4 months when she frequently coughed up blood. During this time her mother took her to see the GP on a regular basis as she was convinced Katrina had contracted a serious illness such as tuberculosis. Despite having numerous medical tests, no organic cause was found and the episode was put down to stress and anxiety. Katrina has no memory of being anxious or particularly stressed at the time. There have been no serious illnesses in her family apart from her paternal grandmother’s cancer.
Katrina remembers her mother being very controlling during her adolescence. She would vet Katrina’s boyfriends and prevent her from seeing friends that she didn’t approve of. This caused many arguments and Katrina was often ‘grounded’ for weeks at a time. However, this didn’t stop her becoming pregnant at the age of 16 after a ‘one-night-stand’. Her mother and maternal grandmother were outraged – she recalls being slapped across the face by her grandmother for bringing disgrace upon the family. Her mother and maternal grandmother placed great pressure on Katrina to have a termination so that she had very little choice but to comply with their wishes.

Katrina left school when she was 16 and got a job in the records department of a local hospital. She had a 5-year relationship with a 17-year-old man, which she ended after learning that he was also involved with another woman. Soon after this, she met her present husband Kevin, 4 years her junior, who also worked at the hospital. When Katrina was 25 and Kevin 21 they decided to live together and moved into a rented flat. They had their first child (Jake) in 1994 and moved into their own house when he was 12 months old. In 1998 they had a second child, Ruby. When Ruby was 19 months old, Katrina and Kevin got married. Katrina disclosed that it was she that pushed for the marriage, as Kevin showed no signs of wanting to formalise their relationship. After both pregnancies Katrina suffered from post-natal depression.

**Current Difficulties**

Katrina reported having felt depressed and anxious since the birth of her son Jake 13 years ago. At this time she was diagnosed with post-natal depression. She believed her baby to be very vulnerable and was convinced that he would die. These feelings reoccurred after the birth of her daughter Ruby in 1998. Ruby was born prematurely with a ‘port wine’ birthmark on her face that she now receives laser treatment for.
Katrina’s main presenting problem is a fear of having or developing cancer. This causes her to repeatedly check her body for signs of the disease – she persistently pokes and probes her body at least 30 times a day. This activity she described as having become uncontrollable and taking over her life, to the extent that she recently resigned from her job at the local hospital. At the time of the assessment Katrina was visiting her GP twice a week (sometimes more) with bodily sensations she feared were evidence of cancer. Despite having had numerous medical tests (including investigations for unexplained stomach pain) her GP has told Katrina that there is no reason to suggest that she is developing or has developed cancer. However, she remains unconvinced and disclosed that her fear of cancer was so great that she couldn’t say the word without becoming tearful and avoided all TV programmes and advertisements that feature the disease. Apart from the primary fear of cancer itself, Katrina was also extremely anxious that she would die leaving her children motherless. This would be catastrophic as she believes that no one but she is capable of looking after them. She is currently having trouble sleeping and wakes up at night feeling overwhelmed with anxiety.

Katrina is aware that she is very protective towards her children. Recently, she forbade Ruby (now aged 9) from travelling with her aunty to the seaside in case something terrible happened to her. Katrina will not allow anyone other than herself to take Ruby to her routine hospital appointments for laser treatment. When Jake (now aged 13) missed the bus home from school one evening, she described being beside herself with worry, fearing the worst. He managed to walk home and Katrina described shouting and screaming at him when he finally returned. Jake was recently offered the chance to go on a school camping trip and Katrina wanted Kevin (her husband) to hitch up their caravan so that they could go with him. After protestations from Kevin, Jake was allowed to go
without his parents, but Katrina wouldn’t leave the house until he came back safe and sound.

Katrina told me that she finds it hard to express her emotions and, due to this, her husband whom she describes as placid, is never sure what kind of mood she is in. She described feeling angry towards her mother for ruining her adolescence, but dares not express this, as she is still very dependent upon her (e.g. she telephones her about 3 times a day to seek reassurance about her health concerns and insists that her mother accompanies her when visiting the GP). However, Katrina believes that her mother favours her younger brother’s family over hers and reports feeling inferior in response to her mother’s frequent comments concerning Adam’s relative success in life – he and his wife are both university lecturers.

Over the years since she met Kevin (her husband) Katrina has fallen out with his parents who, she believes, don’t like her and view her as not being good enough for their son. When her father-in-law recently had a stroke, Katrina found it hard to sympathise due to the long existing tension between them. This is a current source of friction between her and Kevin whom, Katrina says, never stands up for her when she receives disapproval from his parents. Due to this, she feels anger and bitterness towards her husband, but finds it hard to express her true feelings to him.

SECTION 2 - PSYCHODYNAMIC FORMULATION

Current psychodynamic theory has evolved from the work of Sigmund Freud (1856-1939) who was the founder of classical psychoanalysis (Freud, 1940). At the core of Freudian theory is the assumption that much of what individuals think, feel and do is determined by unconscious motivation. Freud’s id, ego and super-ego are still useful concepts to explain the basic unconscious conflicts that can exist between desires and
needs (the id) on the one hand, and an individual’s internalised sense of what is right and wrong (the super-ego) on the other, in which the ego (the central self) often acts as the mediator (Jacobs, 1998).

Contemporary psychodynamic approaches aim to help individuals gain insight by reaching behind defences and anxieties to the hidden feelings beneath and linking these back to their origins in the past - often connected with parents (Malan, 1995). There is a focus on significant external relationships and how these are internalised in the process of human growth and development.

Post-Freudian ‘object relations theorists’ (e.g. Klein 1986, Winnicott 1965, Fairbairn 1952, Guntrip 1977, Bowlby 1990) share the common view that it is not just people that are internalised, but also our experience of them and the two-way relationships we have with them. Object relations theory centres on human relationships and the way these are represented mentally by individuals. In Freudian theory the word object refers to a person or thing to which an individual’s emotional or libidinal drive is directed. In object relations theory the objects are mental representations of significant people in an individual’s life. Klein (1975) places at the core of her theoretical system the continuous conflict between love and hate. For her, healthy development occurs when there is identification with a 'good internalised mother'. Winnicot (1988) stressed the need for the 'good-enough mother’, or the ordinary devoted mother’ to provide a 'facilitating environment' for the self to emerge. This means a mother who is attentive and adaptive to her baby’s needs, but also knows when she is not wanted, gradually introducing the infant to the wider world. Jacobs (1998) notes that too anxious a mother might give rise to an anxious baby and cites Winnicot who contends that a mother may be too preoccupied with her baby, for too long ‘lending her own self to her infant’ rather than encouraging the development of the infant’s self and recovering her self-interest (Winnicot, 1965).
In all modern psychodynamic theory, importance is placed on the influence of the past on the present and the various ways that people seek to defend themselves against anxieties, unpleasant experiences or painful feelings. The most common reason for any defence is to keep conflicting (or ambivalent) feelings for the same individual separate, as it seems impossible to feel love and hate for the same person at the same time. Defences are an attempt to cope with negative feelings that threaten to damage a relationship, while at the same time trying to preserve the good relationship (Jacobs, 2001). For example, obsessional checking can be a way of managing unacceptable hostility: -

“the damage which it is feared, would result from the hostility requires the constant reassurance of the checking. Meanwhile the hostile impulses push for expression via the compulsive quality of the behaviour, and achieve some results by torturing the person, and those round them, with its frustrating repetitiveness (Leiper, 2006)”.

A useful approach to psychodynamic formulation is to construct ‘Malan’s Triangles’, (Malan, 1995). The two triangles are presented in figure 1a below.

**Figure 1a. The Two Triangles (Malan, 1995)**

<table>
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<tr>
<th>DEFENCE</th>
<th>ANXIETY</th>
<th>‘OTHER’ (O)</th>
<th>TRANSFERENCE (T)</th>
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<tr>
<td>HIDDEN FEELING</td>
<td>(usually current or recent past)</td>
<td>(usually distant past)</td>
<td></td>
</tr>
<tr>
<td>PARENT (P)</td>
<td>(usually here-and-now)</td>
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Triangle of Conflict

Triangle of Person

The ‘triangle of conflict’ depicts conflict as arising from a ‘hidden feeling’, which can be a wish or an impulse. This feeling evokes anxiety, because its expression will have
serious consequences as it conflicts with another need that must be satisfied. For example, feeling angry towards a person who also provides love and security is unacceptable as it might lead to rejection by that person. This internal conflict of feelings leads to the process of defence to avoid the anxiety (Leiper, 2006). The ‘triangle of person’ shows how past relationships are repeated in the here-and-now by portraying the links between a person’s current relationships, the relationship with their parents and the relationship with the therapist.

Katrina’s formulation is presented in figure 1b overleaf. In the Triangle of Conflict it is hypothesised that Katrina developed defences that are predominantly somatic to keep her hidden feelings (such as anger, guilt and hostility) out of her conscious awareness and to avoid feeling overwhelmed with anxiety and the emotional pain of the feared consequences of expressing these hidden feelings. It seems likely that these hidden feelings are repressed having developed from poor object relations. The Kleinian view of somatisation (or hypochondriasis as it was known) is that it is a result of splitting of the object and of its projection into the subject’s own body (Aisenstein & Gibealt, 1991). For example, Katrina still depends on her mother and is anxious not to be rejected by her (separation anxiety). However, she is angry at how her mother has controlled her throughout her life, so that she splits off her feelings of anger towards her in order not to threaten this relationship. The angry ‘split-off’ feelings are projected inwards causing bodily symptoms. In other words, her emotions are internalised and repressed (this seems evident from the placid way she came across during sessions, expressing very little emotion apart from sadness).

Her ritualistic bodily checking is a way of warding off her extreme anxiety arising from her inner conflict. It also seems likely that there is a conflict between wanting to be independent of her mother, but at the same time not wanting to lose her. Her depression is likely to arise from her inwardly directed feelings of hostility. Her anxiety in relation to
being consumed by cancer could (in the Jungian tradition) be a metaphor for a fear of being overwhelmed by anger (Jung, 1978).

Katrina also identifies strongly with her paternal grandmother, particularly in relation to the way she died of cancer. In his work ‘Mourning and Melancholia’, Freud (1917) observed that during the process of mourning, the object (or person) that is lost is replaced through the grief process by an inner representation of the same person. The mourner internalises the person they have lost and this person lives on inside them. This is more than just a memory of what the person was like and is similar to experiencing them as still part of the present (Jacobs, 1998). This may account for Katrina’s obsessional belief that she will die from cancer.
Figure 1b. Psychodynamic Formulation Using Malan’s Triangles

Triangle of Conflict:

**Defence**
- Somatisation/
  obsessional bodily
  checking, depression
- Identification with
  grandmother/splitting
- Repressed emotion

**Anxiety**
- Rejection/separation
- Something bad will happen to the children
- Consumed by cancer (anger) painful death

**Hidden Feeling/Impulse**
- Anger/hostility/guilt
- Weakness/vulnerability
- Grief/loss
- Insecurity/inferiority

Triangle of Person:

**Other/Current**
- Insecure/dependent relationship with mother
- Over protective of children
- Passive Husband
- Difficult relationship with in-laws

**Parent/Past**
- Anxious/controlling mother
- Passive/absent father
- Loss of Paternal Grandmother
- Loss of baby

**Therapist/ transference**
- Mother substitute or peer? Insecure/secure attachment?
- Ending: loss

**Counter transference**
- Cry baby, helpless
- Empathy/concern
- Placid
Malan (1995) suggested that the processes within the Triangle of Conflict are re-enacted within the Triangle of Person through other/current and past/parent relationships and through transference with the therapist. As described previously, Katrina’s hidden feelings (e.g. anger, hostility, insecurity, vulnerability, inferiority) are likely to have originated from poor object relations in the past with her parents. Her father tended to be absent a lot and Katrina may have felt abandoned by him (it is possible that her ‘passive’ husband is a representation of her own father); this and her relationship with an anxious and controlling mother would seem likely to indicate difficulty in the appropriate resolution of the tension between secure attachment and necessary separation (Leiper, 2006).

Katrina’s insecure attachment pattern is currently influencing the way she relates to her own children in that she is overprotective towards them, just as her mother was to her. It is possible that her episodes of post-natal depression were also a reflection of her attachment difficulties. In this respect her past relationships are influencing the way she relates to other/current relationships – the O/P link (Malan, 1995). In addition to feeling angry towards her own mother (although she is still highly dependent upon her) Katrina also feels hostile towards her husband and his parents, but finds it difficult to express this outwardly for fear of being rejected or judged negatively. There are also significant losses in her past; of her own baby through the abortion and her much loved paternal grandmother due to cancer. These losses are likely to add to her anxiety in the present about separation and harm/loss of her children.

Key concepts in psychodynamic theory include transference, counter-transference and resistance. Transference is the repetition by the client of former, often childlike, patterns of behaviour relating to significant people in the past, such as parents, but now seen in relation to the therapist (Jacobs, 1998). Malan (1995) calls this the T/P link.
Counter-transference refers to the feelings evoked in the therapist by the client. These can be negative or positive feelings that can sometimes help the therapist identify what other people feel in the presence of the client. Conscious resistance involves deliberate withholding of information that the client knows to be important, whilst unconscious resistance may involve a range of defences (Davanloo, 1990).

During the initial stages of therapy Katrina found it hard to talk about her emotions. She appeared very flat in terms of affect. She was also very vague concerning her early and later childhood experiences, seeming resistant to talk about them. This may have been a defence against revealing her hidden feelings to protect her against rejection and/or negative judgement. Katrina seemed to repress her own hostile feelings, but spoke about others’ hostility towards her including her neighbours and her parents-in-law. She tended to deny any responsibility on her part for the tensions in these relationships.

Katrina seemed at pains to stay in control of her emotions in order to stay calm and pleasant (T/P link). It seems likely that this was another defence to guard against rejection. The therapist sensed that she was presenting a ‘false self’. In the tradition of Winnicott (1965) the emergence of her ‘true self’ has been inhibited due to the lack of a facilitating environment for it to emerge (i.e. her over protective mother and frequently absent father). In other words she received less than ‘good enough’ object relations as a child.

At times she evoked maternal feelings within the therapist – coming across as needy and vulnerable, although there was another part of her that seemed reluctant to become too dependent and kept an emotional distance – perhaps another indication of her insecure attachment style. There was also an innocent child like quality about Katrina (she has a high pitched soft voice) which at its extreme created feelings of irritation within the therapist who perceived her as a ‘cry baby’ who should be able to stand on her own two feet as an adult. These feelings were counteracted with feelings of empathy and concern.
from the therapist in response to the ‘little girl lost’ quality that was operating in the therapy room at times.

SECTION 3 - COGNITIVE FORMULATION

The preoccupation with a belief in, or fear of, having a serious illness, despite there being no apparent medical evidence for the illness, has been traditionally termed Hypochondriasis (Warwick & Salkovskis, 1990). Modern psychological theorists have developed cognitive models of this psychiatric concept (Williams, 1990) and nowadays tend to use the term ‘Health Anxiety’ to describe the behavioural, cognitive, affective and physiological features of the problem (Salkovskis, 1996).

From a cognitive perspective, an individual experiences anxiety because a particular situation or stimulus is perceived to involve a threat and the ability to cope effectively with the threat is doubted (Beck, 1976). The hypothesis behind the cognitive model of health anxiety is that bodily signs and symptoms are perceived to be more dangerous than they really are and that a specific illness is believed to be more likely to occur than it really is. Furthermore, individuals are likely to believe that they are unable to prevent the illness or control it; thus perceiving that they have no effective way of coping with the threat (Warwick & Salkovskis, 1989).

This hypothetical model developed by Salkovskis & Warwick (1986) is useful in helping to explain the development of health anxiety. Initially, knowledge and past experiences of illness (in self or others) leads to the formation of specific dysfunctional assumptions about symptoms, disease and health behaviours. For example, bodily changes and symptoms are a sign of serious disease. Other beliefs concern specific personal weaknesses or illnesses such as: ‘there’s a history of cancer in the family’. These beliefs may be a chronic source of anxiety but can also lie dormant until they are activated in
susceptible individuals by critical incidents, including the detection of unfamiliar bodily symptoms, reading about an illness and illness-related media reports.

Dysfunctional assumptions can also result in an individual selectively attending to information that appears to confirm that there is a physical illness and to ignore or disbelieve evidence suggesting that this is not the case. Consequently, specific assumptions frequently lead to a ‘confirmatory bias’ in an individual’s thinking, once a critical incident has led to the misinterpretation of bodily sensations as indicating serious illness. Further bodily signs may then be noticed as the result of increased vigilance arising from anxiety.

Once triggered the dysfunctional assumptions result in self-focused automatic hypochondriacal thoughts (Marcus, Gurley, Marchi, & Bauer, 2007). Various mechanisms can be involved in maintaining the problem. These are usually behavioural, cognitive, affective and physiological. Barsky (1992, 2001) has developed a similar model to understanding health anxiety, but places a greater emphasis on the hypothesis that health anxious individuals are more sensitive to and aware of bodily sensations (“somatosensory amplification”) and contends that this is a risk factor for health anxiety. More recently Taylor and Asmundson (2004) have integrated cognitive factors, attentional factors and somatosensory amplification into an integrated model of health anxiety.

The processes in the cognitive model of health anxiety developed by Salkovskis and Warwick (1986) are similar to those in the cognitive model of panic (Clark, 1986). In both models there is a misinterpretation of bodily symptoms. However, in panic disorder, catastrophic interpretations result in the perception that there is an immediate danger (e.g. ‘I’m having a heart attack’), whereas in the health anxiety model, the catastrophe (e.g. death or painful suffering) will occur at some time in the more distant future (Wells, 1997).
A cognitive formulation of Katrina’s problems based on the Warwick & Salkovskis model (1990) is presented schematically in figure 3 (overleaf). A central tenet of the model is the hypothesis that health-anxious individuals harbour dysfunctional medical and illness-related beliefs (Marcus, Gurley, Marchi, & Bauer, 2007). It seems likely that Katrina’s experience of illness during her childhood resulted in her forming dysfunctional assumptions regarding health beliefs and illness concerns. From what she disclosed, her mother was rather anxious and overprotective of her and this seemed to extend to medical/health issues (e.g. the head-bumping incident and the coughing up of blood whilst at school). It therefore seems likely that Katrina developed the perception that bodily symptoms always mean that something is wrong and require immediate medical attention. Furthermore, this is confirmed by the death of her grandmother from cancer that insidiously spread throughout the whole of her body. There was also a belief in Katrina’s mind that the case had been mishandled in terms of the length of time it took for her grandmother to receive appropriate specialist treatment.

It makes psychological sense that in addition to the formation of dysfunctional assumptions about illness, Katrina became very sensitive to changes in body function and would always interpret innocuous signs as symptoms of serious disease i.e. cancer, as in the case of her stomach pain. It is unclear what the specific critical incident was that triggered Katrina’s problems. It seems likely that she became more and more aware of bodily changes (as in the case of her stomach pain), which she interpreted catastrophically and consequently became overwhelmed by the negative thoughts that were subsequently triggered.
Figure 2. Cognitive Model of Health Anxiety (Warwick and Salkovskis, 1990)

**Previous Experience**

Experience and perception of:
(i) Illness in self, family; medical mismanagement
(ii) Interpretations of symptoms and inappropriate reactions

> “Whenever I had any symptoms I was taken to the doctor in case it was serious”
> “My grandmother died from cervical cancer”

Formation of dysfunctional assumptions

> “Bodily symptoms are always an indication of something wrong; I should always be able to find an explanation for my symptoms”

**Critical incident**

Incident or symptom that suggests illness

> “I’ve developed pains in my stomach. I have had more bodily symptoms recently.”

Activation of assumptions

Negative automatic thoughts/imagery

> “I might have cancer; It may be too late. This is going to get worse. I’m going to die horribly. My children will have no mother”

**HEALTH ANXIETY, HYPOCHONDRIASIS**

**COGNITIVE**
- Focus on body and enhanced bodily perception
- Monitoring of body changes
- Attention to negative information
- Helplessness
- Preoccupation, rumination
- Discounting positive information

**AFFECTIVE**
- Anxiety
- Depression
- Anger

**BEHAVIOURAL**
- Avoidance and self-imposed restriction
- Repeated self inspection
- Repeated manipulation of affected area
- Consultation, reassurance seeking
- Scanning for information
- Preventative measures

**PHYSIOLOGICAL**
- Increased arousal
- Changes in body function
- Sleep disturbance
Katrina’s health anxiety is maintained by behavioural, affective, cognitive and physiological factors. Behaviourally, she repeatedly manipulates and checks her body for new signs and symptoms of cancer; she frequently visits her GP for reassurance and avoids TV and media coverage of issues in anyway connected with cancer. Katrina agreed that her repetitive body checking, reassurance seeking and avoidant behaviours resulted in a temporary reduction in her anxiety, but that this was always short-lived as these behaviours were actually maintaining her anxiety (Salkovskis, 1996) most likely because they prevented her from a more rationale appraisal of her anxieties. In turn these behaviours are themselves reinforced by the temporary reduction in anxiety that they produce.

In affective terms, she feels anxious and depressed – the anxiety leading to more somatic symptoms and thus further perpetuating the cycle. From a cognitive perspective, she constantly focuses on her body and monitors any changes; she is preoccupied with negative thoughts about developing cancer and ruminates about death and abandoning her children. Physiologically, Katrina suffers from disturbed sleep, and has developed an increased arousal of changes in bodily function. This means that she is hyper-sensitive to normal bodily sensations and tends to misinterpret these as evidence of serious illness (cancer).
SECTION 4 – CRITICAL APPRAISAL OF FORMULATIONS

This report has presented two formulations for Katrina’s problems, each from a different theoretical base. The psychodynamic formulation emphasises the relationship between early development and difficulties later on in life. Katrina’s problems are viewed within her inter-and intra-personal world, and are seen as arising from poor object relations and unresolved unconscious conflicts. A strength of this approach is that it makes use of the dynamics or process within the therapeutic relationship, and focuses on the individual’s emotional world. However, a major weakness is that there is little empirical evidence to support the psychodynamic theories on which the formulation is based. From this point of view it can be argued that object relations theory is unscientific. Furthermore, it does not take account of either the social system or the cultural norms that might contribute to the client’s problems.

A major strength of the cognitive formulation is that there is an empirical evidence base to support the theory behind it. Importantly, this formulation includes factors that actively maintain Katrina’s current difficulties. This approach provides insight into the way individuals interpret or appraise specific situations in terms of what and how they think. It tends to be a much more logical and structured approach because of its well-established theoretical base. As its name suggests, it focuses more on cognitions (ways of thinking) rather than emotions and impulses. This approach also disregards the influence of clients’ wider socio-cultural systems on their difficulties. An additional weakness is that there is less importance placed on the dynamics within Katrina’s relationships with significant others in her life, including the therapist.

Both approaches place importance on previous/past experiences in the formulations, but differ in emphasis on the significance of early experiences and the way the model is applied in the therapeutic setting. For example, Katrina’s cognitive formulation
emphasises previous experiences that may have led to the development and maintenance of dysfunctional assumptions and unhelpful behaviours, whereas the psychodynamic approach places more importance on hidden feelings associated with early childhood development.

Although the cognitive formulation is evidence-based in terms of the theories it draws upon, it does not encompass Katrina’s difficulties in such a comprehensive way as the more flexible psychodynamic formulation. For example, it does not directly address her feelings of anger and inferiority and her anxiety in relation to separation. It is specifically focused on her dysfunctional beliefs, assumptions and thoughts that are hypothesised to contribute to her on-going health anxiety. In this respect it can be argued that it presents a much narrower picture of Katrina’s problems compared to the broader view resulting from the more inclusive psychodynamic formulation.

Both formulations could be improved by viewing Katrina’s problems more systemically as there is evidence of repetitive behaviours and roles being passed down from mother to child across the generations.
REFERENCES


An evaluation of clinical supervision groups set up for nursing staff working in an NHS continuing care unit for older adults.
Abstract

This report describes a study carried out to evaluate clinical supervision groups for NHS nurses working in a continuing care unit for older adults. The introduction outlines national initiatives concerning supervision for nurses within the NHS and cites the available evidence for its effectiveness. A statement of the aims and description of the methods and results follow. In the discussion, the limitations of the methodology and the difficulties experienced in carrying out the evaluation are discussed. Blocking factors are considered which might account for difficulties in implementing clinical group supervision for all staff. Facilitative strategies are drawn from the relevant literature and recommendations are made for future evaluations and implementing supervision into routine clinical practice.
Introduction

Fourteen years ago, the Department of Health released ‘A Vision for the Future: The Nursing, Midwifery and Health Visiting contribution to Health and Health Care’ (Department of Health, 1993). One of the five key areas identified in the report was concerned with research and supervision. Indeed, one of the 12 key targets for action was specifically related to clinical supervision (CS) which was seen as:

“A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills” (Department of Health, 1993).

The concept of CS as defined above evolved in the late 1980’s and early 1990’s, having been accepted in general as standard practice in social work and psychotherapy, but less so in the nursing profession where there was confusion about what the concept meant and how to practice it (Hill, 1989). In the mid 1990’s, Butterworth & Bishop (1995) argued that the practice of CS was a feature of optimum practice for all nurses. The United Kingdom Central Council for Nurses, Midwives and Health Visitors supported this view (UKCC, 1996) and acknowledged that CS was necessary to enable practitioners to establish, maintain and promote standards and innovations in clinical practice in the interests of patients and clients. The supervisor was seen as:

“facilitating a relationship in which the supervisee could reflect upon, critically analyse and evaluate their everyday practice, which in turn, facilitated professional development” (Winstanley & White, 2003).
This and other definitions in the literature (e.g. Wright, 1989; Bishop, 1998; Open University, 1998) had a common theme in that CS was concerned with providing empathic support to enhance therapeutic skills, the sharing of knowledge and the facilitation of reflective practice. The process aimed to create an environment in which the participants had a chance to re-appraise, reflect upon and develop their own clinical practice and provide a support network for one another (Winstanley & White, 2003).

Within the last decade, recent health policy initiatives have emphasised the importance of CS. For example, in April 1999, Clinical Governance was introduced as a means of ensuring greater accountability of NHS organisations for the quality of their services and the maintenance of high standards of care (Department of Health, 1999). This made individuals accountable for setting, maintaining and monitoring performance standards (Department of Health, 1998). Actively participating in CS was seen as a demonstration of an individual’s commitment towards clinical governance (Butterworth & Woods, 1998).

In the year 2000, the national policy agenda again reinforced the importance of CS when the government launched a broad programme of measures designed to improve the NHS (Department of Health, 2000). This programme emphasised that Clinical Governance was central to plans for quality improvement and one of the key points focused on plans for quality improvements that would facilitate nurses participation in CS and lead to statutory supervision for midwives. For many nurses, CS has become an established part of their working practice, particularly in community mental health nursing (White & Brooker, 2001). However, variations in the structure and process of CS exist due to differing local policies and managerial decisions made within each NHS organisation. For example, CS is less established in the culture and daily routine of many hospital-based staff and for some there is basic mistrust surrounding the supervisory process (White,
This may reflect confusion between ‘clinical’ versus ‘managerial’ supervision. It is commonly the case that CS is considered to be complementary to, but different from other forms of supervision experienced by individual nurses (Winstanley & White, 2003).

There are many anecdotal accounts of the benefits and outcomes of CS to both nursing and client care but there is comparatively little empirical evidence available (Sloan, 1999). The small number of existing studies have been summarised by Cutcliffe & Proctor (1998), Sloan (1999), and the researcher below.

Figure 1. Reported Benefits of Clinical Supervision

- Development of clinical competence and knowledge base (Dudley & Butterworth, 1994; Barton-Wright, 1994; Nicklin, 1995)
- Improvement in the quality of patient care (Bishop, 1994; Goorapah, 1997)
- Increase in staff confidence in the delivery of care (Cutcliffe & Epling, 1997)
- Increased feelings of support and personal wellbeing in staff (Butterworth, 1996)
- Reduction of the levels of stress and burnout experienced by staff (Faugier, 1994; Hallberg & Norberg, 1993)
- Decrease in staff leaving nursing and reduction in number of complaints to the NHS (Nicklin, 1995; Goorapah, 1997).
- Higher staff morale and job satisfaction leading to a decrease in staff sickness/absence (Butterworth, Bishop & Carson, 1996)
- Increased staff participation in reflective practice (Hawkins & Shohet, 1989)
- Increased staff self-awareness (Cutcliffe, 1997).
- Improved care skills and increased job satisfaction (Winstanley, 2000).

Several Models of supervision have evolved over the last decade and many healthcare providers have implemented individual programmes of CS. The most widely adopted model in nursing is Proctor’s three-function interactive model (Proctor, 1988; Inskipp and Proctor, 1993). The three components of the model are Normative, Formative and Restorative. The normative element concerns accountability, awareness of and adherence to accepted standards and professional norms. The formative function relates to skill development and developing evidence-based nursing practice, and the restorative element
is concerned with supporting personal well-being and enabling supervisees to understand and manage the emotional stress of nursing practice. There are numerous references to this model in the nursing literature suggesting widespread acceptance (Bowles & Young, 1999). For example, Nicklin (1997) reports familiarity with Proctor’s model in over 30 NHS Trusts. Butterworth and colleagues (1996) suggest that it enables an elegant resolution of managerial concerns with supportive and educative aspects for the practising nurse and it has been supported as a framework for evaluation (Butterworth, Bishop & Carson, 1996; Cutcliffe & Proctor, 1998).

Supervision is practiced in various ways. Usually a contract is established between the supervisor and supervisee(s) regarding the content, duration and frequency of sessions, which are generally confidential. The major findings of a large study suggest that CS sessions in groups away from the workplace are more effective than one to one sessions and longer and more frequent sessions are more beneficial (60 minutes, at least monthly) (Winstanley, 2000).

Implementation of supervision in the National Health Service (NHS)

A survey conducted by Bishop (1998) found that CS had already been implemented in some form, in 92% of all NHS providers in England and Scotland. These results were derived from 267 postal questionnaires returned by Nurse Executives from 410 NHS trusts (a 67% response rate). One in seven trusts reported that implementation had been within the previous 12 months, although most had longer-established programmes for the continuing development of CS in their trusts.

The trust wide policy for CS within Birmingham and Solihull Mental Health NHS Trust (BSMHT) came into operation in January 2005 and was approved by the Clinical Governance Committee. The policy stipulates that all staff engaged in direct clinical intervention with clients must receive regular CS (a minimum of one hour at frequency
intervals of one month to six weeks) and that the format for supervision is a matter for negotiation. However, it states that a contract should be agreed between the supervisee and supervisor and/or group, which outlines the structure, process and boundaries of CS. It further declares that the Trust will have an ‘effective system of monitoring Clinical Supervision’ and ‘that the effectiveness of the Clinical Supervision programme will be subject to an ongoing evaluation’. It does not describe how the necessary systems to achieve these aims will be put in place.

Setting for current study

The setting for this study is an NHS continuing care unit with up to 30 beds for older adults with severe mental health problems and/or cognitive impairments - predominantly a challenging behaviour unit within BSMHT. The typical characteristics of older adult patients likely to be admitted to NHS continuing care units have been summarised by Wattis & Fairburn (1996) and include:

a) Sustained or frequently recurrent difficult behaviour arising from dementia or other serious psychiatric disorder which could not be managed elsewhere except with inappropriate sedation;

b) Physical illness and sensory problems associated with the problems above if the needs of the patient could not better be met in another setting;

c) Dementia or other serious psychiatric disorder with failure to cope or more rapid deterioration in other care settings (Wattis & Fairburn, 1996).
Previous research has shown that nursing staff working with cognitively impaired patients are more likely to suffer high levels of stress, especially during day shifts (Everitt, Fields, Soumerai et al, 1991; Novak & Chappell, 1996) and an increase in this stress is associated with higher levels of patient aggression, especially if the behaviour is perceived as threatening (Rodney, 2000). Furthermore, nurses express more frustration, anxiety and anger towards vocally disruptive residents and a desire to distance themselves from them (Draper, Snowdon, Meares et al, 2000).

The few studies of the beneficial effects of supervision on nurses working with older adults have been conducted in Sweden. For example, Hallberg & Norberg (1993) found that systematic CS decreased the level of stress among staff when attempting to provide individualised planned care to a group of patients with Dementia. In an expansion of the same intervention study (Berg, Welander Hansson & Hallberg 1994) nursing staff reported improved nurse-patient relationships, reduced stress levels, increased self-confidence and a broader and better knowledge base. Jansson and colleagues (1995) found that hospital nurses caring for older adults with dementia understood themselves and colleagues better, questioned things and got new ideas in their work. In a later qualitative study, Berg and Welander Hansson (2000) studied 13 Swedish dementia care nurses’ experiences of systematic clinical group supervision. The nurses reported improvements in co-operation and in providing professional nursing care and personal development.

**Aim**

Clinical supervision groups were set up for nursing staff working on the older adult continuing care unit approximately 2 years prior to this study. Senior nursing staff and clinical psychologists working in the Older Adult Directorate developed these in the context of the unit changing its role from a nursing care home to a challenging behaviour unit, a potentially stressful transition for nursing staff. Six facilitators (3 pairs) are
responsible for jointly running 2 closed groups every 6 weeks for one hour (i.e. a total of 6 different groups run once every 6 weeks). Each facilitator pair comprises a senior nurse manager and a clinical psychologist. In each group there is a named nurse and his or her team – approximately 6 or more participants (each group differed slightly in number according to how many were in the team). The main objective of this study was to evaluate these clinical supervision groups to gauge how supervision has been received within the Older Adult Directorate. In addition to assessing the value of these groups the study was a pilot to explore the feasibility of using a questionnaire survey across the wider Directorate to evaluate CS.

Method

All nursing staff working on the unit’s two wards who received clinical group supervision (n= 40) were invited to participate in the study (including nursing assistants and housekeepers). Each had an invitation letter and questionnaire (see Appendix 2) placed in their pigeonhole. Participation was voluntary and anonymity and confidentiality were assured. Responses were placed in a folder in each ward office and were periodically collected. Each of the 6 facilitators also received a questionnaire (Appendix 3) designed to assess their perceptions of the effectiveness of the supervision. These were returned by internal mail. The items for the supervisees’ questionnaire were scrutinised by the researcher and the clinical supervisor to ensure readability and understanding. Prior to the development of the facilitators’ questionnaire the researcher arranged to interview one of the facilitators to gain a general understanding of how the groups were structured and run. The decision to use a questionnaire survey was taken, due to the aim of the study being to evaluate supervisees’ individual experiences of their clinical group supervision. It was also hoped that anonymised questionnaires would enable participants to be more candid in their
responses by eliminating the level of social desirability commonly exhibited by participants during focus groups and individual face-to-face interviewing (Robson, 1993).

**Measures**

The questionnaire developed for the supervisees comprised a 21-item schedule developed by Bowles & Young (1999) based on Proctor’s three-function model (Proctor, 1988). An additional 17 items were adapted from the Manchester Clinical Supervision Scale (MCSS) (Winstanley, 2000) which also includes elements of all three components of Proctor’s model (Normative, Formative and Restorative). Three items were also included which related to the effects of supervision on teamwork used previously in a qualitative study of dementia care nurses’ experiences of group supervision (Berg & Welander Hansson, 2000). Both the Bowles & Young questionnaire and the MCSS have the same factor structure and were originally developed to assess one-to-one supervision. Items from the MCSS were added to assess time issues, reflective practice, quality of patient care and clinical skills, which are not sufficiently covered by the Bowles & Young questionnaire alone. The final instrument comprised 41 items (14 Formative, 11 Restorative, 13 Normative, 4 Time Issues). A five point Likert scale (1=strongly disagree, 2=moderately disagree, 3=undecided, 4=moderately agree, 5=strongly agree) examined the benefits of clinical group supervision. At the end of the questionnaire was a qualitative ‘free response’ section for supervisees to record other pros and cons related to their supervision group not captured by the main questionnaire. There was also a short demographic section. The facilitators’ questionnaire (see appendix 3) was designed to dovetail the supervisee questionnaire. Also based on Proctor’s model, it asked the facilitators what they perceived as their role as a group facilitator, the aims of the CS group and whether or not they perceived these aims were being achieved. Responses were rated on a five-point Likert scale and in terms of how well objectives had been achieved (0=not
RESULTS

Characteristics and Role of Facilitators

Of the six facilitators involved in running the supervision groups information was received back from 5 (one was absent due to maternity leave). Three facilitators reported that they had received specific training in supervision, although this varied widely from short in-house courses run by the Trust to more lengthy periods of study run by academic institutions. All of the supervisors reported receiving their own group supervision related to running their groups on the unit. The reported frequency of this varied from “infrequently” to “six to eight weeks”. However, one facilitator commented that this supervision should have been in place at the beginning of the groups (over 2 years ago) but that so far only 3 sessions had been run.

Two facilitators reported that no specific model of supervision was used in their groups. One reported the use of a model but this was not named specifically. Of the two that mentioned using a specific model, one made use of solution focussed techniques and the other reported using a person-centred approach together with the process being guided by the Inskipp & Proctor 3-function model (1993). The 7-eyed model developed by Hawkins & Shohet (2003) was also described as a strong influence by this facilitator.

Facilitator’s responses (medians and ranges) to questions about their role in supervision are set out in table 1. There was total agreement that an important part of their role was to provide support and encouragement and to create a safe environment for the supervisees. There was less agreement on their role being to intervene when the group was struggling, to act as a teacher and role model and whether they should direct and lead the
group. There was general undecidedness and disagreement about their role being to provide counselling and act as mediators. The written accounts from the facilitators concerning the process and structure of supervision are summarised in Appendix 4.

Table 1  Group Facilitators’ Perception of their Role

<table>
<thead>
<tr>
<th>Role Statement</th>
<th>(n)</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide support and encouragement</td>
<td>(5)</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To create a safe environment</td>
<td>(5)</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To set the ground rules and boundaries</td>
<td>(5)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To give guidance and advice</td>
<td>(5)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To be an objective listener</td>
<td>(5)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To share knowledge and experience</td>
<td>(5)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To foster a good group alliance</td>
<td>(4)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To intervene when the group is struggling</td>
<td>(5)</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>To act as a teacher and role model</td>
<td>(5)</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>To direct and lead the group</td>
<td>(5)</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>To provide counselling</td>
<td>(5)</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>To act as a mediator</td>
<td>(4)</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Purpose and Aims of Supervision

The facilitators’ views on the purpose and aims of the CS Group and perceived levels of achievement (medians and ranges) are presented in table 2. The top 5 aims were to enable supervisees to reflect on feelings evoked by clinical work, help supervisees develop a sense of accountability for their own practice, enable members to problem solve, reflect on clinical practice issues and enhance clinical skills. The facilitators were largely undecided as to whether a group’s purpose should be to discuss caseload management and

36
to provide educational support. The levels of perceived achievement of these aims are also presented in table 2. For the top 5 aims median achievement levels ranged from 6-7 out of a possible top score of 10.

<table>
<thead>
<tr>
<th>Abridged Statement of Purpose and Aims</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
<th>Rating &amp; Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enable supervisees to reflect on feelings</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>To help supervisees develop a sense of accountability</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>To enable members to problem solve</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>To reflect on clinical practice issues</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>To enhance clinical skills</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>To explore personal issues that affect clinical work</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>To build members’ confidence</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>To improve communication skills</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>To develop knowledge and competence</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>To promote professional development</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>To air organisational/management issues</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To improve co-operation within teams</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>To resolve staff/team conflicts</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>To discuss caseload management</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>To provide educational support</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note: for achievement rating 0= Not at all, 5= moderately achieved and 10= achieved to a large extent.*
The topics raised during the sessions are listed in Table 3 in descending order. One facilitator stated another area frequently discussed was the lack of co-operation from other multidisciplinary team members and outside agencies, e.g. GPs.

<table>
<thead>
<tr>
<th>Topic Areas Commonly Raised by Group Members</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical practice issues</td>
<td>8</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Organisational and management issues</td>
<td>7</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Team conflicts and tensions</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Serious incidents</td>
<td>5</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Personal issues relating to practice</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Professional development issues</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Interpersonal problems relating to practice</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: 0=never mentioned, 5=mentioned occasionally, 10=mentioned frequently

Group Development

Attendance ratings ranged from 2 (very poorly attended) to 8 (well attended). The median attendance rating was 6 out of a possible 10. Two of the facilitators reported very poor attendance in their groups with diminutive numbers due to members having left or having duties that make it difficult for them to attend such as working night shifts and not working certain days. Thus development has been limited although the remaining few who do attend reportedly use the sessions well. Other facilitators report that over time the group members have come more prepared with issues to raise and that reticent members have become more inclined to contribute. In some groups members are reported as being more proactive, creative, able to self-reflect and make person-centred appraisals and formulations. In these groups support and trust between members has increased leading to more personal issues being broached. Other reported advantages of the groups include
members having somewhere to talk about clinical issues and their feelings, which they find supportive and validating as the facilitators make time to listen to them. From an organisational perspective a major advantage stated by one facilitator was that the groups were set up in the first place and that all the facilitators continue to be involved and have recently committed to their own supervision in relation to the groups.

Areas for improvements raised by the facilitators are listed below:

- More consistency and timing of sessions, e.g. on a regular monthly basis.
- More formal and frequent evaluation/monitoring of supervision e.g. twice yearly.
- Reassembly of the poorly attended groups to incorporate new members of staff.
- Encouragement of the night staff, part-time workers and senior clinicians e.g. medics and managers to attend.
- Regular contact with senior management to discuss the wider implications of issues discussed in supervision and to raise awareness of its value.
- A change in the existing culture of the unit so that supervision is viewed as having a vital and important role in the provision of quality care to vulnerable individuals, rather than being perceived as a “tick box exercise” or “key performance indicator”.

**Effects of Supervision on Supervisees**

Eight supervisees returned their clinical group supervision questionnaires (a response rate of 20% of the unit workforce) and only 7 of these provided valid data. Therefore, it was not possible to statistically analyse the data in any meaningful or valid way. Of those who completed their questionnaires there were six females and one male. Four were RMNs (on bands 3-6) and one a Staff Nurse (on band 5) and two were nursing assistants (both on band 3). All participants worked day duty hours and dealt with challenging behaviour. The average time in post was 11 years and 6 months (range 11 months – 32 years and 3 months) with six working 37.5 hours per week and one 21.5 hours per week. The median length of membership was 18 months (range 11 – 24) with one missing
response. The median attendance rating was 4-6 times per year and the median General Satisfaction rating was 5 (range 2 – 5) with 2 missing responses.

The median scores and ranges of the supervision questionnaire are displayed in Table 4. Of note is the general disagreement of the 7 participants that “without CGS the quality of patient care would deteriorate” and their strong agreement that “they can off-load feelings during CGS”. Had the response rate been more satisfactory, the level of internal reliability of the questionnaire would have been calculated and analyses to explore item reduction carried out. Bivariate analysis would have been conducted to test for differences in total scores between newly qualified and experienced staff and a one-way analysis of variance carried out to detect any significant differences in scores between the 3 different components/functions (normative, formative, restorative) of the questionnaire. Due to the limited time available for data collection and small sample size it was not possible to pilot the questionnaire meaning that test-retest reliability has not been established. Reasons for this low response rate are suggested in the discussion (pages 16-19).

Table 4 Supervisees’ Experiences of Clinical Group Supervision

<table>
<thead>
<tr>
<th>Formative Function Statements</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
<th>Valid n</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGS has helped me think through situations more critically</td>
<td>4.5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS helps me to develop new ideas on how to tackle work related problems</td>
<td>4.5</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS has made me more aware of my own behaviour</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS gives me time to ‘reflect’</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS sessions facilitate reflective practice</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS sessions are an important part of work routine</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS has increased my self-awareness</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>In CGS I learn from the group’s experiences</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS has helped me become more creative at work</td>
<td>4.0</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 4 Continued/

Through CGS I have learned new ways to approach practice 3.5 2 5 6
CGS widens my clinical knowledge base 3.5 2 5 6

<table>
<thead>
<tr>
<th>Restorative Function Statements</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
<th>Valid n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can widen my skill base during CGS sessions</td>
<td>3.5</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I have been helped to identify my development needs through CGS</td>
<td>3.0</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Without CGS the quality of patient care would deteriorate</td>
<td>2.0</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>I can off-load feelings during CGS</td>
<td>5.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS relieves pressure of work</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS has helped me to cope with difficult situations</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>*CGS does not solve personal issues</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I can discuss sensitive issues in CGS</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS makes me feel more supported in my practice</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Co-operation in the team has improved as a result of CGS</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS helps my self-confidence</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS helps me feel less isolated in my practice</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS reduces my work related stress</td>
<td>3.5</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normative Function Statements</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
<th>Valid n</th>
</tr>
</thead>
<tbody>
<tr>
<td>*CGS is for newly qualified/inexperienced staff only</td>
<td>5.0</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>*CGS is unnecessary for experienced/established staff</td>
<td>4.5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>*CGS sessions are intrusive</td>
<td>4.0</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I can give an example of a change to my practice as a result of CGS</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>CGS has improved my nursing practice</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS has helped me feel that my practice is of an acceptable standard</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>*CGS sessions are not necessary/don’t solve anything</td>
<td>4.0</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS has helped me to challenge existing practice</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4 Continued/
I am more able to talk about tricky practice issues in CGS than in other settings  4.0 1 5 7
I receive useful advice in CGS  4.0 1 5 7
CGS has helped me look more objectively at my work  4.0 1 5 7
Receiving CGS helps my team work more effectively  4.0 1 5 7
CGS improves the quality of care I give  4.0 1 5 6

<table>
<thead>
<tr>
<th>Statement</th>
<th>Median</th>
<th>Min</th>
<th>Max</th>
<th>Valid n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving CGS helps my team work more effectively</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CGS improves the quality of care I give</td>
<td>4.0</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**Time Issue Statements**

*I find CGS sessions time consuming*  4.0 2 5 6
It is important to make time for CGS  4.0 2 5 7
*Time spent on CGS takes me away from my real clinical work*  4.0 2 5 6
*Fitting in CGS sessions can lead to more pressure at work*  3.0 2 5 6

*Negatively worded items have been reverse scored*

**Discussion**

The original objective of this study was to evaluate CS groups set up for nursing staff working in an NHS continuing care unit for older adults. This was to gauge how supervision has been received within the Older Adult Directorate. In addition to assessing the value of these groups the study is a pilot to explore the feasibility of using a questionnaire survey across the wider Directorate to evaluate clinical supervision.

Due to a poor response rate from the nursing staff on the unit, this report is reliant on data gathered from the group facilitators to assess the value of the CS groups. Those supervisees who did respond reported good attendance ratings and their levels of general satisfaction with the groups tended to be high although two responses were missing. From this point of view the response rate was biased. However, the results do concur in part with previous literature on the reported benefits of CS (Butterworth, 1996; Hawkins &
Shohet, 1989; Cutcliffe, 1997). For example, participants indicated that the sessions facilitated reflective practice, increased their self-awareness and reported that they felt more supported in their practice. However, the development of clinical competence and knowledge base (Dudley & Butterworth, 1994) and reduction in levels of work related stress (Faugier, 1994) were not supported. In view of the low response rate, these findings must be viewed with extreme caution.

The data collected from the five facilitators suggest that those who attend the supervision groups find the experience beneficial and the main aims are largely being achieved. Some groups have developed more than others over time. The style and process of the groups and facilitators’ perceived roles are generally consistent with Proctor and Inskipp’s 3-function model (Inskipp & Proctor 1993;1995). It is interesting that the facilitators felt that an important aim of clinical group supervision was to enhance clinical skills, yet they were undecided whether its purpose was to provide educational support. This may be because they interpret providing educational support as a directive activity, whereas clinical skills may be enhanced by facilitating group members (in a less didactic way) to share their ways of working.

The (meagre) results of the supervisees’ questionnaire indicates that the main benefit derived by the supervisees is being able to ‘off-load’ and vent feelings rather than enhance quality of care – this clearly needs further investigation. It is also apparent from the inconsistent attendance from some and consistent non-attendance from others that the groups have not been sufficiently established for them to be perceived as an integral part of clinical practice.
Poor response rate and limitations of the study

For reasons beyond the researcher’s control the invitation letters and questionnaires were not distributed to the supervisees until the beginning of July. This is a period when many were absent due to annual leave and those remaining on the unit felt stretched with little time for taking part in a research study. As the deadline for data collection was the beginning of September there was a relatively small window of opportunity for the supervisees to respond. Despite posting reminder letters to them and asking senior staff to raise awareness of the study on the unit, the response rate remained disappointingly low. In mid July one of the folders for completed forms disappeared from the wall in one of the ward offices before the researcher had chance to collect the questionnaires inside. An explanation for this curious incident was never found. In retrospect a safer method of questionnaire collection might have been to supply each staff member with a pre-addressed internal reply envelope.

Although the disclosure of demographic details was optional, it might have put some supervisees off responding for fear of being identified. However, it is more likely that the length of the instrument had a bearing and this emphasises the need for further piloting. If the questionnaire had been checked for redundant items and revised, this might have improved response rates a little. It also seems unlikely that the poor response rate was purely a reflection of attendance rates, although this might have had a small influence. The facilitators reported that there were two groups that were particularly badly attended. This left four groups with reasonable to good levels of attendance.

Another limitation of the study was that, due to time pressures and for logistical reasons, it was not possible to introduce the study personally to the supervisees. From their point of view they were being asked to fill out a questionnaire from an unknown person. Future efforts to engage staff in an evaluation might be better received if they are
invited to listen and respond to a short presentation on the purposes and aims of the research, including some of the evidence on the wider benefits of supervision. This would require much organisation to enable each team to be included, particularly the night staff. Data collection might be more successful if the researcher handed out the questionnaires systematically after each supervision session.

Another contributing factor to the low return rate could be related to reluctance from staff to engage in evaluative research, which they perceive, as having little or no benefit to them or their practice. As in most organisations there may be a general resistance to new ideas and practices (Seel, 2002) within the organisational culture of the unit. Scepticism may exist surrounding the need for a service evaluation in which staff perceive they have no vested interest - resistance can be passive, characterised by not engaging, by being silent or absent (Carradice & Round, 2004). Fretwell (1985) argues that the passiveness of many nurses hinders progress and comments that they appear to have an inherent resistance to change.

Resistance to change within health service organisations is widespread (Cork, 1999) and pressures to change can affect staff at an individual and organisational level. For example, change can threaten self-identity and it interferes with existing routines making adjustments necessary (Ashford, Eccles, Bond et al, 1999). In a mental health setting, the mismatch between supervision models, based on autonomy and the therapeutic use of self and the current working realities of mental health nurses which over-rely on the medical model can be a hindrance to the successful implementation of supervision (Bodley, 1991).

Cantrell and Spence (1999) reported on the implementation of CS in a primary care trust. They suggest several ways of minimising obstacles to successful implementation such as having a steering group drawn from staff volunteers, informational workshops for senior managers and nursing staff. They emphasise that the manner in which nurses are
introduced to CS e.g. “their education for the purpose” is clearly crucial to successful implementation. This is particularly relevant for staff on the continuing care unit whose views do not seem to have been actively sought or considered prior to the start of the groups and who do not appear to have received any formal educative in-put concerning the purpose and benefits of supervision. Other general recommendations concerning the groups, including more involvement from senior management and a change in organisational culture, have been made by the facilitators (see results section page 12).

**Recommendations**

This study fostered the development of a clinical group supervision questionnaire suitable for conducting a survey across the wider Older Adult Directorate, although test-re-test reliability and internal consistency still need to be established using an adequate sample size. Before piloting the questionnaire for wider distribution it would seem prudent to survey attendance levels and improve these first if necessary, as part of feasibility study for a larger survey. In order to engage with staff beforehand, steering groups could be set up consisting of staff volunteers, supported by senior managers representing different staff groups, perhaps in liaison with the Trust’s Clinical Governance Committee. Informational workshops concerning the purpose and merits of clinical supervision for staff could then be introduced by the steering committees supported by senior managers in the context of staff professional development. Once these have been established it would then be possible to introduce the idea of an evaluation study for each staff group.

**Conclusion**

How clinical group supervision has been received within the continuing care unit is awaiting further exploration. These groups are yet to be successfully evaluated from the
supervisee’s point of view. Factors that prevented the success of this evaluation concern limitations of the methodology including timing and how the study was introduced; possible resistance by staff and probable misconceptions surrounding the meaning and purpose of CS.
References


CLINICAL PRACTICE REPORT 3

SINGLE CASE EXPERIMENTAL DESIGN

A cognitive-behavioural graded-exposure programme for a child with long-term anxiety related sleeping difficulties

Words count: 5,135
Abstract

This report describes the case of Christopher, a 9 year old boy referred to a Child and Adolescent Mental Health Service by his general practitioner with a request for help with long-term sleep difficulties. Details of the referral, assessment and formulation relevant to the case are presented. These are followed by a description of the AB single-case experimental design that was employed to assess the effectiveness of a cognitive-behavioural intervention designed to increase Christopher’s* total number of sleep hours per night and to reduce the time taken for him to fall asleep. Analysis of data from a weekly sleep record kept by Christopher’s mother is presented that indicates a sustained improvement in Christopher’s sleeping habits once the intervention was implemented. The results are discussed within the clinical context of Christopher’s complex anxiety problems and the methodological limitations of the design with suggestions for improvements of this.

*In the interests of confidentiality the name of the client and those of related persons have been changed
Referral

Christopher aged 8 was initially referred to Child and Adolescent Mental Health Services (CAMHS) by his GP. The primary reasons for referral was his “anxious obsessive behaviour, which requires the lights left on in his bedroom when he goes to sleep, as well as the television blaring loudly”. He also “developed what seems to be a habit of making ineffectual noises, which seem to get worse when attention is given to them”.

After being referred to CAMHS, Christopher and his mother attended an introductory meeting and were then put on the waiting list for treatment. They remained on the list for 8 months before being seen.

Initial Assessment

Relevant History

Christopher is a 9-year-old boy who lives with his mother Lucy, his mother’s partner Crispin and stepsister 2½ year old Emily. He stays over at his biological father’s house once a fortnight. His father lives with his partner Lizzy and they have a baby boy called Henry (see genogram, figure 1 overleaf). Christopher attends a junior comprehensive mainstream school where he does well academically. In general Christopher gets on well with his little step-sister, but said that she did irritate him at times.

When Christopher was born by normal delivery he had to be resuscitated due to his lungs being full of mucous. As a result he had a short 24-hour stay on the Neo-natal unit. No subsequent developmental delays or difficulties were reported, but his mother stated that he was a poor sleeper as a baby and tended to be ‘hyperactive’. Christopher’s paternal grandfather suffers from anxiety and depression. Lucy remembers being an anxious child herself and not ‘feeling safe’ in her mother’s house. When Christopher was aged 4 his mother and father split up. Although they are on good terms now, the break-up was an
extremely tense time. Christopher’s sleep problems began about 2 years later, prior to the birth of his half-sister Emily.

The time directly after Emily’s birth was particularly stressful as she had a paralysed vocal cord and was kept in hospital for a month during which she was fed through nasal gastric tube. Not surprisingly, Lucy was very anxious and therefore, emotionally unavailable for Christopher who was looked after by different relations including his father during this period. During the assessment, Lucy described Christopher as being anxious about most things in life.
**Presenting Difficulties**

Christopher was experiencing long-term anxiety related sleeping difficulties that reached a peak approximately 3½ years ago. At the time of his assessment, he was in the habit of relying on having the main light and TV on in his bedroom in order for him to manage to be alone at night-time. He would watch DVDs usually until 10 – 11 pm. This was the same at home and at his father’s house. He was also tending to wake up in the night and having to turn the TV and light back on before he could get back to sleep. He described feeling anxious at night and seeing coloured shapes in the window and hearing noises in the house and outside. Christopher said that he didn’t like closing his eyes as he saw scary images such as those on the TV. To try and prevent these feelings of anxiety he had to have the light on and the TV (DVDs) on quite loud, which disturbed his mother and her partner. His lack of sleep was having a significant effect on his own ability to concentrate and remember things especially at school. In general, Christopher tended to be restless, finding it hard to sit still. He also made ‘throat-scrapping’ noises when he felt anxious or wanted his mother’s attention.

**Presentation in Session**

Christopher presented as immature for his age and under confident. He was very fidgety throughout the whole session and was frequently told to sit still by his mother. When given paper and felt tip pens he managed to amuse himself quite happily. However, it then became difficult to engage with him as he became less receptive to questions and entirely focused on his drawings.

**Psychometric Assessment**

To monitor treatment progress and obtain an objective measure of Christopher’s presenting difficulties, the Spence Children’s Anxiety Scale (SCAS) (Spence, 1994) was
administered. The SCAS is a 45-item self-report measure on which respondents rate their answer to each statement on a four-point scale. The possible responses are ‘never’, ‘sometimes’, ‘often’ and ‘always’ (see appendix 6). The items are written in child-friendly language and were carefully piloted prior to standardization (Yule, 1997). In addition to providing a total measure of anxiety (T) the SCAS also has six sub-scale scores for different aspects of anxiety; these are: ‘panic attack and agoraphobia’ (PAA), ‘separation anxiety’ (SA), ‘physical injury fears’ (PIF), ‘social phobia’ (SP), ‘obsessive compulsive’ (OC) and ‘generalised anxiety/overanxious’ (GAD). The SCAS has demonstrated good internal reliability with a coefficient alpha of 0.92 and a Guttman split-half reliability of 0.90 (Yule, 1997).

**Formulation**

The scores from the SCAS were a useful aid in the formulation of Christopher’s difficulties. The results (shown below) indicate that his total score of 42 was nearly twice that of male children his age in the general population. Furthermore, he scored particularly highly on the sub-scales for GAD (16) and separation anxiety (9).

<table>
<thead>
<tr>
<th>SCAS scale</th>
<th>Christopher’s scores</th>
<th>Standardised scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD/overanxious</td>
<td>16</td>
<td>5.28</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>9</td>
<td>4.25</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>6</td>
<td>6.01</td>
</tr>
<tr>
<td>Panic &amp; agoraphobia</td>
<td>5</td>
<td>3.92</td>
</tr>
<tr>
<td>Physical injury</td>
<td>3</td>
<td>2.78</td>
</tr>
<tr>
<td>Social phobia</td>
<td>3</td>
<td>4.93</td>
</tr>
<tr>
<td>Total Score</td>
<td>42</td>
<td>27.16</td>
</tr>
</tbody>
</table>
Christopher’s presentation had several facets. His night-time habits suggested a fear (or phobia) of the dark. However, as the SCAS scores indicate, he also displayed symptoms of generalised anxiety disorder (GAD) and separation anxiety. It is possible that his fear of the dark developed out of his separation anxiety and was maintained by his significant GAD. Lovibond (1966) proposed that continuing psychological stress may precipitate the development of a phobia. What is evident is that Christopher was suffering from at least 3 forms of anxiety disorder (one very specific). With generalised anxiety many aspects of the environment are interpreted as potentially threatening, even when no reasonable grounds exist for anticipating danger (Carr, 1999). Spielberger (1973) categorises phobic and generalised anxiety as state and trait anxiety. State anxiety is an acute, transient experience that occurs in specific situations. Trait anxiety is a stable, enduring chronic condition characterised by hyperarousal.

In order to shed light on Christopher’s complex anxiety problems it is helpful to visit the cognitive ideas proposed by Beck (1976) and later Clark (1988). Beck (1976) proposed that psychological symptoms are rooted in events that trigger the activation of dysfunctional (or unhelpful) core beliefs. These beliefs are shaped by the impact of early experiences. Christopher experienced a number of influential early experiences (see formulation diagram figure 2).

When Christopher was born, he stopped breathing and had to be resuscitated. As a result he needed special care from the neo-natal unit for the first few hours of his life. In response to this anxiety-provoking event it seems likely that his mother, Lucy may have been overprotective of Christopher during his early years, which is probably why he never developed his own self-soothing skills. Over protective parental behaviour has been identified as a contributing factor in the development of anxiety in children. Over-control involves high levels of parental vigilance and intrusion, and the discouragement of
independent problem solving. This is believed to limit the development of a child’s autonomy and lead to perceptions of a limited sense of personal competence or mastery. In turn these beliefs are thought to contribute to the development and maintenance of anxiety in children (Barlow, 2002; Dadds, 2002; Rapee, 2001). Lucy also disclosed that she had been an anxious child herself (scared to sleep in her mother’s house) and it is likely that this anxiety persisted at some level into adulthood. In a recent paper by Bögels & Brechman-Toussaint (2006), the authors review numerous family studies that suggest parental anxiety is a risk factor for child anxiety disorders.

Added to this Christopher’s mother and father had an argumentative relationship that culminated in them splitting up when he was just 4 years old. There is overwhelming evidence that parental conflict serves as a general stressor to a child’s environment, threatening the child’s sense of security (e.g. Emery, 1989). Furthermore, the quality of the parental relationship early in a child’s life is predictive of future anxiety. For example, McHale and Rasmussen (1998) found that parents’ marital dissatisfaction when their child was one year old predicted child anxiety at four years of age. These adverse experiences would have shaped Christopher’s beliefs and assumptions about the world, which he believed was a scary dangerous place and that his mother was key to maintaining his safety. According to Carr (1999) males between the ages of 3 and 18 are particularly at risk for post-divorce adjustment problems, particularly if they, like Christopher, have biological vulnerabilities associated with peri-natal difficulties. In the light of his early disruptive home life and both his parents finding new partners and having children with them, it seems likely that Christopher may have had a pervasive fear that his needs for safety, security and protection would not be met as he would be pushed out by the new adults and children in his growing extended family (Wolfe, 1992 in Carr).
Figure 2 Christopher’s Longitudinal Formulation

Predisposing factors

Early experience
Birth Trauma/peri-natal complications – short hospitalisation
‘Hyperactive’ baby – absence of self-soothing skills
Overprotective mother who was also ‘an anxious child’
Volatile relationship between mother & father - arguments
Mother & father split up – when © aged 4

Precipitating factors

Distal
Father moves in with new partner – they have child together (baby boy)

Proximal
Mother finds new partner to live with
Mother & new partner have child (girl)
Mother & partner get married

Core beliefs
The world is a dangerous place
I am weak/vulnerable
I can’t cope on my own
I’m only safe when I’m close to mum

Rules & assumptions
It’s not safe to be out on my own
My mum keeps me safe
Something bad will happen to me

Critical incident
New baby half-sister seriously ill in hospital, therefore mum very tense and pre-occupied and unavailable for © who is ‘farmed out’ to different carers – (temporary) abandonment by mum.

ACTIVATION OF CORE BELIES / RULES AND ASSUMPTIONS / NATS

GENERALISED ANXIETY
Fearful of novel situations
Worried about threats to safety

FEAR OF THE DARK
resulting in sleep problems

SEPARATION ANXIETY
Fearful of situations where mother is not present

Symptoms & Reactions:
Physiological
Cognitive
Behavioural

Maintained by Avoidance & Safety Behaviours
(e.g. having main light and TV on all night)
The increase in severity of Christopher’s sleep difficulties coincided with the birth of his half-sister Emily. This appears to have been a critical factor for him. At this time his mother was not physically or emotionally available for him and it seems likely he feared rejection and/or abandonment (his mother was not there to protect him and now had someone else to look after).

His nocturnal negative automatic thoughts were triggered when he saw coloured shapes in his window and heard noises in other parts of the house and from neighbouring houses outside. These stimuli were interpreted catastrophically and his thoughts (difficult to draw out) centred on harm being done either to him or his mother. For example, “they are trying to get into the house; they will break in and hurt me (or mum); someone is outside the window trying to get in; they are going to kidnap me”.

**Agreed Intervention Plan**

At the end of the assessment Christopher and Lucy said they would like to work on improving Christopher’s sleep pattern. We agreed that he would have 8 regular weekly sessions in the first instance (subject to review) to enable him to learn relaxation techniques and gradually work towards the goal of getting off to sleep without having the TV and main bedroom light on. An important goal was to enable him to drop off to sleep more quickly and increase his number of sleep hours from approximately 7 to at least 10 (commensurate with his age) (Ferber, 1985). It should be noted that Carr (1999) has proposed that anxiety management interventions with children should be multifactoral and include a number of elements. However, the treatment plan was decided collaboratively taking account of Lucy and Christopher’s priorities and the time constraints imposed upon the therapeutic process. It was agreed that Lucy would keep a sleep diary each week to record the time taken for Christopher to fall asleep and the total number of hours he
managed to sleep each night (see appendix 7). The first treatment session took place 2 weeks after the assessment.

According DSM IV criteria (APA, 1994), a specific phobia is characterised by a persistent irrational fear in the presence of or anticipation of a particular entity or object. The individual has a compelling desire to avoid the feared object resulting in significant disruption to the person’s routine. Christopher’s way of avoiding his fear was to keep the light on and have the TV on to mask any threatening noises that might have caused him anxiety. These safety behaviours were maintaining his fear as they prevented him from learning that he could endure the anxiety of being in the dark without any serious consequences. Theorists have contended that specific phobias may develop as a direct result of conditioning (Mowrer, 1939; Pavlov, 1927). However, this behavioural explanation does not explain why Christopher’s phobia gradually intensified. Critiques of conditioning theory suggest that phobias are determined by multiple factors (Manassis, Hudson, Webb & Albano, 2004) and emphasise that interventions need to be tailored to the individual response pattern of the phobic child (Muris, 2005). Lang (1977) proposed that the clinical manifestations of a specific phobia are best represented by a three-response system, namely: behavioural, cognitive and physiological. Therefore, a cognitive behavioural approach was used to treat Christopher’s fear of the dark and resulting sleep deprivation.

**Intervention Process**

Cognitive-behavioural therapy (CBT) has been found to be the most effective intervention for children with anxiety disorders (Compton, Burns, Egger & Robertson, 2002) with the core of treatment focusing on graded exposure to the feared stimulus (Butler, 1989; Muris, 2005). The addition of cognitive restructuring during exposure has
also been found to be beneficial and is less intrusive than a purely behavioural approach (Carr, 1999). The main components of Christopher’s treatment were:

- Psycho-education (Carr, 1999)
- Cognitive restructuring (Beck, Emery & Greenberg, 1985)
- Graded exposure: graded hierarchy with relaxation (Wolpe, 1958; Butler, 1989) and a closely linked
- Reward system (Herbert, 1987).

In a review of the treatment of childhood phobias (King, Muris & Ollendick, 2005) the authors emphasised that parental involvement during therapy was also an important component. Ollendick & March (2004) suggested that this approach has the advantage of the therapist transferring methods and procedures to the parent, thus improving parenting skills and parent-child relationships. In Christopher’s case, as his mother and father were no longer together, his mother was invited to attend sessions with him.

During the preliminary work with Lucy and Christopher the nature and origins of anxiety were explained, including the cognitive, behavioural and physiological aspects, and how these maintained a continuous cycle. Together we drew up a step-by-step plan (see appendix 8) for Christopher to follow so that he could eventually reach his top goal of being able to sleep alone without the TV or main light being on. There were 6 main steps to this plan and it was agreed that every time Christopher managed to stay on each step for at least a week he could earn a reward. For the first step Christopher agreed to have a small bedside lamp on instead of the main light, but still have the TV on. We also practised different relaxation techniques and guided imagery that Lucy could help Christopher with at home to relax him before going to sleep. One of the relaxation techniques was a five-finger exercise (Davis, Eshelman & McKay, 2000). This is a cue-controlled relaxation technique which combines touching each finger with a different form.
of relaxation, such as deep, slow breathing, muscle relaxation and guided imagery. Christopher also agreed that he would go upstairs at 8.30 instead of 9pm so that he could spend more time ‘chilling down’ before bed.

The cognitive component involved encouraging Christopher to develop positive self-statements such as “I know I’ll be okay in the dark”, that he could use when his light was turned off and he was exposed to the dark. He was hard to engage so that enabling him to challenge his negative thoughts was difficult. This might also be connected to his relative immaturity.

Initially, Christopher made good progress with his 6-step plan. At the end of step 1, he was already turning down the volume on the TV by himself and sleeping with just the bedside light on. Lucy estimated that he was going to sleep by 9.30pm and noticed that the extra sleep he was getting tended to improve his memory and reduce the ‘throat scraping noises’.

The next stage of the plan involved having the TV on mute, the bedside lamp on and Christopher falling asleep whilst listening to his MP3 player. Unfortunately Christopher lost his MP3 player, which set things back a little. Lucy also noticed that he had lost interest in the relaxation exercises and tended to view them as a game. We practised some different ones that he could use and perhaps be more interested in. After 3 very positive treatment sessions Lucy and Christopher did not attend again for over 3 weeks. When they returned, I learned that Christopher had been sleeping with all the lights off, but with the TV still on at low volume. As Christopher no longer had his MP3 player, we decided to revise his step-by-step plan a little. He asked if he could listen to a ‘talking book’ on the CD player in his bedroom instead of having the TV on. He also wanted a small light in place of the TV for the 1st week only and then in the 2nd week, he planned to have just the
‘talking book’ with no TV or light on. His final goal was to have no TV, no ‘talking book’ and no light on for which he would receive a large reward (to be negotiated with Lucy).

Christopher was confident that he would eventually be able to sleep without needing to have the TV on. Despite efforts to contact them, Lucy and Christopher did not attend the clinic again to complete the treatment so that further evaluation of Christopher’s progress was not possible. Including the assessment, they attended 5 sessions in total out of the 8 offered. Throughout therapy Lucy, who was training to be a teaching assistant, gave the impression that she spent a lot of her time rushing from A to B. She also disclosed in our second session that she was getting married to Crispin and the arrangements for this (including her ‘Hen Night’) were taking up much of her time. It was difficult to gauge, but it seemed that most of the parenting responsibilities for Christopher and Emily resided with Lucy with little in-put from Crispin.

**Design**

An AB within-subjects design was employed where A represents the baseline phase in which the intervention is not present and B the intervention stage where changes in outcome data are examined.

It is acknowledged that this form of experimental design has a number of limitations, but more sophisticated designs were not feasible due to clinical time constraints. The major draw back of the AB design is that it only gives weak evidence for the causal influence of the intervention as an interfering event may occur at the same time as the treatment is introduced (Barker, Pistrang & Elliott, 1994). It is also possible that changes during phase B might have occurred despite the introduction of the intervention. Furthermore, the AB design does not allow the persistent effects of an intervention to be evaluated, as there is no follow-up stage after the intervention.
A more sophisticated design would be necessary to establish a higher degree of internal validity i.e. the extent to which the existence of a causal effect between the intervention and outcome measures can be established. The main outcome measures in this single-case study were sleep onset latency and total number of sleep hours per night (calculated from a sleep diary completed by Lucy) and level of anxiety measured by the Spence Children’s Anxiety Scale discussed previously.

**Analysis and Results**

A repeated comparison measure of the SCAS could not be obtained due to Lucy and Christopher’s non-attendance of the last 3 sessions of treatment. Therefore, the effectiveness of the intervention was evaluated by the analysis of the sleep diary. Table 1 (overleaf) displays descriptive data for this measure.

**Table 1**

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: sleep hours per night</td>
<td>14</td>
<td>7.0</td>
<td>10.0</td>
<td>8.50</td>
</tr>
<tr>
<td>Intervention: sleep hours per night</td>
<td>20</td>
<td>8.0</td>
<td>11.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Baseline: sleep onset latency (minutes)</td>
<td>14</td>
<td>90.0</td>
<td>210.0</td>
<td>120.2</td>
</tr>
<tr>
<td>Intervention: sleep onset latency (minutes)</td>
<td>20</td>
<td>10.0</td>
<td>180.0</td>
<td>60.0</td>
</tr>
</tbody>
</table>

Graphical presentations of the data are displayed in Figures 3 and 4. Visual inspection suggests that there are no clear trends either at baseline or intervention, apart from an initial burst of greater improvement that would indicate a sustained improvement in sleep once the intervention had been introduced. However, visual analysis has been shown to be unreliable especially in designs with short baselines (Crosbie, 1993). It has
been shown that there is often a lack of agreement among judges with respect to the conclusion drawn from visual analysis (DeProspero & Cohen, 1979). Visual inference has also been shown to have an excessive risk of Type I error (i.e. an erroneous inference of a significant difference between phases) (Matyas & Greenwood, 1990). Due to these problems of reliability and validity, statistical analysis is indicated to support visual analysis (Kinugasa, Cerine & Hooper, 2004). Therefore a split-middle analysis (celeration line approach) was carried out to provide a non-parametric method of revealing trends in the data (displayed in Figures 5 and 6). The split-middle analysis confirmed a consistent improvement over time with no baseline or intervention trends (the medians for both halves of the baseline and intervention stages were the same for sleep hours and sleep onset latency).

As there were no linear trends in the data, rather than examine whether there was a statistically significant change in slope, the decision was taken to examine the differences in overall level between the two phases for each measure. However, before applying a conventional statistical test it was first necessary to check the data for serial dependency in which case an alternative analysis such as time-series would have to be employed instead. If conventional statistical tests are applied to autocorrelated data, the results may lead to a false conclusion that the intervention was effective when it was not (a type I error). In this single-case experiment, none of the lag-1 autocorrelations were significant (baseline r: sleep hours= -.27, sleep onset latency= -.07; intervention r: sleep hours= .14, sleep onset latency= .14).

As there was no serial dependency, a non-parametric Wilcoxon within-subjects test was carried out. The Wilcoxon test involves calculating the differences between the scores for each stage and ranking the difference scores, giving rank 1 to the smallest difference and so on, but ignoring the sign of the difference. The + or – signs of the difference scores
are assigned to the rank values, and the sum of the rank values obtained for the + and minus signed ranks separately. The Wilcoxon test rests on the argument that if there is no difference between the two sets of scores, there will be about the same number of small + differences as there are small minus differences and about the same number of large + differences as there are large minus differences. If the sums of + differences are very dissimilar to the sum of the minus differences, then it is likely there is a reliable difference between the two sets of scores (Bryman & Cramer, 1990).

The Wilcoxon test was chosen over the parametric t-test as it was difficult to be sure whether the small data set met the assumptions of normality of distribution and homogeneity required for the t-test. Furthermore, the t-test is less robust in relation to violation of its assumptions when there are unequal numbers in each group as in this data set. Non-parametric tests tend to have greater power than t-tests when the t-test assumptions are violated (Bryman & Cramer, 1990; Howell, 1998).

The results of the Wilcoxon test were significant (sleep hours: Z= -2.83, p= 0.005; sleep onset latency: Z= -2.32, p= 0.02). Therefore, it can be concluded that there was a statistically significant sustained improvement in sleep hours and sleep onset latency once the cognitive behavioural intervention was implemented.
Figures 3 and 4 - Graphical Presentation of the Data

**Figures 3 and 4:**

1. Figure 3: Graphical presentation of baseline and intervention total sleep time over days 1 to 34. The graph shows variations in hours from 0 to 14 per day.

2. Figure 4: Graphical presentation of baseline and intervention sleep onset latency over days 1 to 35. The graph shows variations in minutes from 0 to 250 per day.
Figure 5  Split-Middle Analysis - Sleep Hours
Figure 6  Split-Middle Analysis - Sleep Onset Latency

The graph shows the sleep onset latency over 35 days, categorized into baseline and intervention periods. The x-axis represents the day, ranging from 1 to 35, and the y-axis represents the minutes, ranging from 0 to 250. The graph includes data points indicated by red markers, illustrating fluctuations in sleep onset latency throughout the study period.
Discussion

It was disappointing that Lucy and Christopher did not attend all the treatment sessions they were offered and that the graded hierarchy plan could not be fully completed. Sometimes difficulties in implementing a behavioural programme are due to problems residing with the care-provider. Parents are powerful determinants of treatment outcome as their children are dependent upon them to take them to appointments and help implement the treatment plan (Hailparn & Hailparn, 2000). One can only speculate as to why Lucy and Christopher decided to stop coming to their sessions. One reason might be that the rapid progress that Christopher made at the start of treatment was enough for Lucy to feel that his sleep-time habits had become much less of a problem and that they had both learned sufficiently from the sessions they did attend in order to carry on by themselves. Therefore, the urgency and motivation to attend was much reduced. Furthermore, her impending wedding was a big distraction for Lucy and the required time and energy needed to arrange it may have overwhelmed her.

A particular limitation of the intervention was that it relied upon self-reports to measure progress. These are typically less reliable and valid than objective measures (King, Hamilton & Ollendick, 1988). Ideally the standardised SCAS should have been re-administered and the baseline scores compared with those recorded near the end of the intervention. This would have provided a more objective measure of any reduction in anxiety. Another important limitation of this intervention was its narrow focus on cognitive and behavioural factors. It was evident from our interactions together that Lucy seemed largely unaware of any part that she or her split from Christopher’s father might have played in Christopher’s anxiety problems. There was no acknowledgement that his feelings of security might have been severely challenged by Lucy finding a new partner and producing another child with this man. These events would have been major threats to
Christopher’s world. Lucy revealed that she too had been an anxious child, but did not make any connection between this and Christopher’s anxious nature. There is research evidence that suggests stressful events within the family may precipitate and maintain anxiety problems (Carr, 1999; Manassis et al, 2004) so it may have been useful to have explored Christopher’s feelings about past family events and try and contain some of his anxieties and involve his father and new step-father as well as Lucy. Family therapy might have been a useful avenue for Christopher and his mother. However, due to time constraints it was only possible to focus on just one specific overtly troublesome aspect of his complex anxiety problems.

Despite Lucy and Christopher’s erratic attendance to treatment sessions, the visual and statistical analysis indicates that he did improve in terms of getting off to sleep more quickly and sleeping for longer. Although the AB experimental design does have major limitations (it is the weakest of those available) the split-middle analysis demonstrated that there was no improving trend in the baseline data and that there was a large immediate improvement that coincided with the introduction of the intervention and that this was reasonably well sustained over the intervention period. Due to the lack of trends in the data the improvement seen is unlikely to be due to a spontaneous recovery. However, the design doesn’t allow the ruling out of an improvement due to the non-specific effects of therapy or a placebo effect. In addition, other external factors may have exerted pressure and the design does not permit a full experimental analysis of these influences (Barlow & Hersen, 1984). For example, Christopher was on half-term when the intervention started and therefore, might have been feeling less anxious at bedtime. However, this does not explain the sustained improvement shown throughout the intervention.
The validity of the design could have been improved if the data collection had extended into the period after the intervention was completed (not possible in the present context). The ABAB design is an extension of the AB design in that the AB design is immediately followed by its own replication. This type of design allows the researcher to conclude whether an intervention (phase B) impacts on a dependent variable by providing information on the changes following the introduction and cessation of the intervention (Kinugasa, Cerin & Hooper, 2004).

More outcome measures could have been collected and analysed to assess the effectiveness of the intervention including how often the light was on and how frequently Christopher made ‘throat scraping noises’ to attract his mother’s attention. A multiple baseline design is more effective at controlling threats to internal validity than ABAB designs and is more appropriate when interventions cannot be withdrawn for practical and ethical reasons. The design is used when a researcher wishes to examine the effects of an intervention across different outcomes. Interventions targeted at each behaviour are introduced sequentially and their impact on all the target behaviours are measured. The idea is to demonstrate that the effect of each intervention (e.g. behavioural versus cognitive) is specific to a particular problem. For example, in Christopher’s intervention plan there was a psycho-educational component in addition to behavioural and cognitive components. It would have been interesting to see what effect each of these had on his symptoms.

Experimental single-case designs are hard to apply to non-behavioural treatments. Their emphasis on observable events and experimental manipulation makes these designs problematic for studying psychodynamic, systemic and even cognitive therapies. In order to evaluate the effect of these types of treatment it would be necessary to use non-experimental case study designs. For example, traditional narrative case studies, the
systematic case study and time-series designs are more appropriate for these types of therapy (Barker, Pistrang & Elliot, 1998).

As a result of the intervention, Christopher learned that he could tolerate going to sleep without having the main bedroom light on. During the treatment process he became aware of a direct link between accepting the risk of exposing himself to his fear of the dark and a subsequent reduction in anxiety. However, it was not possible to demonstrate this reduction objectively as no intervention data could be collected relating to Christopher’s level of anxiety. It is not known whether he finally managed to achieve his top goal of getting to sleep without either the light or TV on.

In conclusion, it is important to view the cognitive behavioural intervention presented here as part of a longer process, rather than in isolation. From a clinical point of view Christopher’s sleep improved and in this respect the outcome was favourable. However, further long-term exploratory work would be needed to address his GAD and separation anxiety. From a methodological point of view the graded hierarchy as an intervention in Christopher’s case was associated with a sustained improvement, although the design had several limitations that could affect the validity of the findings.
REFERENCES


CLINICAL PRACTICE REPORT 4

CASE STUDY

Case study of a 58 year old woman with learning disabilities displaying extreme eating habits

Word Count: 5,439
Abstract

This report presents the case of Marion a 58 year old woman with learning difficulties, who was reportedly displaying extreme eating behaviour by the over consumption of large quantities of food. Background information on Marion’s personal and psychiatric history is provided. This is followed by a formulation of the development and maintenance of Marion’s behaviour using cognitive-behavioural principles and a description of the interventions employed to manage her behaviour. Finally there is an assessment of the outcome and reflections on the work with Marion and her care staff.

All names and other identifying features have been changed in this document to ensure confidentiality
**Referral Information**

Marion was referred to the community psychology service for people with learning disabilities in July 2008 by her care manager. The referral stated that since moving to her new supported living accommodation 18 months ago, Marion had gained 2 stone due to non-stop eating. There were concerns that Marion was making her self ill by overeating and that her body weight was increasing relentlessly, causing anxiety about her general health.

**Presenting Problem**

Marion is a 58 year old woman with mild to moderate learning disabilities. She has been known to the service for approximately 20 years and the extent of her learning disabilities is well documented in her clinical case note files. Since her recent move to supported living accommodation there has been a noticeable change in her eating habits. She is eating large quantities of food throughout the day and possibly at night, which has resulted in substantial weight gain. This is compounded by the fact that she spends long periods in her flat on her own and is reluctant to engage in exercising activity.

**Background Information**

Background information was obtained by searching previous case-file notes and from meeting with Marion’s key worker, the Manager of Marion’s supported living accommodation and from meetings with Marion herself.

Marion was born in North London in 1950. As a child she lived in Surrey with her parents Frank and Pat and younger sister Hilda. When she reached 40 years of age she moved to a nursing home for people with learning disabilities and remained there for 16 years. Eighteen months ago this residential home was closed down and Marion moved to supported living accommodation where she now has her own self-contained flat. Whilst at
the nursing home Marion was diagnosed by a psychiatrist as suffering from schizoid affective disorder due to her responding to ‘voices’. Based on observations by staff in previous case notes it seems that Marion was having conversations with herself. Marion acknowledged that she often heard the voices of people she has known in the past. The voices were like very vivid memories of real past conversations, sometimes pleasant and sometimes distressing. For this reason, she was prescribed Risperidone (an anti-psychotic drug) that she continues to take in her new place of residence.

Marion left school at 16 to find work and earn money for her family. In previous psychology case-notes there was a suggestion that Marion had been bullied whilst at school. There was also a description of how sometimes at her work there would be misunderstandings that would cause Marion to cry. As a younger woman she had a couple of boyfriends one of whom she was very keen on, but he broke off the relationship and never re-contacted her.

Marion’s parents are both in their 80’s now and find Marion difficult to cope with due to their own frailty. Over the years contact with them has gradually decreased. She is occasionally (once or twice a year) visited by her sister aged 54 who is married with 3 grown-up children.

Marion has good verbal communication skills and enjoys conversation, although tends to ‘answer to please’. At times her speech can be difficult to understand as she often mumbles her words. Marion attends college 3 times a week and enjoys needlecraft and flower arranging. At home she likes reading, listening to music, knitting and watching TV. She tends to keep to herself and does not mix with her peers much, preferring to spend time alone in her flat. This low level of social interaction can be traced back to her days at the nursing home where she tended to be a solitary figure.
Assessment

The referral was received on 4th July 2008 and the assessment was undertaken on 17th July 2008. An initial interview was conducted with Marion’s Care Manager, Tanya (the original referrer) and one of her key workers Davina to gather factual information concerning Marion’s eating behaviour. Her Care Manager reported that Marion had put on 2 stone since moving from the nursing home to supported living accommodation and now weighed over 12 stone. Marion’s body mass index (BMI) was 29.6. The World Health Organisation Guidelines (1998) define a BMI score in the range 25.0-29.9 as overweight and scores of 30 or more as obese. Therefore, Marion is just inside the ‘obese’ limit. The BMI was calculated using the formula: weight in kg/height in metres squared (kg/m2) = (76kg/16m2). Both members of staff expressed anxiety concerning Marion’s current eating habits in terms of the potential detrimental effects on her physical health. Her behaviour was attributed to the fact that Marion no longer had her meals prepared for her by staff at specified times as she had in the nursing home. Instead she bought all her own food (assisted by staff) and prepared and cooked her own meals (assisted by staff). In theory Marion was free to eat as much as she liked, whenever she liked.

Her key worker explained that she took Marion food shopping once a week and that Marion particularly liked crisps, cakes, chocolate and biscuits. She receives £30 a week for food shopping and £20 for extra expenses. On a recent visit to her parents’ house it was necessary to lock food away as Marion was eating her way through the kitchen cupboards. Marion also buys biscuits from the local shop around the corner from her accommodation which she eats alone in her room. Staff reported that she spent long periods alone in her room and had no close friends, preferring to keep herself to herself. Staff found her difficult to engage and said that she either ignored them or said things like “don’t tell me what to do” when they suggested that she cut down on her food in-take. They therefore,
tended to let her be and did not encourage interaction with her. Marion was taken to see her GP who ruled out any kind of physical cause for her extreme eating behaviour.

Marion’s key worker felt that staff were inconsistent in their approach to Marion’s eating behaviours (some letting her eat what she wanted and others trying to curb her intake). Staff reported that Marion would eat a whole loaf of bread over two days and get out four chops to cook just for herself. Her key worker and other staff did their best to help Marion cook her lunch and dinner, but she sometimes started without them. Marion sometimes tries to cook meat straight from the freezer without defrosting it properly and also takes food out of the oven before it is fully cooked. Staff reported that Marion will snack between meals and seems to want food all the time.

During an initial assessment meeting with Marion, she was asked about her eating habits. Marion said that she was particularly fond of sweet foods such as cakes and biscuits and that she tended to feel hungry most of the time. However, it became apparent that she was largely unaware that the amount and type of foods that she ate tended to be unhealthy and she seemed largely unperturbed by the fact that she had gained a substantial amount of weight. Marion did report that she liked meal times and enjoyed cooking. She acknowledged that she was enjoying the freedom of supported living that meant that she could now buy and eat what she wanted. Although largely unaware of the effects of her increased food intake, she had noticed that she could no longer fit into her favourite black skirt. Marion said that she went food shopping once a week and that this was enough, otherwise she would get tired if she went more often. She also said that felt tired during the day and this prevented her from taking exercise. Marion said that she had no trouble sleeping at night. At times it was difficult to understand Marion’s speech as she tended to mumble in a very low voice.
As part of the assessment process an observation was carried out of Marion and her key worker Davina buying Marion’s food from the local supermarket. Marion had compiled a shopping list, but put things in the trolley that were not on the list such as sponge cake and ice cream. She also put things in the trolley that she still had in her kitchen cupboard such as breakfast cereal. Her key worker Davina helped her choose fruit that would ripen with time, otherwise Marion would have chosen fruit likely to perish more quickly. There seemed to be little planning in the things that Marion bought and it was difficult to see how she worked out what she needed and whether this was reflected by the list. It was also noticeable that when buying things like baked beans Marion would choose a very large tin instead of a couple of small ones. Her key worker persuaded Marion to choose the smaller tins. Neither Marion nor her key worker paid much attention to the nutritional labels on the foods that were chosen. However, Marion did buy low fat yoghurts and low fat crème fraîche when these were suggested as healthier alternatives to her usual choices. This observation exercise was helpful in the planning of guidelines for Marion later on.

**Formulation**

A widely used and perhaps traditional method of formulating problematic behaviour in people with learning disabilities is to use a behavioural model, for example, in terms of operant behaviour. In this approach behaviour is viewed as a way in which a person exercises control over key aspects of his or her world. The environmental consequences that maintain the behaviour are called ‘reinforcers’. These can either be positive or negative reinforcers depending on the situation (Emerson, 1998). However, this approach was considered to be too narrow to capture the different factors precipitating and maintaining Marion’s reported difficulties.
The method used to formulate Marion’s eating behaviour is derived from cognitive-behavioural theory influenced by the Beckian tradition. Beck’s cognitive model (Beck, 1995) is based on the premise that people’s behaviours (and emotions) are determined by how they interpret the situations they find themselves in rather than by the situations themselves. The model proposes that early life experiences and events shape an individual’s beliefs about themselves, others and the world in general. These ‘core’ beliefs form the basis for the rules, assumptions and attitudes that individuals develop and in turn these influence the thoughts, emotions and behaviours in relation to specific events or situations that individuals encounter throughout their lives.

Cognitive-behaviour therapy has been adapted and used successfully by some therapists working with people with learning disabilities; for example, Dagnan & Chadwick (1997) who advocate careful assessment of the client with learning disabilities to determine whether this approach can be usefully applied.

The formulation is based on cognitive-behavioural principles and also includes environmental factors not originally included in Beck’s model which has been criticised by some practitioners (e.g. Padesky & Mooney, 1990) for failing to adequately capture these external factors that can influence emotions and behaviours in one particular time period rather than another (Grant, Mills, Mulhern & Short, 2004). This formulation is based on the assessment information from staff and Marion and from lengthy case-note files. It is largely tentative and developed in light of the information available at the time. It is acknowledged that there may be other factors that are not included which may have come to light had the intervention continued for a longer period of time. Had this been the case it is likely that the formulation would have been revised in accordance with new evidence.

Contained in Marion’s formulation (presented on page 8) are hypotheses to explain the interplay between her early life experiences, core beliefs and current environment and
behaviours. For example, it is hypothesised that her negative past experiences at school and work have led to core beliefs of ‘people are unkind’ and ‘people don’t like me’. Being abandoned by her boyfriend (see background information) may have led to the beliefs ‘I am not wanted’, ‘I am unlovable’. It seems likely that these core beliefs were later reinforced when Marion moved out of her parental home into institutional care. From these core beliefs, protective ‘rules of life’ were formed, for example: ‘If I keep myself to myself no one will hurt me’. It is hypothesised that these rules resulted in Marion feeling lonely and isolated which in turn led her to crave emotional comfort in the form of food. This craving became fulfilled when she recently moved into supported living accommodation, ‘the triggering event’ which resulted in her living in a less controlled environment where she can buy her own food and consequently has come to believe that she is now free to eat as much as she likes. This lead to a substantial increase in Marion’s food in-take as she satisfied her cravings which in turn, resulted in dramatic weight gain over a relatively short period of time. After many years living in institutional care Marion has a new found freedom in the sense that she is able to take on much more responsibility for looking after herself. Institutional care was strongly criticised in the early 1960’s by Erving Goffman (1962) for pulling down the boundaries that normally separated the three life spheres (living, work and leisure). He described each phase of the daily activities of the members as being carried out in the immediate company of a large number of others, who were all treated the same and doing the same things together. All phases of the daily activities were seen as rigidly schematised (Van Loon & Van Hove, 2001). In this context Marion’s quality of life changed markedly after she moved to supported living accommodation where her choices were less restricted, her autonomy enhanced and her dependence on professional carers reduced.
Figure 1. Formulation of Marion’s eating behaviour

**Early Experience**
- Born with LD – Cognitive disability
- Bullied at school
- Treated badly at work
- Abandoned by boyfriend

**Antecedents**
- Moved out of parents’ home into institutionalised living environment aged 40.
- Loss of autonomy, medical approach to behaviour difficulties, including psychotropic drugs, structured control of daily living

**Core Beliefs**
- I am not wanted
- I am unlovable
- People are unkind
- People don’t like me

**Rules of Life**
- If I keep myself to myself / do as I’m told, no one will hurt me

**Loneliness and Isolation**
- Craves emotional comfort

**Triggering Event**
- Moves from institution to supported living accommodation

**Less environmental control on eating**

**Immediate Belief**
- I am free to eat as much as I like now

**Risperidone**

**Increase in appetite**

**Substantial increase in food in-take**

**WEIGHT GAIN**

**Fatigue – reluctance to engage in exercising activity**

**Thoughts**: ‘they can’t tell me what to do now’

**Staff**
- Tell Marion to reduce her food in-take
- Anxious about health risks & obesity
- Believe Marion is difficult to engage

**Staff**
- Reduce efforts to engage Marion
A further contributing factor is Marion’s receipt of prescribed ant-psychotic medication which, based on a growing number of research studies, has been shown to cause a significant increase in weight in adults with intellectual disabilities (Melville, Hamilton, Hankey, Miller & Boyle, 2006). The Risperidone prescribed for Marion’s ‘Schizoid Affective Disorder’ (previously mentioned in the background information) is likely to have the effect of increasing her appetite and again, she was able to satisfy this constant urge after the move to her new accommodation thus, further contributing to her weight gain. There is a large volume of evidence to suggest that psychotropic medications, some that have serious side effects, have been used in a high proportion of people with a learning disability (Deb & Fraser, 1994). It has been previously estimated that among the learning disabled living in adult institutions between 20 to 50 percent received psychotropic drugs (Rinck, Guidry & Calkins, 1989). Although in a high proportion of learning disabled individuals there is detectable psychiatric illness, there are a significant minority where there is no direct evidence of the presence of psychiatric illness and psychotropic drugs are used mainly to control behavioural problems (Deb & Fraser, 1994). Although difficult to judge, it seems possible that Marion could belong to the latter group; as mentioned in the background information, Marion’s diagnosis seems to have been largely based on her own accounts of responding to ‘voices’ (voices like very vivid memories of real past conversations) and staff observations that Marion was having conversations with herself.

From the assessment interviews with Marion and the staff, it is hypothesised that there are three main systems at work that are maintaining Marion’s behaviour. First, bearing in mind her tiredness and disinclination to take exercise (reported by Marion and staff during the assessment) it seems likely that Marion’s weight gain is causing her to become fatigued which would account for her reluctance to engage in any form of exercise,
which in turn maintains her weight gain. Secondly, her fatigue and reluctance to participate in exercising activity is seen by care staff as evidence that Marion is difficult to engage which leads to them reducing their efforts to enable her to take regular exercise thus maintaining Marion’s inactivity. In the research literature, there is well established empirical evidence of a link between daytime fatigue, higher body mass index (BMI) and limited physical activity (For example, Lim, Hong, Nelesen & Dimsdale, 2005; Resnick, Carter, Aloia & Phillips, 2006).

Lastly, staff by their own admission, are very concerned and anxious about Marion’s weight gain becoming a long-term obesity problem and the associated health risks that this would bring. This anxiety motivates their efforts to persuade Marion to cut down on her food in-take. It is hypothesised that the effect of this is to engender resistance in Marion who due to her new freer living environment does not appreciate being told by staff to cut down and consequently ignores them: “don’t tell me what to do”.

Interventions

The fact that adults with learning disabilities have a higher prevalence of obesity and are more likely to be overweight than the general population is now well documented (Melville, Cooper, Morrison, Allan, Smiley & Williamson, 2008). There is also evidence that adults with a learning disability have very low levels of physical activity (Frey, 2004; Emerson, 2005). Therefore, it seems likely that a sedentary lifestyle contributes to the raised prevalence of obesity in this client group. Furthermore, the available research evidence suggests that women like Marion, with mild to moderate levels of intellectual disabilities, living in less restrictive accommodation are at greatest risk of being overweight (Melville, Hamilton, Hankey, Miller & Boyle, 2006). However, there are no specific guidelines for managing those individuals with LD who are overweight or obese. NICE Guidelines for adults and children recommend multi-component interventions as the
treatment of choice. These include behaviour change strategies (with a cognitive component) to increase people’s physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person’s diet and reduce energy intake (NICE, 2006). However, strategies designed for the general population are unlikely to be effective with adults with learning disabilities unless adapted appropriately for differing levels of understanding.

The White Paper, ‘Valuing People’ (DH, 2001) acknowledges that people with a learning disability require more help with diets and advice on getting enough exercise, particularly those who are overweight and emphasises that carers need to be informed about healthy ways of living. Adults with intellectual disabilities often share decision-making with carers and lifestyle choices are made collaboratively. Therefore motivation of carers will impact on the effectiveness of weight loss interventions. Carers may be better able to support weight management in the longer term if they are included in the intervention learning process (Melville, Cooper, Morrison et al, 2008).

In a comprehensive review of weight loss interventions for adults with intellectual disabilities the treatment goals of the most effective interventions were to maintain modest weight loss, or even simply prevent weight gain (Hamilton, Hankey, Miller, Boyle & Melville, 2007). The review found that behavioural techniques, the involvement of carers, physical activity interventions and the imparting of nutritional and health knowledge were all proven to be effective strategies in the short-term. Further evidence was presented for the feasibility of increasing the health knowledge of people with LD. In terms of health promotion, equipping participants with a cognitive understanding of the health risks of weight gain was found to be important in order to reinforce the maintenance of the behavioural changes in the long term (Hamilton, Hankey, Miller et al, 2007).
Based on the formulation and current literature which advocates a multi-component approach as being the most likely intervention method to succeed, it was decided to combine cognitive-behavioural, physical activity and health promotion components with carer involvement. This meant working one-to-one with Marion in addition to developing guidelines with staff to help them re-appraise their beliefs about Marion and facilitate behaviour change.

**Sessions with Marion**

Four, one-to-one, hour-long sessions took place with Marion and these comprised behavioural methods to change eating habits and increase exercise and a health education or cognitive component to explore her health beliefs and improve understanding of the health risks of weight gain. Although cognitive components were included in the intervention it was sometimes difficult to identify the actual content of Marion’s thoughts, so that sessions tended to focus on cognitive process rather than cognitive content as in more complex forms of cognitive behavioural therapy (Stenfert Kroese, 1998). For this reason sessions were based around the principles of motivational interviewing (Miller & Rollnick, 2002). Motivational interviewing (MI) provides a way of working with individuals who may not seem ready to make lifestyle changes or are ambivalent about change. Traditional health promotion approaches tend to encourage change through the provision of advice or information giving with direct persuasion (Britt, Hudson & Blampied, 2004). The evidence for the effectiveness of this approach is not strong (Rollnick, Kinnersley & Stott, 1993) and individuals often do not take kindly to being given advice in a style that is perceived as being “told what to do” (Stott & Pill, 1990). In MI, lack of motivation (or resistance to change) is seen as something that is open to change. The main focus of MI is enabling behaviour change by helping individuals to
explore and resolve their ambivalence about the behaviour change (Rollnick & Miller, 1995). Although MI is patient-centred in that it focuses on what the client wants, thinks and feels it is directive in the sense that there is a clear goal of exploring the client’s ambivalence so that he or she is more likely to change behaviour in the desired direction (Miller & Rollnick, 1991).

Although originally developed for addiction counselling, a review of the effectiveness of MI in diet modification concluded that it is a promising model than can ‘at the very least’ moderately enhance diet modification and physical activity behaviours (VanWormer & Boucher, 2004).

The initial sessions with Marion were spent looking at the pros and cons of cutting down her food intake. She was encouraged to talk about any specific concerns that she had in relation to her weight gain (Britt, Hudson & Blampied, 2004) but seemed largely unaware of the health risks associated with her current eating habits. However, she did acknowledge that her clothes had become too small for her. One expressed advantage of losing weight for her would be fitting back into her favourite black skirt. With this in mind, she eventually acknowledged that her belief that she could eat as much as she wanted may not still hold true as it lead to undesired consequences – the evidence being that her favourite black skirt was now too small for her.

Being overweight is linked to cardiovascular disease, diabetes, hypertension and various cancers (Marshall, McConkey & Moore, 2003) and these health risks were explained to Marion. Information was also provided on healthy foods versus less healthy ones. Behavioural aspects concerned discussing the feasibility of Marion changing her diet so that she ate more fruit and vegetables less fat and exercised more. Marion expressed an interest in going swimming at the local pool, she disclosed that she had done this previously whilst living at the nursing home, but that this activity seemed to have
stopped since her move to her new place of residence. It transpired that Marion’s reluctance to engage in other physical activity such as keep fit classes arose due to the fact that she had co-ordination difficulties. She said that she found it hard to keep up with the rest of the class and on further exploration, Marion said that she was open to trying gentler forms of exercise such as yoga.

Staff Guidelines

Once Marion became better informed about healthy foods and gained the motivation to change her eating habits, work began with staff on guidelines for managing Marion’s eating behaviours. The guidelines (see Appendix 9) made a number of recommendations for staff to implement in order to encourage Marion to eat less, eat more healthily and take regular exercise.

An important component was for staff to collaborate with Marion to draw up a weekly menu so that she could plan her meals in advance and take out food from the freezer the night before if necessary. It was suggested that the menu would contain detailed information about portion size and the number of food items e.g. two pork chops, three roast potatoes etc. It was also suggested to staff that prior to going out shopping with Marion they should conduct a stock check of what she had left in her cupboards, fridge and freezer, so as not to buy more of what she already had. There was also a recommendation to increase the number of shopping trips so that she would be buying smaller quantities more often. The guidelines emphasized that whilst shopping, it would be helpful for staff and Marion to look at the food labels together to see the number of calories and nutritional content e.g. the proportion of saturated fat, fibre, salt, sugars etc. This would help Marion (and staff) pick out the healthier foods from the less healthy ones.
Staff were encouraged to help Marion break the lethargy-weight gain cycle by engaging with her more and re-appraising their beliefs about her being difficult to engage. By engaging with her more they could elicit her preferences regarding exercising activities, for example, she had expressed an interest in swimming and yoga. It was acknowledged that staff were concerned about Marion’s weight gain and the associated health risks and that staff anxiety fuelled unsuccessful attempts to get her to cut down. Staff saw that their behaviour was having the reverse effect of what they wanted i.e. creating more resistance from Marion who didn’t appreciate being told what to do. Contained in the guidelines and discussed with staff were low arousal approaches for dealing with Marion’s eating behaviours that staff were urged to adopt in a consistent way.

**Outcome/Achievements**

The work with Marion and care staff took place over a period of eight weeks. At the end of this period staff reported that Marion’s weight had plateaued and she had actually lost 3 lbs. Staff felt that the main reason for this was that Marion had started swimming again, once a week. Due to time limitations it was not possible to assess the full impact of the work, although Marion’s key worker reported a greater awareness of healthy eating habits and an increased confidence in helping Marion maintain a healthy balanced diet. When asked what would happen if she did not change her eating habits, Marion was able to remember most of the information concerning the health risks associated with being overweight and no longer believed she could eat as much as she liked. Marion’s knowledge of how to maintain a balanced healthy diet and the importance of regular exercise was no doubt improved but this was not tested in any standardized way due to time restrictions. Ideally, it would have been more rigorous to complete a questionnaire or pictorial outcome measure with Marion to obtain information about her nutritional
knowledge and food intake. For example, where each question was read out and she was asked to circle a picture with a written explanation underneath, to indicate the correct answer. Such an example would be: which food is low in sugar? The choice of pictures could be fruit, sweets and chocolate biscuits (McIntosh & O’Neil, 2002). In addition, questionnaires that measured the impact of knowledge of healthy eating and exercise could also have been administered to her carers at the end of the intervention such as that used by Laidlaw and colleagues in their ‘healthy living messages’ study for people with learning disabilities (Laidlaw, Spanos, Capaldi, Robinson & Nolan, 2008).

Final discussions with Marion elicited that she was keen to increase the number of times she went swimming to twice a week. So far, staff had not managed to implement this or to increase Marion’s shopping trips during the week due to staff absences and transport difficulties. There were plans to offer Marion the chance to attend a yoga class that had recently been identified by staff, but it is not known whether this became a reality.

**Reflections on the work**

Formulating Marion’s difficulties was not straightforward. Although a cognitive behavioural framework was used, it could be argued that an integrative formulation might have been more useful (combining cognitive behavioural and systemic approaches) due to the numerous systemic and contextual influences on Marion’s behaviour (Dallos, Wright, Stedmon & Johnstone, 2006). Tailoring an intervention strategy for Marion was also challenging as there is no evidence-based approach for the psychological treatment of individuals with a learning disability who exhibit extreme eating behaviours. The approaches chosen are based on methods found in the literature. Using the principles of motivational interviewing seemed to make psychological sense as this approach was designed to cope with individuals resistant to change and allows them to assess the pros
and cons of changing their behaviour. However, there is no documented evidence that this approach is effective for those with a mild learning disability. Furthermore, although specialist supervision was received, it was not possible for any specific training in this technique.

It was unfortunate that due to time restraints it was not possible to see Marion on a one-to-one basis for more than four sessions. As the intervention was specifically focused on the issue of Marion’s eating habits and of short duration, there was no time to attempt to explore the personal meaning of her eating behaviours or the emotion driving these as advocated by Lovatt (1985). There were issues of loss and loneliness for Marion that so far appear to have been largely unexplored. It is acknowledged that the design and focus of this intervention to a large extent was geared towards changing Marion’s health beliefs, knowledge and eating behaviours and precluded the therapeutic exploration of her psychological well-being in a more holistic way.

Professional/Ethical Issues

There was a dichotomy between staff anxiety surrounding Marion’s eating habits and subsequent weight gain and Marion’s desire to express her new found freedom by eating when and what she wanted. Marion’s eating habits were seen as problematic by staff who were anxious about the long-term health risks, but it was apparent that Marion’s perceptions were different. For her, it is likely that eating fulfilled biological and emotional needs. This raises the question of whether it was ethical to intervene as although overweight, Marion could not strictly be classified as obese and it could be argued that if she did not have a learning disability she would not have received any professional help unless she sought it herself. However, Marion did give her consent for the referral to psychology. These issues were discussed in supervision.
Working with staff presents challenges of its own in terms of whether guidelines are put in place or not. Sometimes staffing issues and resistance to change mean that guidelines are not effectively implemented. For example, Marion’s shopping trips had not been increased due to competing demands on the accommodation minibus and staff shortages. Another issue that was encountered was the perception of Marion’s key worker that she was in some way being judged as a result of the intervention. It was important to raise this issue in supervision in order to manage this. It became apparent that the key worker in question who had worked with Marion previously in the nursing home was finding it hard to adapt to the new supported living environment and disclosed that she felt inadequate in terms of being able to offer the level of support needed for residents to live as independently as possible. The key worker showed a reluctance to change her working practices in relation to Marion. This was because she believed that more demands would be made on her already heavy work schedule. Supervision helped to explore and understand why the staff member felt threatened by psychological input and helped the trainee to manage the relationship and cope with the resistance shown. Strategies were discussed on how to reassure other staff that psychology had not been called in to check up on and criticise their working practices, but rather to make helpful suggestions that were mutually beneficial to staff and clients.
References


CLINICAL PRACTICE REPORT 5: ORAL CASE STUDY

Case study of Tasmita: a 37 year old woman with depression and co-morbid obsessive compulsive behaviours

Presented: 24th March, 2009

Sarah Ford, Year 3

Summary

This orally presented case study described Tasmita a client who was referred to the CMHT where the trainee was on placement. The scope of the presentation included the reasons for her referral, the assessment methods used, the rationale and theory behind the cognitive behavioural formulation of her difficulties and the evidence for and details of the proposed treatment plan. The formulation described the development and maintenance of Tasmita’s depression and obsessive compulsive behaviours and was informed by the information obtained during the assessment stage. This was followed by an evaluation of the cognitive behavioural treatment plan in terms of Tasmita’s own subjective experience and the results of two standardised self-report questionnaires used to assess her progress pre and post therapy. Finally, reflections on the work with Tasmita were made in relation to the outcome of treatment and areas of the work that could have been improved.

All names and other identifying features were changed in this presentation to ensure confidentiality
Appendices
Appendix 1

Short Health Anxiety Inventory

Each question is this section consists of a group of four statements. Please read each group of statements carefully and then select the one which best describes your feelings, over the past six months. Identify the statement by ringing the letter next to it, i.e. if you think that statement (a) is correct, ring statement (a) ; it may be that more than one statement applies, in which case, please ring any that are applicable.

1. (a) I do not worry about my health.
   (b) I occasionally worry about my health.
   (c) I spend much of my time worrying about my health.
   (d) I spend most of my time worrying about my health.

2. (a) I notice aches/pains less than most other people (of my age).
   (b) I notice aches/pains as much as most other people (of my age).
   (c) I notice aches/pains more than most other people (of my age).
   (d) I am aware of aches/pains in my body all the time.

3. (a) As a rule I am not aware of bodily sensations or changes.
   (b) Sometimes I am aware of bodily sensations or changes.
   (c) I am often aware of bodily sensations or changes.
   (d) I am constantly aware of bodily sensations or changes.

4. (a) Resisting thoughts of illness is never a problem.
   (b) Most of the time I can resist thoughts of illness.
   (c) I try to resist thoughts of illness but am often unable to do so.
   (d) Thoughts of illness are so strong that I no longer even try to resist them.

5. (a) As a rule I am not afraid that I have a serious illness.
   (b) I am sometimes afraid that I have a serious illness.
   (c) I am often afraid that I have a serious illness.
   (d) I am always afraid that I have a serious illness.

6. (a) I do not have images (mental pictures) of myself being ill.
   (b) I occasionally have images of myself being ill.
   (c) I frequently have images of myself being ill.
   (d) I constantly have images of myself being ill.
7. (a) I do not have any difficulty taking my mind off thoughts about my health.
   (b) I sometimes have difficulty taking my mind off thoughts about my health.
   (c) I often have difficulty in taking my mind off thoughts about my health.
   (d) Nothing can take my mind off thoughts about my health.

8. (a) I am lastingly relieved if my doctor tells me there is nothing wrong.
   (b) I am initially relieved but the worries sometimes return later.
   (c) I am initially relieved but the worries always return later.
   (d) I am not relieved if my doctor tells me there is nothing wrong.

9. (a) If I hear about an illness I never think I have it myself.
   (b) If I hear about an illness I sometimes think I have it myself.
   (c) If I hear about an illness I often think I have it myself.
   (d) If I hear about an illness I always think I have it myself.

10. (a) If I have a bodily sensation or change I rarely wonder what it means.
    (b) If I have a bodily sensation or change I often wonder what it means.
    (c) If I have a bodily sensation or change I always wonder what it means.
    (d) If I have a bodily sensation or change I must know what it means.

11. (a) I usually feel at very low risk for developing a serious illness.
    (b) I usually feel at fairly low risk for developing a serious illness.
    (c) I usually feel at moderate risk for developing a serious illness.
    (d) I usually feel at high risk for developing a serious illness.

12. (a) I never think I have a serious illness.
    (b) I sometimes think I have a serious illness.
    (c) I often think I have a serious illness.
    (d) I usually think that I am seriously ill.

13. (a) If I notice an unexplained bodily sensation I don't find it difficult to think about other things.
    (b) If I notice an unexplained bodily sensation I sometimes find it difficult to think about other things.
    (c) If I notice an unexplained bodily sensation I often find it difficult to think about other things.
    (d) If I notice an unexplained bodily sensation I always find it difficult to think about other things.
14. (a) My family/friends would say I do not worry enough about my health.
    (b) My family/friends would say I have a normal attitude to my health.
    (c) My family/friends would say I worry too much about my health.
    (d) My family/friends would say I am a hypochondriac.

For the following questions, please think about what it might be like if you had a serious illness of a type which particularly concerns you (such as heart disease, cancer, multiple sclerosis and so on). Obviously you cannot know for definite what it would be like; please give your best estimate of what you think might happen, basing your estimate on what you know about yourself and serious illness in general.

15. (a) If I had a serious illness I would still be able to enjoy things in my life quite a lot.
    (b) If I had a serious illness I would still be able to enjoy things in my life a little.
    (c) If I had a serious illness I would be almost completely unable to enjoy things in my life.
    (d) If I had a serious illness I would be completely unable to enjoy life at all.

16. (a) If I developed a serious illness there is a good chance that modern medicine would be able to cure me.
    (b) If I developed a serious illness there is a moderate chance that modern medicine would be able to cure me.
    (c) If I developed a serious illness there is a very small chance that modern medicine would be able to cure me.
    (d) If I developed a serious illness there is no chance that modern medicine would be able to cure me.

17. (a) A serious illness would ruin some aspects of my life.
    (b) A serious illness would ruin many aspects of my life.
    (c) A serious illness would ruin almost every aspect of my life.
    (d) A serious illness would ruin every aspect of my life.

18. (a) If I had a serious illness I would not feel that I had lost my dignity.
    (b) If I had a serious illness I would feel that I had lost a little of my dignity.
    (c) If I had a serious illness I would feel that I had lost quite a lot of my dignity.
    (d) If I had a serious illness I would feel that I had totally lost my dignity.
Appendix 2

Clinical Supervision Group Evaluation

Dear Supervisee

I have been asked to conduct an evaluation of the clinical supervision groups that currently run at *******. These groups have been established for some time now, so it would be helpful to find out from you if they are of value, and whether there are any areas for change.

Attached is a Questionnaire designed to explore your experiences. I would be grateful if you could spare 10-15 minutes to complete this and put it in the folder in the ward office, which will be emptied periodically. Participation is purely voluntary.

Please be assured that the questionnaire is anonymous so that all your responses will remain strictly CONFIDENTIAL. If you have any queries please contact me on the number below.

With thanks and best wishes.

Yours truly,

***** ***********
Trainee Clinical Psychologist

Older Adult Psychology Services
Address line 1
Address line 2
Birmingham
Telephone no: ________      July 2007
Clinical Group Supervision Questionnaire
Please complete the questions below:

Demographic Details  (Optional)

Sex:  Male  Female

Please give details of post and band e.g. RMN: Band 5…………………………………

………………………………………………………………………………………………

Area/Unit:  Dementia/Challenging Behaviour  Nursing

Number of Years/Months Qualified: …… Year(s) …… Month(s)

Length of time in present post: …… Year(s) …… Month(s)

Please state working hours as applicable: Day Duty hrs: ………………………….
                      Night Duty hrs: ………………………

About Your Clinical Supervision Sessions (Please Complete)

How long have you been a member of your supervision group: Yr(s)…….. Mth(s)……..

How often do you attend per year?  Nil  1-3 times  4-6 times  7 or more

General Satisfaction

Drawing on your experience of receiving clinical group supervision please indicate your level of agreement with the following statement by circling the number which best represents your answer.

I feel satisfied with the clinical group supervision I receive.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Agree Strongly</th>
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<td>1</td>
<td>2</td>
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Drawing on your experience of receiving clinical group supervision (CGS) please indicate your level of agreement with the following 21 statements by ticking the number which best represents your answers.

1= strongly disagree, 2= disagree, 3= no opinion, 4= agree, 5= strongly agree

1. I can off-load feelings during CGS           R
2. CGS relieves pressure of work               R
3. I can give an example of a change to my practice as a
   result of clinical supervision            N
4. CGS has helped me become more creative at work  F
5. I have been helped to identify my development needs through CGS   F
6. CGS reduces my work related stress          R
7. Through CGS I have learned new ways to approach practice      F
8. CGS has improved my nursing practice         N
9. CGS helps my self-confidence                 R
10. CGS has helped me to challenge existing practice            N
11. CGS helps me feel less isolated in my practice            R
12. I am more able to talk about tricky practice issues in CGS than
    in other settings                              N
13. CGS has helped me to cope with difficult situations     R
14. CGS has helped me feel that my practice is of an
    acceptable standard                            N
15. CGS has made me more aware of my own behaviour      F
16. CGS makes me feel more supported in my practice      R
17. CGS has increased my self-awareness            F
18. CGS helps me to develop new ideas on how to tackle
    work related problems                          F
19. CGS has helped me think through situations more critically F
20. I receive useful advice in CGS                  N
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<td><strong>21. CGS has helped me look more objectively at my work</strong></td>
<td><strong>N</strong></td>
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<tr>
<td><strong>22. Receiving CGS helps my team work more effectively</strong></td>
<td><strong>N</strong></td>
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<td><strong>23. CGS improves the quality of care I give</strong></td>
<td><strong>N</strong></td>
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<tr>
<td><strong>24. Co-operation in the team has improved as a result of CGS</strong></td>
<td><strong>R</strong></td>
</tr>
<tr>
<td><strong>25. CGS sessions are not necessary/don’t solve anything</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td><strong>26. Time spent on CGS takes me away from my real clinical work</strong></td>
<td><strong>T</strong></td>
</tr>
<tr>
<td><strong>27. Fitting in CGS sessions can lead to more pressure at work</strong></td>
<td><strong>T</strong></td>
</tr>
<tr>
<td><strong>28. I find CGS sessions time consuming</strong></td>
<td><strong>T</strong></td>
</tr>
<tr>
<td><strong>29. CGS does not solve personal issues</strong></td>
<td><strong>R</strong></td>
</tr>
<tr>
<td><strong>30. CGS sessions are intrusive</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td><strong>31. CGS gives me time to ‘reflect’</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>32. CGS sessions facilitate reflective practice</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>33. I can discuss sensitive issues in CGS</strong></td>
<td><strong>R</strong></td>
</tr>
<tr>
<td><strong>34. CGS sessions are an important part of work routine</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>35. It is important to make time for CGS</strong></td>
<td><strong>T</strong></td>
</tr>
<tr>
<td><strong>36. CGS widens my clinical knowledge base</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>37. CGS is unnecessary for experienced/established staff</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td><strong>38. CGS is for newly qualified/inexperienced staff only</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td><strong>39. Without CGS the quality of patient care would deteriorate</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>40. I can widen my skill base during CGS sessions</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>41. In CGS I learn from the group’s experiences</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>42. The facilitators provide support and encouragement</strong></td>
<td><strong>R</strong></td>
</tr>
</tbody>
</table>

F= FORMATIVE (14), R= RESTORATIVE (11), N= NORMATIVE (13), T=TIME (4)
Further comments about your supervision group.

Please add comments concerning how helpful/unhelpful you find/found the experience of your supervision group (not already mentioned above).

Thank you for taking the time to complete this questionnaire.
Appendix 3

Clinical Supervision Group Evaluation Questionnaire for Facilitators

1. Have you received any specific training in supervision?

Yes ☐ No ☐

If yes, please give details: ........................................................................................................
........................................................................................................................................
........................................................................................................................................

2. Do you receive supervision related to your group at ********?

Yes ☐ No ☐

If yes, how often? ...................................................................................................................

3. Do you use a particular model of supervision in your ********* group e.g. person centred? Yes ☐ no specific model ☐

If yes please give details ......................................................................................................
........................................................................................................................................
........................................................................................................................................

4. Is your group well attended? Please indicate on scale below:

<table>
<thead>
<tr>
<th>Very Poorly Attended</th>
<th>Moderately Well Attended</th>
<th>Very Well Attended</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>4</td>
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<td>10</td>
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</tbody>
</table>
5. Was a contract made at the beginning of the supervisory process between the supervisees and facilitators?  
Yes  ☐  No  ☐

If yes, did this cover:—

Confidentiality  Yes  ☐  No  ☐  
Boundaries  ☐  ☐  
Time keeping/dates of sessions  ☐  ☐  
Commitment to attend  ☐  ☐  
Format of sessions  ☐  ☐  
Aims of sessions  ☐  ☐  
Any other contractual issues?  
………………………………………………………………………………………………….
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6. Please describe the format/process of the group including:—
What the facilitation process involves; how the sessions begin; how they are structured (e.g. does each supervisee have the chance to bring up issues? How is this decided?) How are the sessions ended?
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5. How do you perceive your role as a group facilitator?

Please indicate your level of agreement with the following statements by circling the number which best represents your answers. 1= strongly disagree, 2= moderately disagree, 3= undecided, 4= moderately agree, 5= strongly agree.

| a) To set the ground rules and boundaries | 1 | 2 | 3 | 4 | 5 |
| b) To intervene when the group is struggling | 1 | 2 | 3 | 4 | 5 |
| c) To give guidance and advice | 1 | 2 | 3 | 4 | 5 |
| d) To act as a teacher and role model | 1 | 2 | 3 | 4 | 5 |
| e) To be an objective listener | 1 | 2 | 3 | 4 | 5 |
| f) To provide counselling | 1 | 2 | 3 | 4 | 5 |
| g) To direct and lead the group | 1 | 2 | 3 | 4 | 5 |
| h) To share knowledge and experience | 1 | 2 | 3 | 4 | 5 |
| i) To provide support and encouragement | 1 | 2 | 3 | 4 | 5 |
| j) To create a safe environment | 1 | 2 | 3 | 4 | 5 |
| k) To act as a mediator | 1 | 2 | 3 | 4 | 5 |
| l) To foster a good group alliance | 1 | 2 | 3 | 4 | 5 |

Other: ...........................................................................................................................................
6. What do you see as the purpose and aims of the clinical supervision group? Please indicate your level of agreement with the following statements by circling the number which best represents your answers. 1 = strongly disagree, 2 = moderately disagree, 3 = undecided, 4 = moderately agree, 5 = strongly agree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
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<tbody>
<tr>
<td>a) To enable supervisees to reflect on feelings evoked by clinical work</td>
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<td>b) To help supervisees develop a sense of accountability for their own practice</td>
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<tr>
<td>c) To explore personal issues that affect clinical work</td>
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<tr>
<td>d) To improve communication skills</td>
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<tr>
<td>e) To resolve staff/team conflicts</td>
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<td>f) To enable members to problem solve</td>
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<td>g) To discuss caseload management</td>
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<td>h) To improve co-operation within teams</td>
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<tr>
<td>i) To reflect on clinical practice issues</td>
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<td>j) To develop knowledge and competence</td>
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<tr>
<td>k) To promote professional development</td>
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<td>l) To provide educational support</td>
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<tr>
<td>m) To build members’ confidence</td>
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<tr>
<td>n) To enhance clinical skills</td>
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<td></td>
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<tr>
<td>o) To air organisational/management issues</td>
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</tbody>
</table>

1 = strongly disagree; 2 = moderately disagree; 3 = undecided, 4 = moderately agree, 5 = strongly agree.
Other aims? .............................................................................................................................................................................
.............................................................................................................................................................................
.............................................................................................................................................................................
.............................................................................................................................................................................

7. To what extent do you feel that these objectives were/are being achieved?

Please write a number between 0 and 10 in the box after each statement to indicate level of achievement, bearing in mind that 0 = Not at all, 5 = moderately achieved and 10 = achieved to a large extent.

a) Enabling supervisees to reflect on feelings evoked by clinical work

b) Helping supervisees develop a sense of accountability for their own practice

c) Exploring personal issues that affect clinical work

d) Improving communication skills

e) Resolving staff/team conflicts

f) Enabling members to problem solve

g) Discussing caseload management

h) Improving co-operation within teams

h) Reflecting on clinical practice issues
j) Developing knowledge and competence
k) Promoting professional development
l) Providing educational support
m) Building members’ confidence
n) Enhancing clinical skills
o) Airing organisational and management issues

8. What are the topic areas most commonly brought up by the group members?

Please write a number between 0 and 10 in the box after each topic to indicate its frequency, bearing in mind that 0 = never mentioned, 5 = mentioned occasionally and 10 = mentioned frequently.

a) Clinical practice issues
b) Professional development issues
c) Interpersonal problems relating to practice
d) Organisational and Management issues
e) Personal issues relating to practice
f) Team conflicts and tensions
g) Serious incidents
h) Other: ............................................................
In what ways has the group developed since its inception?

What do you think has worked well in the group?
What could be improved or changed to make it work better?


Thank you for Completing this questionnaire
Appendix 4

Process and Structure of Supervision

At the beginning of the supervisory process all but one of the facilitators recalled making a verbal contract with the supervisees. For these, the contract covered confidentiality, boundaries, time keeping/dates of sessions, commitment to attend, format and aims of sessions. One facilitator also emphasised the power issues within the group process and the influence of group dynamics. Another raised the issue of responsibility for pursuing solutions or actions residing with the supervisees rather than the facilitators.

The general supervision style was loosely structured and non-directive i.e. facilitative. Two facilitators reported that they often spent time waiting for the supervisees to assemble and they frequently have to go and locate them and remind them that the session is running. A commonly used approach to open the sessions was to ask an open question to find out how the supervisees were managing at work as a prelude to eliciting topics/residents and areas of concern for discussion. After identifying these, in some groups the facilitators then decide how best to structure the session in terms of how much time is spent on topics and what people hope to gain from the discussion. In other groups at this stage the action points and issues raised in the previous session may be re-visited if appropriate. Four of the facilitators emphasised that all members of their groups, in particular the less vocal members, are given a chance to contribute to the discussion and raise their own issues. In most cases issues raised by group members are discussed by the group as a whole and then summarised by the facilitators. Establishing “what needs to be done next and who will do it” then follows and can involve implementing an intervention into a care plan. In some groups facilitators actively enable the supervisees to reframe the issues/problems they have raised by providing alternative perspectives on them and introducing appropriate theoretical models of behaviour and behaviour change to aid the planning and execution of clinical interventions. The sessions are usually concluded with a summary of what has been discussed to ensure that everything has been covered and one facilitator stated that when appropriate there is “an emphasis on process” and the “relation to the wider social/working context”.

Appendix 6
Spence Children’s Anxiety Scale

Spence Children’s Anxiety Scale (SCAS)

Your name: ___________________________ Date: ___________________________

Please tick the box under the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things

2. I am scared of the dark

3. When I have a problem, I get a funny feeling in my stomach

4. I feel afraid

5. I would feel afraid of being on my own at home

6. I feel scared when I have to take a test

7. I feel afraid if I have to use public toilets or bathrooms

8. I worry about being away from my parents

9. I feel afraid that I will make a fool of myself in front of people

10. I worry that I will do badly at my school work

11. I am popular amongst other kids of my own age

12. I worry that something awful will happen to someone in my family

13. I suddenly feel as if I can’t breathe when there is no reason for this

14. I have to keep checking that I have done things right (like the switch is off, or the door is locked)

15. I feel scared if I have to sleep on my own

16. I have trouble going to school in the mornings because I feel nervous or afraid

17. I am good at sports

18. I am scared of dogs

19. I can’t seem to get bad or silly thoughts out of my head

20. When I have a problem, my heart beats really fast

21. I suddenly start to tremble or shake when there is no reason for this

22. I worry that something bad will happen to me

23. I am scared of going to the doctor or dentist
24. When I have a problem, I feel shaky
25. I am scared of being in high places or lifts (elevators)
26. I am a good person
27. I have to think of special thoughts (like numbers or words) to stop bad things from happening
28. I feel scared if I have to travel in the car, or on a bus or train
29. I worry what other people think of me
30. I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)
31. I feel happy
32. All of a sudden I feel really scared for no reason at all
33. I am scared of insects or spiders
34. I suddenly become dizzy or faint when there is no reason for this
35. I feel afraid if I have to talk in front of my class
36. My heart suddenly starts to beat too quickly for no reason
37. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of
38. I like myself
39. I am afraid of being in small closed places, like tunnels or small rooms
40. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)
41. I get bothered by bad or silly thoughts or pictures in my mind
42. I have to do some things in just the right way to stop bad things happening
43. I am proud of my school work
44. I would feel scared if I had to stay away from home overnight
45. Is there something else that you are really afraid of?

Please write down what it is:

How often are you afraid of this thing?
### Christopher's Sleep Diary

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>What time did Christopher go to bed?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>What did he do while waiting to fall asleep? e.g. kept light on? Watched TV?</td>
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<td></td>
</tr>
<tr>
<td>What did Mum do while Christopher was waiting to fall asleep?</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>How many times did he call out/make noises?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What time did Christopher fall asleep?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What time did Christopher wake up in the morning?</td>
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</tbody>
</table>
Appendix 8
Christopher’s step-by-step plan

Christopher’s Weekly Bedtime Plan to Help him go to Sleep without Feeling Scared

6. All lights off, TV off and door open.
5. TV off, music on CD player, hall light on, bedroom door half open.
4. TV on mute, MP3 player on until 9.30, hall light only, door fully open.
3. TV on mute, MP3 player on until 9.30, bedside lamp on.
2. TV on mute, MP3 player on as required, bedside lamp on.
1. TV on, bedside lamp on, hall light on, bedroom door fully open.
Appendix 9
Marion Smith: Behaviour Management Guidelines

Introduction:

Marion moved to xxxxx Road approximately 18 months ago after the closure of xxxx nursing home. xxxx nursing home had been Marion’s home for over 16 years. Since moving to her new residence Marion has adjusted well and is enjoying the relative freedom of supported living accommodation. However, staff have noticed a change in her eating behaviour. Marion tends to eat a lot more frequently (in between meals) and tends to prepare large quantities of food for her own consumption. Staff are concerned that over the last 18 months she has gained 2 stone in weight.

The following guidelines outline how staff can manage Marion’s eating behaviour in a consistent way.

Increase in food in-take

Whilst living at xxxx nursing home Marion’s meals were all prepared and cooked for her by staff at the same times each day. Now that she has moved to supported living accommodation Marion has new responsibilities for buying and cooking her own food. As she has little prior experience of this, there is a need to educate and provide guidance on healthy eating and appropriate portion sizes, so that she can adjust to this new way of living.

- If possible collaborate with Marion to draw up a weekly menu so that she can plan her meals in advance and take out food from the freezer the night before if necessary. A detailed menu could contain information about portion size. For example, lunch might be: ‘2 pork chops, 3 roast potatoes and a generous portion of broccoli’ and a tin of peaches and small carton of custard for pudding etc.

- So that Marion can reduce her portion size staff should make sure that she has a medium sized plate for her meat and separate side plate(s) for her vegetables.

- Staff should make sure that Marion does not start preparing her mid-day meal before 11.45 so that they can give her guidance as to the quantity of food to prepare. Staff should say something like ‘it’s too early for lunch Marion, I’ll come back in half an hour to help you’.

- To prevent Marion taking food out of her oven before it is fully cooked a battery operated oven timer could be helpful, so that Marion can see the time remaining before her food is ready. Staff need to make it clear to her that the food must not be removed before the timer has bleeped otherwise she may become ill if she eats undercooked meat.

- Staff need to remind Marion to wrap up left over food appropriately (in foil or cling film) and return it to the fridge to preserve its life.

- Marion should be encouraged to eat a piece of fresh fruit or a low fat cereal bar rather than high calorie biscuits or crisps if she feels hungry between meals.
Food Shopping

- It would be beneficial for Marion to go shopping at least twice a week, so that she buys less food on each trip. Moderating the amount she buys will help reinforce that she needs to cut down her in-take. Staff need to encourage her to buy healthy meals including low fat yoghurts, fruit and vegetables. It may be helpful for staff and Marion to look at the food labels together to see the number of calories and nutritional content e.g. the proportion of saturated fat, fibre, salt, sugars etc. This will help Marion learn about the healthier foods versus the less healthy ones.

Exercise

- Marion has expressed an interest to go swimming once a week. If she enjoys this and is willing, this should be increased to twice a week. Staff need to encourage Marion to engage in more exercise e.g. going for local walks. Marion is not keen on keep fit classes as her co-ordination difficulties prevent her from keeping up with the exercises. If possible she should be encouraged to take part in gentler exercise activities such as yoga classes.

In general the best way of preventing and responding to problematic behaviour is to adopt a low arousal approach. This includes the following general rules.

<table>
<thead>
<tr>
<th>Do</th>
<th>Do not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice</td>
<td></td>
</tr>
<tr>
<td>Speak quietly</td>
<td>Raise voice</td>
</tr>
<tr>
<td>Speak slowly / listen</td>
<td>Talk quickly / not listen</td>
</tr>
<tr>
<td>Be respectful / no teasing</td>
<td>use sarcasm / be rude</td>
</tr>
<tr>
<td>Posture</td>
<td></td>
</tr>
<tr>
<td>Stand at a comfortable distance / sit to talk</td>
<td>Stand too close / lean over</td>
</tr>
<tr>
<td>Adopt a relaxed posture</td>
<td>Adopt a threatening</td>
</tr>
<tr>
<td>Move slowly / take time</td>
<td>Make quick movements/ wave</td>
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<tr>
<td></td>
<td>arms or touch</td>
</tr>
</tbody>
</table>

These guidelines will be reviewed at regular meetings with staff and Marion.