Volume II: Clinical Component
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Psychological Models

CPR 1

A behavioural and systemic formulation of Billy, a 21-year-old autistic male demonstrating ‘posting behaviours’

Please note that to protect the client’s identity all names have been changed throughout this report
Abstract

Billy* is a 21 year old male referred for pica-related behaviours. It became evident throughout the initial assessment that the ‘posting behaviour’ was posing more difficulties than his pica behaviours for staff within the home. As a result a series of observations was made, both within the care home and within the community; alongside these observations, subjective accounts were obtained from staff members, professionals, and Billy’s mother. Formulations from a behavioural and systemic perspective were provided, which highlighted the lack of structure provided within Billy’s life, along with limited communication due to lack of skills amongst care staff. Both formulations have their own merits, however in this instance, an integrative formulation appears to be more effective in understanding the behaviours exhibited.

* Please note that to protect the client’s identity all names have been changed throughout this report
Reason for referral

Billy is a non-verbal 21-year-old male with autism who was referred by Psychiatry to the Learning Disabilities Psychology Service in August of 2006 with respect to his pica-related behaviours. Billy was reported to be eating chewing gum, labels off his clothes, and buttons. Staff at Billy’s care home were increasingly concerned about these behaviours due to the physical health risk to Billy, and subsequent distress this was causing staff members.

Background information

Family

Billy has a brother (IB) who also has a diagnosis of Autism, and a sister who is without a learning disability. Billy’s mother is a wheelchair user, and his father has a history of heart problems. As a result, it is not possible for Billy and IB to live with them in the family home. Billy resides on a full-time basis at a local care home. He visits his parents every fourth weekend. His parents are now able to visit Billy at the care home, however until recently this was difficult, as disabled access was not provided within the home for Mrs B. Billy is in contact with his brother by letter, and occasionally meets him outside of either care home.

Education

Prior to living at his current address, Billy was a resident at a specialist residential school for children with learning disabilities, until he was 18/19. On leaving school he returned to live with his parents for a few months as procedures relating to his current placement were not complete.
Billy’s school report suggests that he would engage in activities at school including pottery, dance, jigsaws, watching videos and colouring. Billy was able to write simple letters with assistance, and had developed his use of the Picture Exchange Communication System (PECS) up to Phase 4. Billy was also able to write his own name. Billy displayed various behaviours including ear flapping, ear folding, squealing, and flapping his arms and hands. Billy was reported to be prone to ear infections, and to stick things in his ears, and up his nose, yet there was no record of Billy eating chewing gum, “blu tac”, or other objects during his time at school.

Billy currently attends one course at a local college, he did attend more courses, but care home staff reported that the college thought that Billy would benefit from a quieter environment. Care home staff state that they are looking into alternative courses.

Ecomap

Due to Billy’s current living arrangements and the number of people involved in providing direct and indirect care and services, it seems appropriate to display this in the form of an ecomap. An ecomap shows those involved in providing direct care in Billy's life, e.g care home staff, and family; and also those who have a role in the perception and construction of the meanings of the problems experienced (Dallos, Wright, Stedmon & Johnstone, (2006). An ecomap provides a clearer visual aid than a genogram which for Billy would become complicated as a result of his living arrangements. A copy of Billy's ecomap can be found under Figure 1.
Assessment

The assessment of Billy’s difficulties was made during the initial interview with Billy’s care home manager and key worker; through three separate hours of observation carried out by the therapist; and conversations with Billy’s mother and other professionals involved (Speech and Language Therapist, and a behavioural specialist employed by the care provider).

Staff members within the care home were asked to complete “Antecedents, Settings, Events, Conditions” forms (see Appendix 1) for each occasion that Billy engaged in his ‘posting behaviour’ or his pica in order to ascertain triggers for these behaviours. However, initially the therapist was informed that staff members were unsure how to
fill the forms in and as a result had not completed any forms. After spending time explaining how to fill the forms in, staff members were asked again to complete the forms for the above behaviours. When the therapist returned to collect these forms, staff appeared unaware of any forms to be filled in, and of their whereabouts.

As a result, the following background information is based on clinical interviews with care home staff, professional conversations with other professionals involved, and Billy’s mother; and through observations made by the therapist.

**Presenting difficulties**

Billy did not stay within the room during the initial assessment, spending most of the time walking between the room used and the lounge. In addition, Billy is nonverbal, so therefore he was not involved in the assessment. WD, care home manager, and CS, Billy’s keyworker were present for this assessment. Billy’s mother was not present, due to Billy living full time in the care home, although she was aware of the referral.

WD and CS were grateful for the appointment as they had been concerned about Billy’s pica and also about his ‘posting behaviour’ that had not been mentioned in the referral. Staff at the care home had administered the Motivational Assessment Scale (Durand & Crimmins, 1988; See Appendix 2) which had identified a sensory component to Billy’s pica. Billy’s pica behaviours are reported to take place on a daily basis both in the care home and in the community, with staff reporting that Billy frequently picks chewing gum up off the floor and eats this. During the initial assessment, WD and CS were asked whether Billy had a structured timetable. Staff
reported that Billy no longer has one displayed in his room, as he eats them, yet when asked, WD and CS were unable to explain what activities Billy engages in throughout the week other than Billy's attendance at college one day a week and tranquillity sessions.

In addition, Billy is reported to chew objects, such as buttons off his jeans in order to flatten them enough so that he can post them down the back of the radiators within the care home. Billy is also reported to post several other objects, for example pens, paper, CDs and DVDs on a daily basis. (During the initial assessment, Consultant Clinical Psychologist, SM did suggest that staff provide a ‘postbox’ for Billy to use instead of the radiators).

It became evident throughout the initial assessment that the ‘posting behaviour’ was posing more difficulties than his pica behaviours for staff within the home.

Following the initial assessment, it was decided that it would be more useful to work with staff in order to address Billy’s ‘posting behaviours’ which may in turn decrease the difficulties relating to pica. As a result, the following assessment procedures and formulations will focus on Billy’s ‘posting behaviours’.

*Observations*

On three separate occasions I observed Billy: twice within the care home and on one occasion when I accompanied Billy and his carer within the community. Below follows a summary of these observations (a more detailed account of these observations can be found under Appendix 3)
Throughout these observations, both within the care home, and within the community, Billy behaved entirely appropriately for the majority of the time, with Billy being observed posting pens down the radiator when he had completed an exercise. No other instances of Billy’s posting behaviours were observed. Staff interaction was minimal, with limited positive reinforcement being observed. Billy, and other residents were left to engage in activities on their own initiative. In addition, no attempt to offer Billy a choice of activity was observed, and Billy was not informed of any other activities that would follow his current activity. When staff were observed communicating with Billy, they did not appear to make allowances for Billy’s communication difficulties, as staff did not show evidence of using PECS strategies, which Billy is reported to be able to use to a high standard. Without the use of PECS, Billy is unable to communicate with staff his needs and it is unclear how much understanding Billy has of what staff say to him.

As a result of these observations, it was hypothesised, during supervision that care home staff were lacking knowledge of Autistic Spectrum Disorders, and as a result, were unclear about the importance of using PECS with Billy, and of structure.

**Subjective accounts**

*Care home staff*

In addition to the initial assessment, staff members were asked about Billy’s posting behaviour, and also volunteered information.

Staff reported that they have to remove the safety covers from the radiators on a
regular basis to remove the objects that have been posted by Billy. Staff members involve Billy in this process. They recall that when they have finished removing the objects, and the cover has been replaced, Billy will post an object.

Enquiries were made regarding Billy’s weekly timetable, I was informed on two occasions by different staff members that “Billy attends college on a Friday”, but staff were unable to recall what he does on a daily basis.

Staff members also report that Billy will retreat to his room if the lounge becomes too noisy and describe Billy as “a bit of a loner”.

Mrs B

During conversation with Mrs B, it became apparent that posting behaviour was not present during Billy’s home visits. Mrs B reported that when Billy returns for a home visit, he has structured days within his weekend; with visual schedules in place so that he is aware of individual aspects involved throughout individual Activities of Daily Living, for example getting dressed. Mrs B reports that Billy likes order within his belongings, and that he has been known to become angry when his personal possessions are not in the correct order. Mrs B was unaware of any ‘postbox’ whilst Billy was at school.

Mrs B described Billy as a highly energetic young man, who she says is not able to use up his large amounts of physical energy when he is living at the care home. Mrs B states that Billy will walk next to her wheelchair for walks of approximately 10 miles. She recalls a time when Billy would ride around the school grounds on his
bike, and that she did not have to give him pocket money, as Billy had two paper rounds, and earned extra money litter-picking in the local park. She also recalls that during one of Billy’s reviews at the care home, a member of staff had asked who owned the bike in the shed (Billy’s), and that she had to explain to staff that the bike belonged to Billy, suggesting that this hadn’t been used.

Mrs B also spoke of limited communication from the care home, stating that she had had to request weekly written updates about son. Mrs B recalls informing the care home that Billy cannot occupy himself, and suggesting they offer him a choice of two activities. She reports that these suggestions were not taken on board by care home staff, and recalls staff being vague when she enquired about what activities were scheduled for her son.

**DB (behavioural specialist)**

DB was involved in Billy’s transition from the specialist school to his placement at his current residence. DB has not been involved with Billy since this placement two years ago, but does recall information about this transition, and observations he has made during visits to other residents.

During his time at the specialist school, DB recalls that Billy would have a structured timetable, and a consistent member of staff would be present with Billy throughout this daily timetable. DB recalls that Billy had a postbox, and that on completion of an activity, Billy would post an item from the activity into his postbox to symbolise the ending of the activity, before moving onto the next activity.
Billy had been referred for an assessment by Speech and Language Therapy. During a conversation regarding Billy, it became apparent that KB had been revisiting Billy’s use of PECS. KB reports trying on several occasions to disseminate training to care home staff, though this was without success. KB also reports several PECS images she had left for staff as being mislaid.

**Autism and Structure**

Literature surrounding autism suggests that individuals with autism prefer routines and unexpected change to these routines can be upsetting. People with autism need structure to their day and anything unexpected may cause their anxiety levels to rise significantly, and may result in unpredicted behaviour (National Autistic Society website). Jolliffe (1992) provides a quote from a research participant with autism, highlighting the importance of structure.

"Reality to an autistic person is a confusing, interacting mass of events, people, places, sounds and sights. There seem to be no clear boundaries, order or meaning to anything. A large part of my life is spent trying to work out the pattern behind everything. Set routines, times, particular routes and rituals all help to get order into an unbearably chaotic life. Trying to keep everything the same reduces some of the terrible fear."

(Jolliffe, 1992 in Howlin, 1998, pp. 201-202)

**Behavioural Formulation**

The following behavioural formulation seeks to include an understanding of the onset and reasons for the development of Billy's 'challenging behaviour', identifying
personal, environmental and interpersonal factors which have initiated/maintained the challenging behaviour (British Psychological Society, 2004). This formulation seeks to address the meaning of the behaviour for Billy within his environment. In addition, to the British Psychological Society's (BPS) guidelines this formulation will draw upon the theory of Operant Conditioning developed by Skinner (1938).

Operant Conditioning consists of both negative and positive reinforcement of behaviours. Negative reinforcement occurs when an individual achieves a positive outcome of escape or avoidance. Positive reinforcement occurs when an increase in the frequency of a response is followed by a favourable event (positive reinforcer). Reinforcers can be one of four types: primary, secondary, social and stimulation. Primary reinforcers include food and drink, etc; secondary reinforcers include money, tokens, stars, etc; social reinforcers include praise, attention, hugs, etc; stimulation reinforcers include activities and sensations, etc.

In Billy’s case, it is useful to use the Theory of Operant Conditioning to hypothesise about the functionality of Billy’s behaviours, and how staff members may be contributing to the maintenance of his posting behaviours.

Figure 2 demonstrates a series of factors contributing to Billy’s behaviour of posting objects down radiators. Factors, which may be reinforcing Billy’s behaviours, are also included.
**Figure 2 Behavioural formulation**

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<td>Limited activities on offer</td>
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<tr>
<td>No or limited direct communication with Billy</td>
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<td>Lack of structure</td>
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| **POSTING BEHAVIOUR** – posting objects down radiators after an activity (resorting to a previously learned behaviour) |

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<td>No active engagement of staff with Billy observed</td>
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<td>Billy may gain positive social reinforcement from interactions with staff, particularly when he is asked to help remove objects from radiators</td>
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<tr>
<td>Removing object from radiators may become an activity in its own right</td>
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<tr>
<td>No current use of PECs in order for Billy to communicate</td>
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Predisposing factors

Billy has a diagnosis of autism, and is described as having large amounts of energy. Prior to Billy’s placement at the care home, he was supported by a clear structure, and could communicate through the Picture Exchange Communication System (PECS). In addition, Billy learned a clear way to signify the end of an activity by posting an object related to the activity, before moving onto the next activity within his structured timetable.

Current situational triggers

Currently Billy is left to occupy himself and limited structured activities are introduced. It is hypothesised that Billy experiences increased boredom and anxiety. Little or no direct communication has been observed between staff and Billy due to staff not being trained to use PECS. As a result Billy is unable to communicate his needs and wishes with care home staff that he has finished an activity. These factors contribute to Billy’s posting behaviour, which has become maladaptive as Billy is now directing his posting towards radiators within the home.

Maintaining factors

Billy’s posting behaviour is maintained in a variety of ways: perhaps the most important of these being the lack of structure observed, and the lack of use of PECS with Billy. No visible timetables for Billy or other residents were evident throughout the care home. During observations, there was no clear use of one-to-one funding observed, or active engagement of staff with Billy. In addition, Billy may gain positive social reinforcement from the interaction with staff he gains when asked to help removing objects from radiators; which may be seen by Billy as an activity in its
own right, potentially serving as a stimulation reinforcer through repetitive manipulation of objects, (Turner, 1999).

Whilst Billy is engaged in an activity limited interaction was observed, and as a result, low levels of positive reinforcement were observed, for example, when Billy achieves something or completes an activity, no praise is given; in fact limited communication was observed between staff and Billy.

Billy has continued to use the adaptive strategy of 'posting' within the care home, to communicate that he has finished an activity and would like to move on to another. However, as staff members do not understand the function of this behaviour, it has become maladaptive and one that is described as ‘challenging’ for the care home staff. On occasions, Billy may return to an activity after posting something, because staff have not understood his attempt to notify them that he has finished and wishes to do a different activity. Billy then completes the activity and repeats the posting behaviour, as another indicator to further stress that he has finished, in the hope that staff will understand his request and react, thus moving onto a different activity.

As staff are not understanding Billy’s requests, operant conditioning suggests that the behaviour should be extinguished. However staff consistently involve Billy in removing from the radiators, any objects that he has posted. They will remove the radiator safety covers and get Billy to help remove all the pens and paper, etc. During this process the removal of objects from the radiators may become an activity in its own right, and when staff replace the safety cover, Billy may see this as the end of the activity and will post one of the objects to signify the ending of that activity.
Therefore, it is hypothesised that Billy has learned that upon posting ‘enough’ objects, staff will engage him in the removal of objects. This provides the social reinforcement through the social interaction he gains with staff members. Staff therefore, may be maintaining this behaviour through social interaction, which in turn causes Billy to repeat the posting behaviour as he has learnt that if enough items are posted then he will gain social interaction with staff and another activity whilst removing them from the radiators.

**Systemic formulation**

Systemic therapy is an approach to problems experienced within the context of human relationship-systems within which they are constructed. The Milan method of systemic practices is a broad-based, sophisticated “epistemology”, a way of thinking about and acting in social systems (Roper-Hall, 2006). The goal of the Milan method is to facilitate the evolution of family systems in ways which do not cause unnecessary distress. Milan therapists think of families systemically and dynamically. In this view, the structure of the family resides in the relationships among the members of the family, not in the attributes of each member (i.e. the whole is more than the sum of its parts). Palazolli *et al* (1980) suggested that the therapist hypothesises through formulation based upon the information gathered through clinical interview. Such hypotheses are either validated or negated, the latter leading the therapist to form a second hypothesis based on information gathered whilst testing the first hypothesis. Systemic family therapy can be applied to other systems outside of families, hence the applicability to Billy’s case.

Cronen and Pearce (1985) highlighted the concept of reflexive and circular processes,
The Coordinated Management of Meaning describes how, as communicators, we make sense of our world, or create meaning. Such meaning can exist in a hierarchy, depending on the sources of that meaning. Each level has a mutual effect on one another, which includes two processes: contextual and implicative forces. Contextual forces exist when one level is influenced by a higher level; implicative forces exist when a lower level influences a higher level. It is important to note that levels do not only influence the levels directly above or below. The effect of one level must be seen within the context of the level in which it occurs, for example, an individual’s behaviour must be seen within the context of the relationship in which it occurred.

Systemic family therapy may also address 'family scripts', which Byng-Hall (1995) describes as 'the family's shared expectations of how family roles are to be performed within various contexts', these contexts being the levels/layers defined above by Cronen & Pearce. Due to Billy's living arrangements, it is important to acknowledge the scripts of Billy's family, the care home staff, and also Billy's own individual script, in order to explore the expectations within these different groups.

The Coordinated Management of Meaning, incorporating family, care home and Billy's individual scripts is applicable to Billy’s situation, and is demonstrated under Figure 3 with an explicit explanation provided below.

Grey (1993) found that parents of children with autism perceived that they experienced stigma as a result of their child's disorder, indicating that autism has uniquely stigmatising aspects as a result of the disruptive nature of autism, and lack of
public knowledge and understanding regarding the disorder. Billy previously lived within the culture of a 'specialist' residential school, and now lives within a 'specialist' care home culture, which results in Billy potentially experiencing isolation from society as a result of this, and of his diagnosis. In addition, limited attempts to engage Billy in Activities of Daily Living and aspects of normalisation were observed, which may further compound the potential for Billy to experience isolation and stigma.

This culture impacts on the scripts that exist within Billy’s family, the care home, and Billy’s personal script. Autism is present within two of Mr and Mrs B’s three children. In an attempt to overcome the stigma related to their sons’ diagnoses, they have made it their business to become knowledgeable about autism. As a result, Mr and Mrs B carry a strong family script about the importance of structure and providing Billy with a choice of only 2 activities.

In contrast to Billy’s family script, the care home script is of an organisation of workers who are less knowledgeable and as a result feel out of their depth working with Billy (and potentially with other residents within the care home). Care home staff demonstrate their belief that the residents under their care are capable of using their own initiative, for example leaving residents to occupy themselves throughout the day.

Billy is unable to directly communicate his personal script, but it may be suggested from observations and subjective accounts, that Billy needs structure and order, and that he will tell people when he has finished an activity, using his previously learned posting behaviour.
It is hypothesised that the distinct differences between Billy’s parents’ and the care home scripts may lead to relationship difficulties, in particular, communication between the care home and Billy’s family. These relationship difficulties appear to stem into communication and cooperation difficulties experienced by professionals involved. Communication within care home staff appears reliant upon a staff hierarchy, with specific individuals seen to make decisions regarding residents’ care. Differences in these scripts may also affect the care relationship each group has with Billy, for example, Billy’s parents will offer a structured timetable throughout his visits, yet care home staff, care from a distance, with limited interaction and communication with Billy, appearing to ‘keep and eye’ on Billy, adopting a reactive, rather than proactive strategy to his posting and pica behaviours.

In particular, the limited communication between care home staff and Billy may account for Billy's repetition of his previously learned behaviour in an attempt to communicate his need to change activities. As this behaviour is not present within his home environment tensions may increase between the care home and Billy’s parents relating to the possible hypotheses for Billy’s behaviours. Such hypotheses reinforce Billy’s parents' script relating to the need for structure and order within their son’s life. The care home script may therefore be reinforced with staff believing that they are out of their depth as regards caring for Billy. This may in turn reinforce the possibility of Billy becoming further isolated as staff members are unsure of which methods to adopt in order to engage Billy in Activities of Daily Living, and normalisation activities within the community. This may further enhance the level of stigma faced by individuals with autism, and their families (Grey, 1993).
Figure 3: Coordinated Management of Meaning (Cronen and Pearce, 1985)

**Culture**
- Autism – stigma
- Life in an (isolated) specialist care home.
- Previously attended specialist school

**Family script**
- Family – knowledgeable about autism, importance of clear structure, choice of 2 things

**Care home script**
- Care home – feeling out of their depth with Billy, leave residents to own initiative

**Personal script**
- Personal – I need structure, order is important, I will tell you when I have finished an activity

**Relationships**
- Mum and Billy – hands on caring, applying knowledge
- Care home staff and Billy – caring is from a distance
- Care home staff – hierarchy within, who makes decisions
- No clear communication between staff, staff-family, staff-professionals

**Behaviour**
- Posting item down radiator
- Withdrawing to his room

**Key**

**In the context of**

- Contextual force
- Implicative force

Cronen and Pearce (1985) suggested there may be two, mutually exclusive possibilities within a life-script: a ‘strange loop’. Within the levels of context
(Coordinated Management of Meaning) an infinite loop emerges within the scripts of those around the individual. This idea can be applied to Billy’s situation in terms of the necessity of structure, and is displayed in Figure 4.

**Figure 4: Strange loop**

When Billy is at home, his parents impose a structured system upon him, giving him a clear choice between two activities. Billy is able to pick an activity and get on with this. As a result it could be construed by those caring for Billy full time (i.e. care home staff), that Billy doesn’t in fact require structure to be present. Thus, care home staff leave Billy to his own devices, which in turn results in Billy obtaining an activity, and posting a significant object when he has completed the activity. Billy’s school reports suggest that this was a learned behaviour to help Billy to understand when an activity was complete, in order to move onto the next activity. This suggests that Billy is in fact reliant on structure, causing the loop to begin again.
Critical Appraisal

The above case was formulated from both a behavioural and a systemic perspective. These perspectives both have their advantages and disadvantages, and this appraisal attempts to highlight these.

A behavioural approach relies less on the cognitions of the individual, therefore it may be argued that this provides a better representation of Billy’s capabilities, as a result of him being non-verbal. Within the systemic formulation it is not possible to access Billy’s cognitions and his personal script, therefore hypotheses are made. In this respect, a behavioural formulation may serve a more accurate account of the situation. However, BPS guidelines (2004) state that it is good practice to involve the individual with a learning disability, and those working with him/her; otherwise the formulation may not be practical or socially valid. It is important to note that challenging behaviour may be a result of communication difficulties, as in Billy’s case; therefore engaging a non-verbal person in the formulation process would pose some difficulties. In spite of this, a behavioural formulation still remains more effective, as the reliance upon his cognitions is less than that of the systemic formulation.

Emerson, Hastings & McGill (1994) proposed that staff might hold beliefs/scripts that are related to their responses to challenging behaviour, therefore both a behavioural and systemic approach would serve to address these beliefs/scripts, and would provide opportunities to feed these beliefs/scripts back to care providers, in order to ‘check-out’ their accuracy.
A behavioural formulation requires the focus of change to be in the systems and services which support the individual with challenging behaviour, so that they can meet the person's needs more effectively (British Psychological Society, 2004), whilst also accounting for the actions of others, that may constitute antecedents and consequences for a significant amount of the challenging behaviour (Hastings, 1997). Whilst the systemic approach does not attribute causality, its focus is upon obtaining information from the systems and services involved, and working alongside these systems and services.

A systemic approach would be considered useful as the many contexts of an individual’s support system come together, rather than working as separate entities (Jenkins and Parry, 2006).

Often an individual’s ‘challenging” behaviour is perceived to be within the individual, with others failing to recognise how the support system may exacerbate, maintain or alleviate difficulties. The use of systemic principles in practice opens up the possibility of multiple explanations within the system, and helps introduce new meanings for problematic situations (Lynggaard et al, 2001). In particular, the systemic approach is directed towards looking at the relationships within a system, and the effect of one part of the system upon another, acting like a mobile above a crib: when one part of the mobile moves, so do the other parts of the mobile (Bateson, 1971), i.e. no one part of the system can move in isolation.

A systemic approach also identifies issues relating to communication with in the system, and is able to identify themes relating to communication styles, which are observable within this case. Once identified, the issues can be addressed.
Formulation is an interpretation of accounts; in this case obtained from individuals within Billy’s system. As a result, when providing feedback it is useful for the therapist to ‘check out’ the interpretation with each ‘aspect’ of the system. With respect to the complex system that Billy lives within, both a behavioural and a systemic formulation would aid communication with those involved when feeding back.

Billy's 'challenging behaviour' was formulated from two different models, however, it is important to note, that whilst each formulation has its own merits, there is growing literature encouraging the use of an integrative formulation (Baumeister, 1991; Guess et al., 1991; Holland, 1999; Murphy, 1994). Such a formulation would involve drawing upon cultural, social, behavioural and biological processes. In Billy's case, combining orientations may provide a more complete, or more effective intervention.
References


Hastings RP (1997) Staff beliefs about the challenging behaviours of children and adults with mental retardation Clinical Psychology Review 17(7) 775-790


Thorndike, EL (1911) Animal Intelligence: Experimental Studies. New York: Macmillan

Small Scale Service Related

Project

CPR 2

An evaluation of a Psychological consultancy service for staff working at a local respite and intensive support service for adults with a learning disability.
Abstract

The aim of this service evaluation was to evaluate a psychological consultancy service for staff working at a local respite care home and intensive support service for adults with a learning disability. This evaluation would take place over a period of 6 months and deliver feedback to both consultees and consultants involved in order to enable them to further develop the delivery of consultancy. Using a test-retest design and employing both quantitative and qualitative methods, the evaluation found that staff did not feel that attendance at the sessions had changed the way that they work, although these findings should be treated with caution due to the very low response rates at both pre-and post intervention data collection.

* Please note that all identifying information has been removed throughout this report
**Introduction**

This piece of work aims to report the evaluation of a pilot study of a consultancy service for staff members working with adults with learning disabilities in a local respite care home, and intensive support service. A description of the psychology service providing the consultancy, and the local respite care home and intensive support service (consultees) will be provided. A number of government directives, and service-related literature will be outlined below, along with a summary of the process of consultancy.

The design and evaluation of the pilot study will be presented, followed by a discussion summarising strengths and limitations of the pilot study, incorporating barriers to completing the study; an understanding of the change process within consultancy; and recommendations in order to take the service, and future evaluations further.

*A Description of the Psychology Service for Adults with Learning Disabilities*

The Psychology Service for Adults with Learning Disabilities, is part of the local Mental Health and Social Care NHS Trust. The department receives referrals from an urban area with an adult learning disabled population of approximately 3,823 ([name] Metropolitan Borough Council, n.d.)

The population of the area served by the Psychology Service was recorded by the 2001 census at 282,904 (National Statistics Online). The area is predominantly white (79.7%), with 20.3% of the population belonging to a minority ethnic group (9.1% Indian, 3.3% Caribbean, 2.9% Pakistani).
Referrals are received from a range of sources, including psychiatrists, social workers, residential homes, GPs, and clients themselves. The inclusion criteria for acceptance of a referral is: 1) having a learning disability, 2) being over the age of 18, and 3) living within the catchment area of the service. The service is comprised of three Clinical Psychologists, between one and three Trainee Clinical Psychologists at different stages in training, and one Assistant Psychologist.

Valuing people

The Government White Paper: Valuing People: A New Strategy for Learning Disability for the 21st Century (2001) set clear objectives in order to deal with outcomes for people with a learning disability, and to deal with the systems in order to deliver better outcomes. With reference to the latter, Valuing People sets to 'ensure that social and health care staff working with people with learning disabilities are appropriately skilled, trained and qualified, and to promote better understanding of the needs of people with learning disabilities amongst the wider workforce'.

LDAF

As outlined in the Valuing People paper (2001) the Government has been introducing the Learning Disabilities Awards Framework (LDAF), a National Vocational Qualification, in order to increase the levels of skills, training and qualification in the learning disability workforce. LDAF provides a recognised route to qualification and career progression for care workers in learning disability services. The Valuing People Annual Report (2005) states that more people who work with people with a learning disability now hold this qualification, which is based on four vocational
qualifications which provide a comprehensive summary of learning outcomes, mapped against occupational standards.

New Ways of Working (2007)
The Valuing People Support team is helping new ways of working to emerge (2005). In addition, to this there are now guidelines for applied psychologists and other workers: New Ways of Working (2007). Over the last 20 years the evidence base demonstrating the effectiveness of psychological therapies has grown significantly and these interventions now feature strongly in NICE Guidance. The New Ways of Working (NWW) paper (2007) was developed as a result of the increased demand from service users and carers for improved psychological services and availability of psychological interventions. As a result, there is a need for those working within Health and Social Care to improve the level of psychological understanding and care, with a range of professionals providing psychological interventions, and developing psychological mindedness.

As a result of the New Ways of Working paper, the clear purpose for applied psychologists is ‘to improve the psychological wellbeing of the population through working with individuals, families, teams, organisations and communities’. Further to this, applied psychologists can also make an important contribution to improving the effectiveness of services through consultancy at systems level, and peer consultation:

“Within these organisations, applied psychologists must contribute in constructive and innovative ways in these organisations if they are to have
Alongside NWW, the Improving access for Psychological Therapies group (IAPT) identified that applied psychologists must provide leadership in the promotion of new service models (i.e. stepped care) and the specification and development of integrated care pathways, which meet the varied and complex needs of service users. Psychologists have important contributions to offer in helping services innovate and change. The report commissioned by the Mental Health Care Group Workforce Team (MHCGWT) suggests that psychological therapies are fundamental to basic mental health care, and can make a highly significant contribution to outcome and user satisfaction (Organising and delivering psychological therapies, 2004).

In addition, psychologists have a wider role in providing consultancy to organisations on organisational and systems improvement (e.g. leadership and teamwork development).

**Consultancy**

Psychological consultancy has been defined by Wallace and Hall (1996) as “qualified psychological consultants helping consultees to (a) resolve work related issues pertaining to individuals/clients/programmes they are responsible for; (b) become active agents in achieving to solutions to problems; or (c) strengthen consultees’ work-related competencies to address similar issues in the future.” In addition, Caplan (1970) informed the modern consultation process stating the consultants address client's mental health problems by focussing more on the skill deficits, biases, and emotional deficiencies of deliverers of services. Consultancy takes place between
the consultant, the consultee, and the client. Figure 5 provides a visual illustration of the tripartite relationship of consultancy as used in this piece of work. As can be seen from this illustration, the consultant is a Psychological professional, the consultee is often a member of the helping profession, involved in providing care for an individual, and the client is often a service user.

Figure 5: Non-linear tripartite relationship in consultation
It is important to address what psychological consultancy is not, in order to aid the understanding of consultancy. Consultancy is not supervision, training, or therapy, rather consultancy is non-authoritarian, an egalitarian interaction between consultant and consultee, with the consultee retaining a degree of autonomy. In addition, consultancy sessions are temporary and voluntary, demonstrating depth, and benefiting from being held in a non-evaluative atmosphere.

Table 1 provides a clear illustration of the different stages involved in consultancy, highlighting the focus of each stage, the Consultant's task during that stage, and also the philosophy surrounding the stage. These stages bear a strong similarity to clinical work of a Clinical Psychologist, from the outset of assessment through to evaluating and terminating the piece of work.
Table 1: Stages of Consultancy

<table>
<thead>
<tr>
<th>Stage</th>
<th>Focus</th>
<th>Consultant’s task</th>
<th>Philosophy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary contact</td>
<td>Getting started Creating a basis for consultation Agreeing on working terms</td>
<td>Determining the ‘fit’ Accepting the consultant role Contracting</td>
<td>To establish a solid foundation To explore applicable models</td>
</tr>
<tr>
<td>Entry</td>
<td>Entering the organisation</td>
<td>Accomplishing physical, psychological, and social entry Building solid working relations</td>
<td>To gain acceptance and trust To recognise and manage resistance</td>
</tr>
<tr>
<td>Assessment and diagnosis</td>
<td>Identifying the consultation problem</td>
<td>Scanning Gathering data Forming clear diagnosis Deciding on appropriate methods</td>
<td>To collect valid and reliable data To confirm presenting problems</td>
</tr>
<tr>
<td>Goal setting</td>
<td>Establishing the direction of consultation</td>
<td>Setting measurable goals</td>
<td>To identify desired outcomes</td>
</tr>
<tr>
<td>Intervention</td>
<td>Applying strategies that address problems</td>
<td>Selecting and implementing change strategies</td>
<td>To resolve consultation problem</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Determining the effectiveness of interventions</td>
<td>Measuring outcomes of interventions Evaluating the consultation</td>
<td>To determine the success of consultation</td>
</tr>
<tr>
<td>Termination</td>
<td>Ending the consultation process</td>
<td>Bringing closure to consultation Follow up</td>
<td>To conclude consultation at an appropriate juncture</td>
</tr>
</tbody>
</table>

Rationale for this piece of work

The Learning Disabilities Psychology Stakeholder Survey in 2005 invited colleagues within the trust, and other agencies to identify opportunities for greater collaboration. This generated a request for “support to develop a more holistic approach to the service” from a local respite care home for adults with learning disabilities. In addition, a local intensive support service requested monthly input from psychology to enhance their experience in the service they provide to people who challenge
services and have mental health needs. By the end of 2006 the specialty was in a position to respond to these requests and offered a series of consultancy sessions.

Prior to the development of the consultancy session the specialty operated a traditional 'referral-allocation-discharge model' maintaining direct contact with clients/carers. It was anticipated that a departure from this model to a consultative model would take careful planning, monitoring and evaluating. The purpose of this Clinical Practice Report is to evaluate a psychological consultancy service for staff working at a local respite and intensive support service for adults with a learning disability. This evaluation would take place over approximately 6 months and would deliver feedback to both services/consultees and consultants involved to enable them to further develop the delivery of consultation.

**Method**

**Materials**

In accordance with Government objectives health and social care workers should be working towards achieving Learning Disabilities Awards Framework (LDAF) qualifications. As a result, the questionnaire used in this study was compiled using topics taken from LDAF levels 2 & 3 (n.b. there is no level 1 part to the qualification). It was deemed appropriate to use units from LDAF because staff would already be familiar with the concepts. A selection of 15 aspects were taken from these levels, encompassing mandatory units at both level 2 & 3: understanding positive communication, understanding and protecting people with a learning disability from abuse, and optional units taken from both levels. In addition, some of the aspects were taken from LDAF in accordance with local government directives, for example the
[Name] Health Improvement and Modernisation Plan (2002) states that access to advocacy will be one of the priorities of the policy. As a result, it seemed important to include this to bring this to the attention of the participants of this study. As can be seen in Appendix 4 the other aspects of the questionnaire address a number of different issues, pertinent to both government directives and difficulties experienced by staff, for example dealing with challenging behaviour, autism, self-harm, sexual expression.

This questionnaire was used at both T1 and T2, however, at T1 participants were asked to place the aspects in order of importance for them, in terms of how important they believed it was to develop their ways of working psychologically. The purpose of this was to enable the researcher to collate and feedback the information to the participants in order that they can discuss potential topics for discussion during the consultancy sessions. At T2 participants were asked to complete the initial ratings as at T1; in addition, participants were asked to complete a series of qualitative questions, aimed at ascertaining their understanding following attendance at consultancy sessions.

Participants

Participants were staff members at a local respite care home for adults with learning disabilities, and an intensive support service for adults with learning disabilities. The respite care home provides respite for families of adults with learning disabilities, and for individuals who are waiting for a placement in a new care home to be found due to unforeseen circumstances, for example the death of their main carer. The intensive support service accepts referrals from day centre managers for help with 'difficult'
individuals, or individuals that are having a difficult time.

**Design**

This pilot evaluation uses a broad test-retest design involving both qualitative and quantitative methodology.

**Procedure**

A baseline measure was designed to enhance the sense of ownership within the services to establish what they wanted or need to achieve from consultation, rather than being 'told' this by the consultants. This baseline measure, required participants to complete a ratings questionnaire (Appendix 4) which asked them to rate how comfortable they felt working with each topic covered on the questionnaire. In addition, they were asked to rank each topic in order of importance with respect to how important it was for them to develop psychological thinking around the topic (1 being the most important topic to develop, 15 the least important topic to develop).

The questionnaires were analysed once completed, and a summary of the findings were reported back to the participants (Appendix 5 and Appendix 6). The purpose of this was so that individuals would have a prompt in order to aid communication with the consultants about topics of discussion. The consultancy sessions commenced after the participants had received their feedback. The intensive support service received 2 sessions, and the respite care home received 6 sessions.

Following attendance at the consultancy sessions, participants were required to complete the ratings questionnaire again, whilst answering qualitative questions about
the sessions, and the impact of the sessions upon their future practice (Appendix 7).

In addition, the two Consultant Clinical Psychologists providing the consultancy
sessions were asked to provide a narrative about the sessions, incorporating what was
discussed during these sessions, how to develop the service in the future, what
barriers were encountered, what the consultants have learnt from the experience
( Appendix 8).

Results
Following the pre-intervention questionnaires, the data was presented to the respite
care home and the intensive support service individually as outlined below. A
detailed copy of this feedback is provided under Appendix 5 (respite care home) and
Appendix 6 (intensive support service).

Response rates $T_1$
Out of 30 questionnaires given out to staff members at the respite care home, 12 were received. Out of 8 questionnaires given out to staff at the intensive support service, 4 were received. Of these 4, only 1 completed the ranking of each aspect, therefore as can be seen below, it was difficult to feedback this data to the staff team.

Response rates $T_2$
Questionnaires were only distributed to those known to have attended the consultancy sessions. Out of 15 questionnaires given out to staff at the respite care home, 3 were received. Out of 4 questionnaires given to staff at the intensive support service, 2 were received completed.
Feedback of questionnaire results at $T_1$

Table 2: Questionnaires completed by Respite Care Home relating to how comfortable staff members felt working with each aspect before the consultancy sessions

<table>
<thead>
<tr>
<th>Aspects uncomfortable working with</th>
<th>Aspects comfortable working with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>Understanding change and transition</td>
</tr>
<tr>
<td>Understanding support needs of older people</td>
<td>Contributing to the management of substance use and abuse</td>
</tr>
<tr>
<td>Contributing to the management of mental-ill health</td>
<td>Responding to people with a learning disability who self harm</td>
</tr>
<tr>
<td>Understanding epilepsy and helping service users to manage it</td>
<td>Understanding positive communication</td>
</tr>
<tr>
<td>Understanding dementia and helping service users to manage it</td>
<td>Understanding and protecting people with a learning disability from abuse</td>
</tr>
<tr>
<td>Understanding loss and bereavement</td>
<td>Understanding and managing challenging behaviour</td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
</tr>
<tr>
<td></td>
<td>Working as a member of a team</td>
</tr>
</tbody>
</table>
Table 3: Questionnaires completed by the Respite Care Home relating to which aspects staff members thought were important to develop before the consultancy sessions

<table>
<thead>
<tr>
<th>Aspects most important to develop</th>
<th>Aspects least important to develop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding autistic spectrum disorders</td>
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<td></td>
</tr>
</tbody>
</table>

Table 4: Questionnaires completed by Intensive Support Service relating to how comfortable staff members felt working with each aspect before the consultancy sessions

<table>
<thead>
<tr>
<th>Aspects uncomfortable working with</th>
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</tr>
</thead>
<tbody>
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<td>Understanding change and transition</td>
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<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
</tr>
<tr>
<td></td>
<td>Working as a member of a team</td>
</tr>
</tbody>
</table>
Due to the small number of complete responses by the intensive support service, it was not possible to collate the rankings. As a result, the intensive support service received the following statement:

“We also asked you to individually rank each aspect in order of how important you felt each aspect was to develop your ways of working psychologically. Due to the small number of responses, it was difficult to compile which aspects the group as a whole felt were the most important and least important to develop. Therefore, you may find it more useful to look at each aspect in the table above, and discuss as a group, and also with [name] how you would like to use the consultation sessions. You may also have other aspects of your work that you would like to cover in the consultation session, which you can discuss with [name].”

Content of consultancy sessions

Two themes emerged from the first meeting with the respite care home staff:

“dilemmas that the staff feel they face and need skills to work with” and “resources that they feel they have as individuals and as a team that they presently use to address these dilemmas”. Staff at the care home described a variety of topics that were covered, although these have not been confirmed by the consultant due to time constraints outlined in this report. The topics described were: setting clear boundaries, effective communication, understanding challenging behaviour, a build up for seizures, understanding borderline personality disorder.
**Questionnaire findings at T2**

Table 5: Questionnaires completed by Respite Care Home relating to how comfortable staff members felt working with each aspect following consultancy sessions

<table>
<thead>
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<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>Understanding positive communication</td>
</tr>
<tr>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
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</tr>
<tr>
<td></td>
<td>Understanding and managing challenging behaviour</td>
</tr>
<tr>
<td></td>
<td>Understanding loss and bereavement</td>
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<td></td>
<td>Working as a member of a team</td>
</tr>
</tbody>
</table>

Looking at the above table, it is clear that staff members have maintained the same stance on a number of aspects: contributing to the management of mental-ill health, understanding dementia and helping service users to manage it, supporting sexual expression and sexual health of people who have a learning disability, responding to people with a learning disability who self harm, understanding positive communication, understanding and protecting people with a learning disability from abuse, understanding and managing challenging behaviour, and working as a member of a team.

It is also clear that staff members have shifted position in terms of stating that they understood aspects that they previously didn't feel comfortable working with such as
understanding autistic spectrum disorders, understanding the support needs of older people, understanding epilepsy and helping service users to manage it, understanding loss and bereavement.

Table 6: Questionnaires completed by Intensive Support Service relating to how comfortable staff members felt working with each aspect following consultancy sessions

<table>
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<tr>
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<td></td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td></td>
</tr>
</tbody>
</table>

The above table shows that some aspects have remained consistent, for example understanding change and transition, understanding and protecting people with a learning disability from abuse, understanding and managing challenging behaviour, and working as a member of a team.
It is also evident from Table 6 that the number of aspects that staff members felt uncomfortable working with has increased since the consultancy session. Aspects that staff members have shifted to feel less comfortable with include understanding epilepsy and helping service users to manage it, understanding loss and bereavement, promoting advocacy skills and opportunities with people who have a learning disability.

Within the Intensive Support Service, it is apparent from the above table that following the consultancy sessions, staff members did not feel more comfortable about any aspects that previously they had felt uncomfortable about.

**Qualitative findings**

Due to the low levels of responses the above information may not provide the most accurate information. A number of qualitative questions were put to participants, a summary of these findings, and a few useful quotes have been detailed below. Again, it is important to note that responses to questions in most cases were brief.

**Respite Care Home**

Staff members attending consultancy sessions at the respite care home were consistent in detailing the content of the consultancy sessions, highlighting how the team works, and what methods are available to cope with the stresses and strains at work. In addition, staff members detailed topics relevant to their work as discussions around challenging behaviour, and supporting each other in all aspects of care. Staff members did not feel that their attendance at the sessions had changed the way they would work with the aspects discussed. The following quote presents the most useful
thing learnt from these sessions:

“When faced with overwhelming pressure of situations most of the team will pull together regardless of those who could not care less”

It is important to note that this is only the view of one individual from the respite care home. The other two individuals did not complete this question.

Consistently, staff at the respite care home did not feel that attending the sessions had prompted them to work psychologically, nor did they anticipate any barriers to making changes or feel that the sessions had been useful/helpful.

Intensive Support Service

Staff at the intensive support service described a variety of topics: setting clear boundaries, effective communication, understanding challenging behaviour, a build up for seizures, understanding borderline personality disorder. Staff were consistent in describing topics discussed that were relevant to a particular aspect of their work: understanding underlying issues with the people they support.

Staff consistently described how the consultancy sessions had changed the way that they work with the aspects mentioned, stating that they have accessed new strategies, and are able to utilise the skills they already possess:

“Because I am having psychologist input it has given myself a new approach and I can be more creative - knowing and understanding
Staff felt that the most useful things they learned from the sessions were that a client's challenging behaviour may be as a result of issues that may not have been addressed, in addition, staff stated that the information obtained from various sources can be used in a variety of situations.

Staff at the intensive support service were mixed in their opinion about whether the sessions prompted them to change the way that they worked psychologically, however the ways in which one person said they would change, was to utilise knowledge gained from the meetings to benefit the individual that they would be working with.

One staff member identified council policies and procedures as potential barriers to making changes in the way they work.

Consultants' perspectives

Due to timescale of the study, it was only possible to gain the perspective of one of the consultants, who worked with the respite care home. From this narrative, which can be found under Appendix 8, it is evident that the consultant was looking at overall themes emerging from session, in this example “dilemmas that the staff feel they face and need skills to work with” and “resources that they feel they have as individuals and as a team that they presently use to address these dilemmas”.

The consultant highlighted the difficulties of engaging with staff levels from different backgrounds and level within the organisation, during the process of defining

new ways of working with the people I support”
expectations of what is needed and potential outcomes of the consultancy sessions.

In addition, other potential barriers identified included those at a local authority level: clinical policies and procedures that staff are obliged to work to; and what support will be available to staff whilst accessing an infrequent form of consultancy that is not attended by a consistent staff group; and what else needs to be done alongside the consultancy sessions – who else needs to be aware of what is being done, in order to maximise the chance of success and change, and to minimise the chance of disappointment and false hope. In addition, staff may have a battery of skills and ideas that may work with individuals, based on hands on experience, however there doesn't appear to be a common model or language used within the staff group.

Following the identification of potential barriers, ideas surrounding how to develop the service for the future included the introduction of shared language to increase a sense of competence and coherence, more work around the logistics of initiating a new model of service into an organisation that has predominantly worked with the concept of 'referral-allocation-discharge'

In terms of what the consultant had learned from the experience of delivering a consultancy service, the consultant highlighted that, as with clinical work, a great deal of time within the model involves engaging the consultees. As outlined above, the consultant needs to be aware of the differing opinions amongst a varied workforce; and of the possibilities for consultation in practice, whilst paying attention to the boundaries of this.
A comparison of the comments made by staff members at the respite care home, and those made by the consultant providing the consultancy service reveals a difference in semantics: i.e. The consultant discusses the topics as “dilemmas” and “resources”, whereas staff state the topics discussed as “methods used to cope with stresses and strains at work”.

**Discussion**

The aim of this service evaluation was to evaluate a psychological consultancy service for staff working at a local respite and intensive support service for adults with a learning disability. The evaluation would serve as a pilot study which would enable the Psychology department to further develop the consultancy service.

It is important to note that the response rates for this study are below the expected rates. As a result the findings of this study should be interpreted with caution, as they are not necessarily representative of the wider population within which the consultancy service was conducted.

The results show that the intensive support service staff members are comfortable working with a lower number of aspects than staff employed by the respite care home. This may not be an accurate reflection of the current situation however, as there may be other issues, not covered by the questionnaire used in this study, that the intensive support service may feel more comfortable working with. It is evident from the results that staff at both the respite care home and intensive support service feel confident in understanding positive communication, understanding challenging behaviour, understanding and protecting people with a learning disability from abuse.
There could be a number of reasons why staff feel uncomfortable with certain aspects following the consultation, the main one being that the questionnaires following the consultancy sessions were completed by staff members that attending the sessions, and these may not necessarily have been the same members of staff that completed the initial questionnaires. As a result the findings may not represent a true group comparison. In addition, attendance at the consultancy sessions may have brought up discussions about aspects that staff members previously felt comfortable about; such discussions may actually have brought to the individual's attention the fact that they do not feel comfortable working with such aspects.

**Strengths and limitations**

There are a number of limitations to this study, most notably the number of participants involved in the evaluation, due to poor response rates. This study aimed to compare group scores before and after the consultancy sessions, however, these findings should be interpreted with caution as a result of the limited number of participants. In hindsight, it is apparent that the two services involved in the study required very different things from the service as a result of skills, knowledge and confidence.

Other limitations include the number of sessions conducted, the turnover of staff present, the design of the study, and potential barriers to taking forward anything learnt from the consultancy sessions. These limitations are discussed in more detail below.

The low number of sessions conducted throughout the 6 month period was a direct
result of commitments of both the consultant and the consultee. It had been agreed that the consultants would meet with staff at least monthly in order to provide 6 consultancy sessions for evaluation. However, in this situation it must be made clear that the number of sessions that were conducted were negotiated between both parties.

Due to the number of sessions conducted with the intensive support service, attendance was good, with staff members being consistent. Attendance at the sessions with the respite care home staff was varied due to changing shift patterns; as a result, some staff members only attended one session. However, this could also be counted as a positive aspect of the sessions in terms of disseminating the idea of consultancy and topics discussed across a number of staff members.

Using surveys/questionnaires is problematic in the fact that findings may be generalised to the population, with a strong possibility that there will be a difference between those who responded and those that chose not to for whatever reason. In this study it is important to acknowledge that a large number of the sample did not respond both pre- and post-intervention.

Following the attendance at the consultancy sessions there may be potential barriers to staff using anything they have acquired – policy at organisational level, local government level or national government level. In addition, there may be factors relating to an individual’s ability to change within the organisation – this may be relating to management issues, staffing issues and staffing attitudes (to change) for example.
In contrast, this study demonstrates the difficulties of conducting a piece of research evaluating a new method of working, consultancy. In addition, as this piece of research is a pilot study, it provides the opportunities to deal with any difficulties that have arisen throughout this pilot study, and make recommendations for further evaluation of this ongoing piece of research.

**Understanding the change process within the setting**

It is important to note that during the process of consultancy there may be a resistance that is created by the fear of change (Wallace & Hall, 1996). In particular, consultees may have a negative opinion about the consultant prior to, during, and after consultancy sessions. The consultant may be seen as an unwelcoming threat, who is invited by senior management to discover/report their weaknesses. The consultant is seen as a symbol of change (Wallace and Hall, 1996) and is often working to undo a status that staff may have worked hard to achieve, for example where staff may find it easier to work with a discomfort rather than change their ways of working. In addition, consultees may utilise defence tactics against the threat of the unknown.

**Reflections on conducting this piece of research**

Completing this piece of research has highlighted some of the difficulties of conducting 'real-world' research. In particular, the difficulties experienced whilst trying to obtain completed questionnaires, both pre- and post-intervention. The aim of anonymous questionnaires was to ensure that individuals were not identifiable, however it may have been beneficial to take some details in order to match consultees questionnaires pre- and post-intervention.
It may be more appropriate to obtain consultees' perspectives about the process of consultancy initially, in order to spend time engaging them in the process, and ensuring that consultancy is a non-authoritarian, egalitarian interaction between consultant and consultee, with the consultee retaining a degree of autonomy. In addition, it is important to take into consideration who had actually requested the input of a psychological consultancy service: management of ground level staff. The findings of this piece of research may be indicative of staff feeling that management are ‘checking up on them’ rather than providing them with “resources to deal with dilemmas”.

*Recommendations for the future of consultancy*

This piece of work is a pilot study, which generates a feedback loop that ensures that the initial findings in this piece of work will generate possibilities for change, which may be implemented and further evaluated in order to develop this psychological consultancy service.

It is important to acknowledge the comments made above, by both consultant and consultee when shaping the process of consultancy within this population., in particular acknowledging the importance of engaging with the consultees before starting the intervention stage of the consultancy service.
Conclusion

This piece of work was undertaken as a result of the departments need to design and evaluate a pilot study for a local consultancy service. The service evaluation arose as a result of requests from a respite care home for adults with learning disabilities, and an intensive support service. In addition, this service evaluation was developed out of a number of government directives, most notably, Valuing People (2001), Learning Disabilities Awards Framework (LDAF), and New Ways of Working for Applied Psychologists (2007).

Due to the low response rates the findings of this evaluation should be treated with caution as they are not representative of the general population working within these organisations. However, conducting the service evaluation has highlighted a number of limitations with the present evaluation, in particular the questionnaire design, which may have contributed to the low response rates.

In addition, it is important to acknowledge the change process within these settings, and pre-empted opinions held by consultees can be responsible for a resistance to change following consultancy sessions.
References


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CPR 3

Cognitive-Behavioural formulation and interventions for a 68-year-old lady with depression and anxiety related to rheumatoid arthritis
Abstract

Jane* was a 68-year-old lady who was referred with depression and anxiety related to the diagnosis of Rheumatoid Arthritis. During the assessment and initial therapy sessions it became apparent that Jane was experiencing negative automatic thoughts relating to remaining in the house alone. The presenting problem is introduced, followed by a detailed assessment and subsequent formulation, which was used to develop a Cognitive-Behavioural intervention. An evaluation of this intervention and reflections on the process are then offered.

* Please note that to protect the client’s identity all names have been changed
throughout this report
Presenting problem

Jane was a 68-year-old lady, referred to the Psychology Service for Physical Health by the Rheumatology Nurse Specialist following an out-patient appointment. She had presented as distressed and admitted to being depressed and not feeling in control of her life. Jane’s Rheumatoid Arthritis wasn’t active, but she was experiencing joint pain, and suffering with tinnitus.

Client’s description of the problem

During the assessment Jane reported feeling anxious when in her home on her own and when returning to the house, knowing she will be alone. She was having difficulty getting out of bed each morning, and had to coax herself to eat when alone. Following her recent diagnosis of Rheumatoid Arthritis, she stopped attending a college art course and bird watching group; for fear that arthritis would prevent her from continuing with these, or cause her to make a fool of herself.

Until 2005 she had not had any physical health problems other than spending six weeks in Great Ormond Street Hospital as a baby. Jane suffered a fractured skull and broken leg, following a fall downstairs whilst being carried by her father.

In 2005 Jane was admitted as an emergency for a strangulated hernia, which was repaired but her recovery was not without its problems. Jane was then diagnosed with Rheumatoid Arthritis in 2006. At the time of the referral, this was affecting her hands, although she had noticed similar pains in her feet and ankles. She suffered with tinnitus.

Initial Assessment

In order to assess Jane’s difficulties, and to aid formulation and relevant diagnostic classification, psychometric assessments were completed at standard intervals, as per the service’s current outcome evaluation; and a thorough assessment was completed with the client.

The assessment was conducted during a 1 hour session, using clinical interview techniques in order to complete the department’s assessment form. The assessment covers the following areas: physical health problems for which she had been referred
and current treatment/medication; a typical day and the impact of the condition; adjustment to the condition; background information (childhood, family, occupation, relationships); and risk assessment. Further information about Jane’s childhood and transition to adulthood and motherhood was obtained further into the sessions, but has been included below.

Physical health problems and current treatment/medication
Jane was diagnosed with Rheumatoid Arthritis in 2006 and was under the care of a local consultant and Rheumatology Nurse Specialist, who were happy with the progression of her condition. At the time of the referral the arthritis was not active, but Jane still experienced joint pain. She had arthritis in her hands and forearms, but Jane worried about her condition deteriorating, and had noticed symptoms in her ankles recently.

Typical day and the impact of the condition
Jane found it difficult to motivate herself to get out of bed each morning, which could take several hours, unless she had something planned for the day. Jane’s thinking time was preoccupied with negative automatic thoughts about the future of her condition, and predictions that she would be housebound as a result. Jane was a very active person prior to her diagnosis, and had stopped doing any activities for fear of ‘making a fool of herself’ or panicking. She could not complete any artwork at home, due to thinking that her time would be spent better doing something else, and that she was wasting her time and that of others.

Adjustment to her condition
Other physical health problems lead her to think that her condition was deteriorating, contributing to her negative thoughts. Such negative thoughts contributed to an increase in Jane’s physical symptoms.

Background information
A copy of Jane’s genogram can be found in Figure 6. Due to the close bond with her grandmother and aunts, they have been included.
**Figure 6. Jane’s genogram**

**Childhood**

Jane was born in London and had always blamed herself for her and her father’s accident when she was very young, stating that she must have been “creating a fuss” which had distracted her father, causing him to fall.

Jane and two of her sisters were evacuated from London at an early age during WWII to live with her maternal grandparents, and two aunts. Jane’s three oldest siblings were evacuated to live with her paternal grandparents.

She recalled visiting relatives as a child, where she was laughed at and felt humiliated for using the wrong dialect.

She also recalled classmates saying that her parents didn’t love her otherwise she’d be living with them. Jane said this didn’t upset her because she chose to stay in the Midlands once the war was over. She remembers feeling free as a child, because her aunts were happy-go-lucky, with no rules.
Transition to adulthood
Jane lived with her parents in London whilst training for her hairdressing qualification. Whilst living with them, she felt that she had let them down over her choice of employment, and her choice of boys, and talked of doing things wrong within the home. She described her father as a private man, who was difficult to talk to. He approved of Jane’s interest in art and history, and wanted her to take a well paid and recognised job. He did not approve of her hairdressing qualification.

Occupation
Jane was hopeful of going to Art College, but her aunts needed her to contribute financially to the house. Jane had talked about attending Slade Art College once she was good enough, but her aunts saw this as her being ungrateful after they had raised her. Jane took on various jobs in order to fund a hairdressing course in London. She reported not staying in jobs for long, for fear that she would be ‘found out’ and fired. Once she qualified as a hairdresser, Jane’s sister became her employer until she [her sister] became pregnant. At this point Jane also chose to get married and became pregnant, and stayed at home to raise their three sons.

Relationships
Jane felt that she often chose the wrong boys, going on dates with boys who wanted a one night stand rather than the “sensible option”. Whilst completing a detailed life history, Jane commented that she felt pressured by others to settle down, and often expressed uncertainty as to whether her and her husband Tom were suited. She described her relationship with Tom as volatile, with him often being jealous of other men looking at her, and becoming physically abusive on occasions. Jane wanted to have children, but Tom did not, and didn’t want to be involved in their up-bringing, leaving her to look after the children and the home, reportedly going out of his way to make things difficult whilst Jane was studying for her diploma in Higher Education (dipHE). After 2 years, Jane left the course.

Tom died in 2000 following a thrombo-embolism. Jane blames herself for not doing more to prevent his condition deteriorating.

Risk Assessment (suicidal ideation, drug/alcohol use)
Jane had never had any suicidal ideation, nor did she take drugs or indulge in
excessive use of alcohol.

Interpretations of the assessment data

Clinical Symptoms of Depression:

1. Affective
   Jane reported a depressed mood, feeling sad and worthless and was experiencing symptoms of anxiety relating to her health problems (tight chest, dry throat)

2. Behavioural/Motivational
   Jane reported decreased activity following her diagnosis of Rheumatoid Arthritis, and was struggling to get out of bed every morning leading to her withdrawing from social activities.

3. Cognitive
   Jane reported being very indecisive, self-critical, and having negative thoughts about herself and the future. She did not express any suicidal ideation.

4. Somatic
   Jane reported a reduced appetite, poor sleep, and an increase in her tinnitus and arthritis symptoms when panicking.

Psychometric Screening

Following the initial assessment session, Jane appeared to meet DSM-IV (American Psychiatric Association, 1994) criteria for depression with symptoms of anxiety. In accordance with outcome measures already employed by the service, the following measures were also administered:

1. Hospital Anxiety and Depression Scale (HADS, Zigmond and Snaith, 1983) (Appendix 9). This is a self-report measure assessing prolonged ‘state’ rather than trait. It consists of 14 questions, seven for anxiety and seven for depression. The HADS is sensitive to change both during the course of illness, and in response to psychotherapeutic and pharamaceutical intervention (Herrmann, 1997). The HADS has high levels of acceptability amongst physical health patients, high inter-item, test-retest reliability, validity. Both the anxiety and depression subscales are rated as: normal presentation (0-7), borderline presentation (8-10) and clinical presentation (11+)
2. Acceptance of Illness Scale (AIS, Felton et al, 1983) (Appendix 10). This is an 8-item scale used to assess the emotional acceptance of illness and has a good level of internal consistency (Watters et al, 2001). A low score on the AIS represents a poor acceptance of their illness.

The above questionnaires were administered upon opting into the service, and then again within the 24 hours prior to the assessment session. They can also be completed at any point throughout therapy, for example during a session prior to a review, and during the final session prior to discharge. This provides a baseline measure of an individual’s difficulties, in order to compare scores during and following therapy. In Jane’s case she was to have a review in 3 months time, so there is no data for either scale at the point of discharge.

At opt-in, Jane scored 18 on the anxiety subscale of the HADS, 16 on the depression subscale, and 11 on the AIS. At the time of the initial assessment, Jane scored 19 on the anxiety subscale of the HADS, 14 on the depression subscale, and 8 on the AIS. Jane’s anxiety and depression subscale scores fell within the clinical category of the HADS.

**Formulation**

Cognitive behaviour therapy (CBT) for depression was developed by Beck, Rush, Shaw and Emery (1979) and is now one of the most widely adopted, evaluated and influential models (Fennel, 1989). More recently, the NICE Guidelines for Depression (2007) recommend CBT in the treatment of depression. In particular, the NICE Guidelines for Depression suggest that where depressive symptoms are accompanied by those of anxiety such as in Jane’s presentation, the first priority would be to treat the depression. Therefore the following cognitive behavioural formulation for Jane’s difficulties focuses on her depressive symptoms.

The “negative cognitive triad” (Beck, 1976) also features in the cognitive behavioural model, focusing on an individual’s negative cognitions about the self, events and the future. This appeared to be relevant to Jane’s dysfunctional thinking, because she had a negative view of herself, anything she attempted, and her future, particularly the future of her arthritis and other physical health problems. Such negative thinking can contribute to the development of depression.
Depression and Rheumatoid arthritis

Rheumatoid arthritis affects 1% of the population, or approximately 400,000 people in England and Wales. Of these, approximately 15% have severe disease. It is three times more prevalent in women than in men and the condition impacts severely on quality of life. The life expectancy of people with rheumatoid arthritis is reduced by 5–10 years compared with that of people without the condition (NICE guidelines for Rheumatoid Arthritis in Adults, 2007).

Major depressive disorder affects between 20% and 25% of patients with Rheumatoid Arthritis (Creed 1990). Depression is more common in patients with rheumatoid arthritis than healthy individuals, and may be attributable, in part to levels of pain experienced by these individuals (Dickens et al, 2002).

Neugebauer, Katz and Pasch (2003) conducted a longitudinal study with patients with Rheumatoid Arthritis in which they found that greater physical impairment, greater disability in valued activities and engagement in unfavourable social comparisons resulted in low satisfaction with their abilities. This in turn was the most significant predictor of depressive symptoms.

Leibing et al (1999) compared cognitive-behavioural therapy for patients with rheumatoid arthritis with those receiving standard rheumatological treatment. Cognitive-behavioural therapy proved to be a useful adjunct to standard rheumatological treatment, offering improved coping, emotional stabilization, reduced impairment than to reduced pain intensity, and an improvement in the patients’ "Acceptance of Illness".

Predisposing factors

Throughout Jane’s childhood she developed the core belief that she was not good enough, and a failure. Jane went on to accept a number of different jobs that she was not qualified for, which she left because she believed that she would be found out and consequently fired. This contributed to her core beliefs. Her father disapproved of her hairdressing qualification, and she spoke of feeling like she had “let them down” over a number of issues, including her choice of employment and partners.
Precipitating factors
Jane had been able to get up in the morning, and spend time around the house, doing chores, etc prior to her diagnosis of Rheumatoid Arthritis. She had always been active once their sons had left home, and became involved in numerous activities. The recent diagnosis resulted in Jane dropping out of these activities, apart from spending time with her grandchildren. As a result, Jane was spending more time than she had ever done, alone in the house. This contributed to Jane’s negative thoughts about the progression of Rheumatoid Arthritis, creating a self-perpetuating circle relating to her difficulties of not being able to stay in the house, and the fear that she would become housebound. Jane’s negative thoughts are also triggered when she is faced with the possibility that her son whom she lives with, will not be at home.

Perpetuating factors
At the time of the referral Jane was engaging in avoidant behaviours, staying at her son’s house until her son, whom she lives with returned home. Jane was finding it difficult to leave the house unless she had something to do, so upon recognising any symptoms of panic, she would contact her next-door neighbour.

Protective factors
Jane has a good support network in her sons and next-door neighbour, and she also attended every therapy session apart from one, due to the weather.
Early Experiences
- Constantly told her handwriting was not good enough at school
- Art work was never good enough in Jane’s eyes
- Didn’t finish things in case she failed
- Worried whether she was a good enough parent
- Husband put pressure on Jane not to finish dipHE

Core Beliefs:
- I’m not good enough
- I’m useless
- I’m a failure
- I’m worthless
- I’ll be reliant on others
- I’ll be trapped in my house
- I won’t succeed at anything

Dysfunctional assumptions
- If I don’t complete something then I can’t fail at it
- If I don’t help my sons with their children then I will be rejected
- If my arthritis gets worse then I’ll be trapped in the house
- If I’m trapped in the house then I’ll notice everything that needs doing
- If I’m doing my art I’m letting other people down
- If I don’t do something (I’ve set out to do) then I’m a failure

Critical incident
- Diagnosis of Rheumatoid Arthritis

Triggers
- Being in the house on her own
- Pain from Rheumatoid Arthritis
- Making a decision

Assumptions activated

Negative automatic thoughts
- I’m not good enough/I can’t get anything right
- I’m worthless
- I’m a failure
- I’ll be trapped in my house and dependent on others
- I’ll let other people down
- I’m stupid

Cognitive
- Indecisiveness
- Self-criticism
- Rumination
- Catastrophising
- Over-generalisation
- Awfulising
- Fortune-telling
- All-or-nothing

Affective
- Depressed
- Lonely

Somatic
- Tinnitus increases
- Tight chest
- Increased arthritis symptoms
- Loss of appetite
- Nausea
- Chest tightening
- Dry throat

Behavioural/Motivational
- Reduced activity, procrastination
- Struggling to get out of bed every morning

Figure 7 Cognitive Formulation of Jane’s difficulties
Intervention
Following the assessment session we agreed to meet for 6 sessions, after which we would review the therapy and make a decision about the next stage. During the review session, it was agreed that I would offer Jane another 9 sessions, taking me to the end of my placement. Jane was aware that I was leaving and that we would make a joint decision about future therapy at the end of our sessions.

During the initial assessment session I gave Jane copies of the depression and anxiety handouts taken from the Mental Health Handbook (Powell, 2000), and an achievement diary for her to document any achievements in-between sessions.

The main aims of this intervention were:

- to establish and maintain a therapeutic alliance with Jane
- to give Jane an understanding of the cognitive behavioural model
- to identify and challenge her negative automatic thoughts
- to identify a target for immediate action

Establishing and maintaining a therapeutic alliance
The initial assessment was conducted with my supervisor, so I lead the session in order to engage with Jane in preparation for future sessions. Jane was unsure if there was anything that anybody could do for her, and her core belief of being worthless was evident throughout the assessment. Providing a summary of her difficulties at the end of the assessment demonstrated to Jane that I had an understanding of her situation, and helped her to understand that there was something that could be done to help improve it.

Throughout the sessions, Jane needed encouragement to complete any achievement diaries and to challenge her negative automatic thoughts. Completing working examples with Jane increased her confidence to do this on her own, although it remained a struggle for her to recognise her achievements throughout our time working together.

Jane explained that she found it very difficult to talk about issues from her past, yet was able to spend a couple of sessions doing this, once I had highlighted that these
were the issues she was thinking about the most. It was clear that Jane felt safe during therapy sessions, and I think this allowed her to express the difficulties she was having in talking about pertinent issues.

Upon sharing my formulation with Jane, she appeared to have a ‘lightbulb moment’ when I presented the connection between her earlier life experiences and a life history of negative thinking. This process helped Jane to feel more understood, and thus helped to build on the therapeutic alliance.

A lot of the second-to-last session was spent working towards ending therapy sessions with me, because Jane had expressed anxiety about what would happen once our work had finished.

*To give Jane an understanding of the cognitive behavioural model*

At the beginning of the sessions I spent some time covering the symptoms of depression and relating her diagnosis of Rheumatoid Arthritis to her current depressive symptoms. In particular for Jane, although she had a history of distorted thinking, she had managed to raise three children and embark on an art course at the local college. It wasn’t until she was diagnosed with Rheumatoid Arthritis that she began to feel depressed about her situation, suggesting that it was the diagnosis that contributed to her not being able to ‘cope’.

I used the ‘hot-cross bun’ model (Appendix 11) to explain the cognitive model of depression, demonstrating the relationship between thoughts feelings and behaviours. It was of particular importance to highlight the impact of her physical difficulties upon her thoughts and behaviours. Jane was an intelligent lady who appeared to understand the ‘hot-cross bun’ model. She was able to offer additional examples to support both the model and the formulation. In particular, Jane understood the connection between her thoughts of not being a good enough mother and her core beliefs of being worthless, a failure and not good enough. When attempting to complete achievement diaries, Jane had tried to do some jobs which contributed to her arthritic pain, leaving her feeling that she hadn’t achieved anything, further adding to her core beliefs.

*To identify and challenge her negative automatic thoughts*
It was apparent that Jane employed a number of thinking distortions, in particular fortune-telling relating to the prognosis of the Rheumatoid Arthritis. Other thinking distortions included catastrophising, all-or-nothing thinking and mental filtering. I explained to Jane about Negative Automatic Thoughts (NATs) and identified Jane’s thinking distortions.

Jane was able to offer some challenges to her NATs during the sessions, but needed encouragement and support to do this. She was not able to challenge her NATs on her own, but was able to identify and write down the NATs to bring to the next session.

I presented Jane with a copy of common thinking distortions (Appendix 12) and asked her to identify which distortions she recognised within herself, before introducing Craig White’s schema maintenance diagram (Appendix 13), which Jane understood, and helped her understand how these distortions are contributing to the belief she is a failure, and not good enough. Jane demonstrated a good understanding of this and finished the session with the comment, “So, I’m creating my own hell?”.

Jane was aware that we would be reviewing her progress during the sixth session, and had spent the previous week ‘fortune-telling’ - thinking that I would tell her there was nothing else I could do and she would be discharged. We agreed to meet for another couple of months until the end of my placement, before making any decisions about a planned discharge.

In particular, Jane’s NATs appeared to have resulted from her relationship with Tom in which she developed the thoughts that she was not good enough. These thoughts were enhanced by her own high standards and those of others, in particular Tom and his mother. Numerous conversations throughout the therapy were about challenging the NAT that she was not a good enough wife or mother, because she could not see that others were not without blame. We also discussed what Jane described as ‘doctor phobia’, and worrying about the future of her physical health problems, which fed into her thoughts of being trapped in the house and being dependent on her sons.

To identify a target for immediate action
Jane’s biggest concern was that she would be trapped in the house as a result of the
Rheumatoid Arthritis. At the time of the initial assessment sessions, Jane was having difficulty remaining in her house on her own, and would experience symptoms of panic which contributed to negative thoughts that she would be trapped in the house. It seemed appropriate to set goals for Jane to attempt during the course of therapy so I introduced the concept of SMART goals to Jane, explaining that any goal that she would attempt would have to be:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Timebound**

Due to time constraints, it was agreed that Jane would attempt to remain in the house for a specific length of time on her own on 2-3 occasions in the week. Before we had established the critical SMART aspects of her goal Jane had attempted to stay in the house, with the anticipation that she could tell me she had achieved it. Unfortunately she was not successful, which contributed to her fear of failure. We spent time in the session developing this into a SMART goal and used the formulation and challenging NATs sheet to explore her fear that she would fail at the goals, highlighting the impact of her negative thinking upon her behaviour. Jane agreed that she would try to complete the SMART goal.

Jane had succeeded in achieving her SMART goal once during the week, but only rated her achievement 7/10 because she’d agreed to attempt this 2/3 times during the week. Jane was still reluctant to enter her achievements onto the achievement diary. We discussed the importance of her being able to enter these for her own personal reflection, and by way of self-motivation. We revised the SMART goal, incorporating Jane’s art work, and changed the goal so that she would only have to stay in the house until she had completed the piece of art work.

Jane managed to do her revised SMART goal, but reported having to push herself to do it, because she didn’t want to let herself down – or me. She was honest about having done a sketch using pen, taking as little time as possible, with the idea that once it was completed, she would be able to leave the house. Jane agreed to try to complete the SMART goal again, however she only managed this once more before
the end of therapy.

Evaluation

Figure 8 shows Jane’s scores at opt-in, initial assessment, and during the final session (prior to a 3 month review). Jane showed a slight improvement in terms of her symptoms of anxiety, although depression improved more, as measured by the Hospital Anxiety and Depression Scale (HADS). There was greater acceptance of Rheumatoid Arthritis on the Acceptance of Illness Scale (AIS). Jane’s HADS anxiety score, however remained well within in the clinical category. Her HADS depression score reduced from clinical presentation to borderline. The greater reduction in her depression, rather than her anxiety scores may be due to recommendations within the NICE Guidelines for Depression to treat symptoms of depression first.

Figure 8 Line Chart showing Jane’s HADS and AIS scores

Throughout the sessions, I made sure that Jane was happy with the pace of conversations, particularly when Jane appeared uncomfortable talking about the transition into adulthood and her marriage.

During the last session, Jane said that whilst she had found the sessions useful, it had been difficult talking through some issues during adulthood. She understood the
importance of this, but it is important to note that she might not have acknowledged any improvements because of her tendency to underestimate her achievements, and also by the fact that such thoughts were contributing to her low mood.

Jane still needed support to work through her negative automatic thoughts, and her core beliefs of being a failure, and worthless. In addition, given the timescale of this piece of work, the focus was solely on Jane’s symptoms of depression. It felt appropriate for Jane to take a break from therapy because she seemed to be becoming dependent on the sessions. This gave her the opportunity to process things we had covered in the sessions. Jane agreed to this, with the view to attending a review session with the Consultant Clinical Psychologist within the department. At this review it would be decided whether it was necessary for Jane to attend for further sessions, specifically focusing on her negative automatic thoughts, core beliefs and her anxieties relating to her diagnosis of Rheumatoid Arthritis.

Jane had the initiative to look for new activities to do once our sessions had finished, for example she had enquired about a local art course. I advised Jane to continue with her set SMART goal, and emphasised two aspects: ‘achievable’ and ‘realistic’ because of her tendency to set goals too high, increasing the likelihood that she will not achieve them, thus contributing to her core beliefs that she is a failure, and not good enough.

**Reflections**
Throughout these sessions I have felt that I have established and maintained a good therapeutic relationship with Jane. I had completed the initial assessment with my supervisor; however I led the assessment, ensuring that I had established a good rapport from the start.

The presence of my supervisor meant that she had more of an idea of Jane as a person, and her difficulties from the start, rather than from my presentation during supervision. Initially I felt confident in working with Jane, and I think that this came across in supervision. Following the Christmas break, Jane appeared to have moved a step backwards, something which my supervisor had warned could happen. This
created more of a challenge, as I had to adapt to where Jane actually was, compared with where I had predicted she might be based on her improvements. After the Christmas break, my supervisor pointed out that Jane’s case was more complicated than we had originally thought, which helped to reduce any anxieties I had about my skill levels, and thoughts about whether the standard of my work was ‘good enough’. My supervisor helped me to focus the rest of my work with Jane, in order to move her forward, whilst acknowledging she had a lot of issues. This piece of work has helped me to acknowledge when I need to be more confident in my own abilities.

A couple of things strike me about my experience of working with Jane. One is that Jane initially tried to do everything that was asked of her, and this may have been related to a desire to impress me, and to not let people down. The other is the importance of incorporating endings into the sessions. During the review session and second-to-last session Jane expressed her worries around what was to happen. Reflecting back on this piece of work through this clinical practice report and supervision, has enabled to me to identify the moments when it became clear that Jane was finding ending therapy difficult.
References


A single case study of a 6-year-old boy who displays aggressive behaviours.
Abstract

This clinical practice report is a Single Case Experimental Design focussing on Ben*, a 6 year old boy with epilepsy who was referred to the Paediatric Psychology Department by his GP because of “temper tantrums” which were causing disruption within both the home and school environment. The process of assessment and collection of baseline data is discussed. The formulation considers current behavioural literature, whilst incorporating systemic thinking with respect to the maintenance of this aggressive behaviour. The intervention focussed on providing Ben’s parents with more appropriate parenting strategies. A reduction in aggressive behaviour was reported by Ben’s mother, and this was indicated by a significant reduction in behaviours during an intervention phase when compared to the baseline phase. The behaviour was not completely eradicated; rather his mother believes his behaviour is now acceptable and manageable for a child of his age. The results of the intervention are presented and discussed in terms of theoretical issues raised by the choice of intervention, and the issues which arose during the assessment, intervention and coinciding supervision.

* Please note that to protect the client’s identity all names have been changed throughout this report
Referral information

Ben is a six-year-old boy, referred to the Paediatric Clinical Psychology Department by his General Practitioner (GP). The referral stated that Ben was having temper tantrums in both the home and school environment, and that his mother Mary was “at the end of her tether”.

Assessment

The following information was obtained during two assessment sessions. The first was attended by both Ben and his mother Mary, and the supervising Clinical Psychologist. The second session was only attended by Mary. The assessment sessions took the form of an in-depth clinical interview, employing open-ended questions to gain an overview of how Ben’s difficulties were impacting on him and his family. Ben’s father John worked away from home, and was not present at any of the sessions, so the following information was obtained from Mary.

Ben’s class teacher was also contacted to obtain further information regarding the impact of Ben’s difficulties on his schooling. Ben was the subject of a Team Around the Child Information Sharing Assessment meeting, which was attended by the author. Appropriate information from this meeting has been documented within the intervention part of this Clinical Practice Report.

In accordance with the department’s policy, Ben’s mother completed a copy of the Strengths and Difficulties Questionnaire (Goodman, Meltzer and Bailey, 1998). The Strengths and Difficulties Questionnaire highlighted that Ben scored very high for emotional distress, behavioural difficulties, hyperactivity and attentional difficulties and the impact of any difficulties on the child’s life. Ben’s overall stress score was high, whilst his difficulties
getting along with other children were slightly raised, and his emotional distress score was close to average.

During the assessment session and subsequent sessions attended by both Mary and Ben, it was apparent that they had a close relationship. An example would be Ben choosing to sit close to his mum, almost sitting on her chair, or leaning against her knee when he was standing. Ben and Mary maintained good eye contact during any interactions between themselves. It was felt that Mary and Ben became engaged with the therapist during the first session, and remained so throughout the sessions. Ben responded to any questions asked, however, he would occasionally look to his mother before answering. A further indicator of their engagement was that Mary (and Ben when required) attended all of the sessions apart from one due to arriving home late after their holiday, and they often arrived early.

**Background information**

Ben is the youngest of 4 children, having 2 older brothers and an older sister. He lives with his older brother, sister and his parents; his eldest brother lives with their maternal grandmother in the same street. A genogram can be found under figure 9. Mary works as a dinner lady at Ben’s school.

Mary reports a good relationship between Ben and all members of the family, although there are frequent disagreements between siblings. She describes the majority of these as ‘normal’ sibling behaviour, but is concerned at the level of Ben’s aggression on occasions.
Figure 9: Ben’s Genogram

Developmental history

When Ben was 4 years old, he suffered a severe epileptic seizure, and was admitted to an out-of-area Paediatric department whilst they monitored and treated the epilepsy. Ben was initially prescribed Phenytoin, however this did not reduce his seizures, and his medication was withdrawn whilst introducing Sodium Valproate.

Mary did not have any concerns about Ben’s development prior to the diagnosis of epilepsy, and stated that he reached all of the developmental milestones appropriately. As with her other children Ben had colic, which made Mary more wary when others were feeding him, but she was not overcautious.

Following the diagnosis of epilepsy, Mary recalls feeling more protective of Ben, something which was later corroborated by his class teacher.

Presenting problem

Prior to being diagnosed with epilepsy, Ben was reported to be a ‘normal boisterous little
boy, no different to Mary’s older children. Mary recalled a history of aggression and temper tantrums following his first seizure, which coincided with the introduction of Sodium Valproate. She attributes his current difficulties to his prescription of Sodium Valproate.

Ben was reported to be having temper tantrums on a daily basis at the time of the initial assessment, lasting between 30 mins and 2 hours. Such temper tantrums involved Ben shouting, swearing, kicking, hitting and biting people, slamming doors, or throwing pieces of furniture. Mary reported that she was often the target for such behaviour, suffering bruising to her arms and legs after being hit, kicked or bitten by Ben. Her explanation for why she was the main target was because his father John was away during the week and therefore was not subjected to as many incidents of aggression.

On further exploration, it became apparent that Mary and John had very different parenting styles, in particular when dealing with such incidents of aggression. Mary herself admitted to not maintaining consistency when dealing with Ben’s temper tantrums, sometimes disciplining him, and other times allowing him to do an activity he had previously been told was not possible. John was reported to plead with Ben to stop his temper tantrums. Mary was unclear what led to Ben having a temper tantrum but suggested it could have been as a result of his siblings ‘winding him up’ by taking things off him or telling him he couldn’t have/do something; or she would pick him up from school and he would be upset, following his teacher not being present.

Also comparing Ben to her older sons, Mary felt that since the first seizure Ben required more attention from waking to sleeping, and he was no longer able to occupy himself with jigsaws and drawing as he had previously been able to do. This was the opposite of how Ben
presented during the initial assessment session, where Ben was able to sit throughout the session and could follow all of the conversations that he was involved in and occupy himself for those he was not. Ben was able to express that sometimes he got angry, but didn’t understand why.

Further discussion with Mary revealed that Ben gets frustrated with the word “no”; and when people ignore him. She thinks that Ben understands that it is rude to ignore people and gets aggressive when this happens to him. Ben’s aggression is also evident when he does not understand a situation or it has not been explained to him. In particular, Mary reports that Ben can become upset and aggressive if his class teacher changes without warning. If the teaching assistant remains constant then Ben’s aggression is more manageable. During the second assessment session Mary reported that the frequency of Ben’s aggressive outbursts has reduced as has the severity, in particular, she has noticed that Ben is now more remorseful after an aggressive outburst. Mary attributed this to the reduction of Sodium Valproate.

Interview with Ben’s class teacher

Ben’s class teacher, Mrs Hough reported that he is often a disruption in the classroom, running out of both the classroom and the school grounds when he asked to do something he does not wish to do. Ben is also known to kick, scream and punch other children for no apparent reason. On frequent occasions Ben will attempt to get her attention whilst she is with another child, but will persist until she listens to him. Mrs Hough is also the school’s deputy headteacher, and as a result has to complete such duties meaning that Ben’s class is occasionally taught by a supply teacher. It is on these occasions that Ben can become ‘difficult’ exploding into a rage. Mrs Hough reported that Ben has two types of tantrums, one
where he appears to be in control and can be talked round, and another where he is not in control and becomes upset and inconsolable. Since his diagnosis of epilepsy he has to give his mother a cuddle before going into the afternoon session. Both Ben’s teachers and his mother report that frequently he can only be calmed down by his mother when he exhibits aggressive behaviour during school time. Mrs Hough commented that Ben’s parents ‘mollycoddled’ Ben in the short time after his seizures, and believes that this may be responsible for his current behaviour.

Functional Analysis
It was necessary to conduct a functional analysis of Ben’s difficulties and their impact through the use of an ABC chart, where observations would be made on Antecedents, Behaviours and Consequences, i.e what came directly before the behaviour?; what does the behaviour look like?; and what comes directly after the behaviour? An example of the ABC chart can be found under Appendix 14. Mary was asked to complete an ABC chart for each incident of aggression, but did not complete any stating Ben had ‘exploded’ for no reason, or when another child had hit him first. As stated earlier these explosions would involve Ben kicking, hitting or biting. On further exploration, Mary was unable to identify any triggers to his behaviour, and was vague about how she had dealt these situations, offering evidence of her self-reported inconsistencies. Mary was encouraged to complete the ABC chart throughout the intervention, with the therapist highlighting its role in exploring triggers to his aggressive behaviour.

Behavioural Monitoring
During the initial assessment session Mary was asked to monitor Ben’s temper tantrums using a daily observation monitoring chart (which can be found under Appendix 16). It was
anticipated that by keeping a daily record, Mary would be more accurate than if recalling the number of incidents during each fortnightly session. Having more accurate data would highlight any trends in behaviour, and thus enable potential triggers to be explored more thoroughly.

Mary was given clear instructions to record any incidents of aggression that occurred each day throughout our work together; and to rate the severity of each incident on a scale from 1-10, (with 10 representing a more serious incident). The monitoring chart would provide a basis for discussions during each session, for example exploring what had worked well on the days that Ben had not had any aggressive incidents, highlighting with Mary the strategies that she has in place to maintain non-aggressive behaviours. During the session in which the observation monitoring chart was introduced, it was completed with Mary, based on an incident that had occurred the previous day, to ensure that she was aware of how to complete it correctly, and to enable her to ask any questions.

Formulation

There are several side-effects of Sodium Valproate, including increased alertness, aggression, hyperactivity, and behavioural disturbances (British National Formulary website). Whilst Mary’s mother attributes Ben’s behaviour to his medication, she has also given an indication of inconsistent parenting.

The side effects of his medication were kept in mind, however given the inconsistencies in parenting styles it is useful to apply the Theory of Operant Conditioning (Skinner, 1938) to Ben’s case, to hypothesise about the functionality of his aggressive behaviour. In particular, Ben’s behaviour is indicative of him receiving both social and stimulation reinforcers, such as
Kazdin (2005) developed Parent Management Training (PMT), based on Skinners Operant Conditioning principles, and some of these principles are discussed within this formulation. He refers to early applications of Operant Conditioning in the 1960s to address routine behaviours and parental concerns (tantrums, thumbsucking, toileting, and complying with requests). Kazdin (2005) outlines Patterson’s (1965a, 1965b) applications of Operant Conditioning demonstrating that reinforcement could alter important behaviours. Patterson (1982, cited in Kazdin 2005) demonstrated that parents can display coercive behaviour following a child’s aggression, in that they will shout at the child. Ultimately one person will back away from the interaction. This means that the high-intensity interaction of one person (the child) ends the aversive behaviour of the other person (usually the parent). This is an example of negative reinforcement, i.e. when behaviour terminates an aversive condition it is likely to increase in frequency in the future, thus reinforcing the behaviour of the child. Aggressive children are inadvertently rewarded for their aggression, and as this coercion process occurs, they are likely to become more aggressive in the future.

As per Mary’s reporting of her inconsistent parenting and that of her husband, Patterson, DeBaryshe, and Ramsey (1989) reported that such inconsistencies inconsistent were found to have a negative impact on a child’s emotional and behavioural adjustment.

Figure 10 details the behavioural formulation highlighting the antecedents, behaviours and consequences with respect to Ben’s aggressive behaviour identified during the in-depth clinical interviews with Mary and his teacher. The whole formulation focuses on Ben’s aggressive behaviours, however is broken down into the three individual situations identified
by Ben’s mother and his class teacher: 1) when Ben wants to do an activity and is told “no”; 2) when Ben feels he is being ignored; and 3) when Ben does not understand a situation.

1) When Ben wants to do an activity he is not allowed to do his mother Mary will tell him “no”. This leads Ben to express his frustration, and upset through aggressive behaviour. Mary is inconsistent in how she deals with this, sometimes allowing him to do the activity to shorten the time that Ben is aggressive. This acts as positive reinforcement because Ben associates his behaviour with getting what he wants. Other times Mary is firm with Ben and insistent that he will not be allowed to do the activity and disciplines him for his aggressive behaviour. This acts as negative attention, reinforcing his bad behaviour with interaction from Mary. Mary doesn’t always manage to stay firm and on occasion will give in to Ben’s demands. This is giving Ben mixed messages, for example he is aware that if he is aggressive he will either get attention from his mother, albeit negative attention, followed by the activity he’d previously been told he couldn’t do; or he gets the activity straight away.

In addition, when his father is around he is aware that he can get other things in order to stop his aggressive behaviour.

All of these messages are reinforcing the likelihood that his aggressive behaviour will occur.

2) On occasions Ben will try to get his parents’ attention. When this does not happen, he feels ignored. Ben starts to become aggressive, because he is aware that he will gain his mother’s attention in the form of discipline in particular, because he doesn’t often receive positive attention (praise, play, etc).

On the occasions that his father is around Ben is aware that his father will plead with
him to behave and offer a ‘reward’ if he stops that behaviour. This also teaches Ben that his aggression results in attention from either of his parents, and/or an activity to appease his behaviour from his father.

These reactions from his parents are reinforcing his aggressive behaviour.

3) When Ben is at school his teacher sometimes changes, which Ben does not understand. This leads him to become aggressive. The staff at Ben’s school cannot always control Ben’s behaviour, so call his mother, when she is on the premises, to calm him down. Ben’s mother will discipline him, meaning Ben is receiving negative attention for his behaviour. Ben does not receive positive attention for behaving at school; therefore his aggressive behaviour is reinforced.

It is important to acknowledge the impact of the absence of John, Ben’s father, which leaves Mary to take on both parental roles. When John returns at the weekend, he and Ben are often doing fun activities as opposed to the day to day activities that take place during the week, for example school. On the occasions when Ben exhibits aggressive behaviour, John does not discipline Ben rather choosing to appease his behaviour or leave it to Mary to discipline Ben.

In summary, each of the antecedents to Bens aggression results in him being disciplined, allowed to do a previously forbidden activity, or being ‘bribed’ not to do that particular behaviour, these in turn provide Ben with attention. If Ben associates his aggressive behaviour with gaining any attention, his behaviour will be reinforced, increasing the likelihood he will repeat the behaviour in the future.
Figure 10: Behavioural formulation of Ben’s aggressive behaviour
**Intervention**

Behavioural interventions with family problems are based on the assumption that dysfunctional behaviours are learned and can therefore be reduced or replaced with more constructive behaviours through new learning processes. Operant Conditioning principles suggests that when a child receives little attention, or reinforcement for his or her positive behaviour, but receives considerable attention from parents for negative actions, for example verbal and physical aggression, it is likely that the attention will reinforce and thus strengthen the negative behaviour (Epstein, 2003 cited in Wetchler & Hecker, 2003).

Patterson (1982, cited in Webster-Stratton, 1997) suggested it was necessary to target parenting behaviour as the primary focus of intervention given that parents of children with oppositional defiant disorder or conduct disorder lack certain fundamental parenting skills. Furthermore, Webster-Stratton (1993) proposed that parent training interventions are highly promising, particularly for young children (4-8years) with early-onset conduct problems. The National Institute for Health and Clinical Excellence (NICE, 2006) issued guidance to help parents and carers who have children with conduct disorders. This guidance highlighted that parenting programmes, either group or individual based, should be clearly structured, include relationship-enhancing strategies, for example play and praise, and preparation and review of homework.

Mary attributed Ben’s behaviour to the prescription of Sodium Valproate, and whilst it was apparent that Mary employed a strict routine throughout the childrens’ days she commented that both her and John’s parenting styles were inconsistent. Throughout our discussions she agreed it would be useful to look further at their parenting skills and to provide them with
more strategies to help address Ben’s aggressive behaviour. Therefore, this piece of work aimed to address and subsequently improve the parenting strategies reported by Mary during the initial assessment.

Mary attended 10 sessions in total, and Ben was only present at some of these sessions as it was not appropriate to talk about parenting skills whilst Ben was present, because he may have picked up on the strategies, giving him the upper hand.

During these sessions, Mary was given a copy of the department’s parenting strategies for behaviour problems (Appendix 15). This provided information on developing a star chart that she could make with Ben, in order that he receive positive attention for his positive behaviours. This would ensure he was aware that there are other types of attention that he can receive from his parents. Ben was present during one of the sessions so that I could explain how the star chart worked to both of them at the same time. At this point, Ben took over drawing the example star chart, which became the chart he would use. Ben was aware that a series of stars would result in a small reward. The therapist modelled to Mary an example of giving Ben praise by highlighting what he had done well that had earned him a star. Mary reported that this was working well throughout the intervention, although on occasion Ben would pull his star chart from the wall and put it in the bin. He would then become upset about what had happened and would retrieve his star chart from the bin.

Ben’s teachers received a copy of the assessment letter to the referrer indicating both the recommendations for Ben’s parents to undertake, and also the recommendations for Ben’s teachers to undertake. They were advised to deal with his attention seeking behaviour
consistently, for example explaining to Ben that he needed to wait his turn when wanting to speak to teachers, to monitor and reward his good behaviour, and ensure that Ben understands all situations. It was hoped that these recommendations would be put in place and monitored, but due to the timing of the referral and the ending of the school term it was not possible to monitor this. The school did not complete a record of aggressive incidents during the two week assessment period, and the intervention took place in the school holidays. This piece of work was completed prior to Ben’s return to school, so it was not possible to obtain reports of any behaviour changes within the school environment.

Team Around the Child: Information, Sharing and Assessment Meeting
Towards the end of the intervention with Mary and Ben, a Team Around the Child Information, Sharing and Assessment Meeting was convened with Ben’s parents and all professionals involved with a view to gathering more information about Ben’s difficulties. The school health nurse remarked that Ben was demonstrating similar behaviours to other children who have been prescribed Sodium Valproate, and was confident that on the reduction of this medication, his behaviours would subside with appropriate parenting. The area’s Family Solutions team representative commented that they would not be getting involved as they would complete similar to work to this work. The Education Welfare Officer commented that since there were no unauthorised school absences there was no need for their involvement. As it was coming to the end of the school year, Mrs Hough advised the meeting that they had taken on board suggestions that Ben needed to be informed in advance of any forthcoming changes. In particular Ben’s new teacher would not be familiar to Ben, as a result they had arranged for the new teacher to come in during the last week to meet her new class.
Design

This piece of work involved undertaking a Single Case Experimental Design. Single Case Experimental Designs focus on the individual as the sole unit of analysis, providing direct feedback to clinicians and families about the effectiveness of the behavioural intervention (Tervo, Estrem, Bryson-Brockmann & Symons, 2003). This serves to identify and isolate mechanisms of change within the therapeutic process (Bergin and Strupp, 1970, cited in Kazdin 1984). Individually defined behaviours are measured frequently in relation to specific questions held, for example frequency, intensity, and duration. Given that this particular design focuses on the individual, they serve as their own control.

The current study employed an A-B design with measurements taken in the baseline phase (A) and the intervention phase (B). The independent variable was the intervention applied, in this case providing Mary and John with parenting strategies to deal with Ben’s aggressive behaviour, and the dependent variable was the number of times Ben displayed aggressive behaviour during each day. Due to the time constraints it was not possible to obtain similar information from Ben’s teachers in order to see if there was a difference in his behaviours in this environment.

As previously mentioned, Mary was asked during the initial assessment session to monitor Ben’s behaviour using a daily monitoring sheet, to record the frequency of incidents that occurred on each day. In addition she was asked to rate each incident in terms of severity on a scale from 1-10.
Results

Visual inspection of the data reveals that the mean number of incidents of aggression in the baseline was 1.1. During the intervention the number of incidents ranged from 0 – 1 over an 8 week period. The mean score for the intervention phase (0.1) is lower than the baseline phase (1.1) suggesting that some improvement in the number of incidents of aggression may have been a result of the intervention itself.

A significant autocorrelation was observed for aggressive behaviour at lag=1 (r = .448; p < 0.001). Accordingly, traditional statistical procedures premised upon the assumption of independence of observation are not appropriate for the analysis of these data. The number of incidents of aggression at both the baseline and intervention phases are presented in Figure 11.

Figure 11: Frequency of incidents of aggression per day during the baseline and intervention phase

Split Middle Technique was applied to the data as described by Morley and Adams (1991) and can be seen in figure 11. The Split Middle Technique supplements the information
obtained by visual inspection (Kazdin, 1984) and enables description of the rate of behaviour change over time in a single case.

The rate of change in the number of incidents of Ben’s aggression over the baseline and intervention periods was calculated. The ratio for the rate of change during the baseline period was 1. This shows that they remained stable throughout. The ratio for the rate of change during the intervention phase could not be calculated due to the 0 score at the end of the celeration line and indicates that the intervention resulted in significant decline in the number of incidents of Ben’s aggression. All of the intervention points lie on or below the projected baseline suggesting a reduction in the frequency of incidents of Ben’s aggression in comparison to the frequency in the baseline.

Binomial analysis found that the 6 data-points appearing on the projected baseline suggests a highly significant result (p <0.001) It can be concluded that a significant decrease in the number of incidents of aggression has occurred.

Mary was asked to rate the severity of each incident of aggression (from 1-10). Mary rated all of the incidents as 5/10 so this has not been presented visually, as there was no difference in severity before or after the intervention started.

**Discussion**

It is important to acknowledge that an individual’s behaviour is not simply within the individual, rather others within the support system may exacerbate, maintain and alleviate behaviours. As a result it may have been useful to adopt a wholly systemic stance in
approaching this piece of work. Systemic ideas were not ignored, in particular in relation to ideas around Ben’s family system and the impact of the absence of Ben’s father. However it was necessary to first improve Mary and John’s parenting strategies.

Ben’s mother noticed the reduction of aggressive behaviours throughout the intervention, but was insistent that this was due to the reduction of Sodium Valproate, thus Mary may not have seen the need to change her parenting. However, it is possible that Mary’s knowledge of the potential side effects may have resulted in a difference in how she saw Ben’s difficulties, and subsequently she may have treated Ben more positively, which may have in turn reduced the frequency of his aggressive behaviours.

In addition, throughout both the baseline and intervention phases Ben’s mother only rated incidents that were 5/10 in terms of severity. Mary consistently reported all of Ben’s aggression to include hitting, kicking and biting, not indicating any variation in severity. She highlighted that anything under a 5 was classed as ‘normal’ behaviour for a child of Ben’s age, and she did not believe that he exhibited any behaviour higher than a 5. Mary often completed the frequency table at the end of the week, rather than daily. As a result there may be some doubt to the accuracy of the above information. This may also have been due to Mary not seeing the need to monitor his behaviours due to seeing his medication as the sole cause.

Further opportunities for analysis of Ben’s incidents of aggression would be through examining the duration of each incident. This would have given an indication as to whether the duration of the incidents had reduced in accordance with the reduction in frequency, or
whether they had stayed the same or perhaps increased in duration.

It would have been worth exploring more about Mary’s perceptions of anything less than a 5/10 in terms of severity being ‘normal’, and possibly the impact of both her and John’s experiences of parenting on how they have parented Ben and his siblings. In addition, it would have been useful to take a measure of Mary’s (and John’s) stress levels during the initial assessment and the last session, with a measure such as the Parenting Stress Index (Abidin, 1997). This would have provided information about Mary and John’s parenting competencies, health, depression, issues of role, and attachment, for example. Whilst the Strengths and Difficulties Questionnaire was completed with Mary prior to the initial assessment session, it would have been beneficial to complete this during the last session, however this was overlooked by the therapist. Having a pre- and post measure would give an idea of the impact of the intervention on Mary’s perceptions of Ben.

Given that there has been both an evident and reported reduction in Ben’s aggressive behaviours and both Ben’s parents and his school teachers are aware of methods they can employ to maintain this reduction, it was anticipated this would continue when Ben returned to school. As previously outlined, it would have been more beneficial to extend the intervention to Ben’s school environment. However, due to the school holidays approaching, this would have reduced the amount of data that could have been collected by the school whilst in his current class, and towards the end of the intervention Ben would have just started a new school year, with a new class teacher. As a result, a comparison may have been invalid because he would have had a different class teacher who may have dealt with any incidents of aggression differently, thus being a confounding variable.
Whilst the Single Case Experimental A-B Design is simple and makes logical inferences that the environmental condition has influenced the change in behaviour, the design does not control for extraneous variables, for example the school holidays occurring throughout a large amount of this intervention. As a result, there could have been a natural reduction in aggressive behaviour through not attending school.

It is important to note that Ben’s prescription of sodium valproate was already being reduced gradually throughout the intervention and was stopped on day 68 of the intervention. Two of the side-effects of sodium valproate are related to behaviour problems and aggression, as a result this could have been responsible for the reduction demonstrated in Figure 11. In addition, Mary held strong beliefs attributing his behaviour to his medication; further work with Mary could utilise a Cognitive Behavioural Therapy approach to explore her beliefs about medication. Further work could involve all of Ben’s family, including Ben himself, to explore the relationship dynamics, and the impact of his behaviours on him and his family. This was not appropriate at the time due to Ben’s father working away during the week.

Ben was currently under the care of a Consultant Neurologist who was monitoring his epilepsy. It would have been better to communicate with his Neurologist from the first point of contact with Ben and Mary, rather than at the end when he was informed of the work that had been undertaken with Ben and Mary.

**Reflections**

Throughout this piece of work I was aware that Mary was the parent of four children and three of these were raised without significant behavioural problems. I am not a parent, and
although this discussion did not occur I often wondered whether Mary was aware of this and what impact it would have had on the therapeutic alliance. In spite of this, one of the principle systemic ideas employed throughout this piece of work was that of engagement (Grunbaum, 1988). Mary presented as a mother that previously had not felt listened to or supported by those around her with respect to Ben’s difficulties. I believe that Mary felt listened to during the first session, and as a result was engaged throughout the sessions that followed. Due to the strategies that Mary was provided with I believe Mary felt empowered, and also felt that I had the belief in her to make the necessary changes.

Linked to my position of being a non-parent, are my doubts about my ability to offer strategies given that I do not have parenting experience. These were discussed with my supervisor, who also was a parent. These discussions focussed on my presentation of relevant literature during supervision which supported my suggested strategies, and also about owning my own authority to suggest these strategies to Mary.

Mary reported that there was an improvement in Ben’s behaviour; however these were not recorded daily so the accuracy of her reporting could be contested. I am curious as to whether Mary reported this improvement because she wanted me to think that a change had occurred so as not to feel that she had let me down in making these changes.
References


British National Formulary online

http://www.bnf.org/bnf/bnf/56/3600.htm?q=%22sodium%22%22valproate%22 [accessed on 24th September 2008]


National Institute for Health and Clinical Excellence Parent-training/education programmes in the management of children with conduct disorders


CPR 5

A service evaluation: Evaluating the effectiveness of an outcomes tool introduced within an Adult/Older Adult Psychology Specialty: A Service Evaluation of the implementation of outcome measures within an adult/older adult specialty
ABSTRACT
The aim of this service evaluation was to evaluate the effectiveness of the Outcome Rating Scale and Session Rating scale within a combine adult/older adult psychology specialty. The Outcome Rating Scale seeks to provide useful information about efficacy and outcomes of therapeutic intervention, whilst the Session Rating Scale seeks to establish client satisfaction with intervention. The Outcome Rating Scale and Session Rating Scale are valid, reliable and feasible scales and a strong evidence base highlights better adherence to therapy due to an improved therapeutic alliance. This stage of the service evaluation was a pilot for the specialty, using a sample of client data taken over a four month period, with a view to expanding the use of these measures dependent upon the current findings. Due to poor clinician response rates for various reasons, it has not been possible to draw any statistically significant findings from this service evaluation, although relevant statistical analyses are discussed briefly. Challenges to organisational change are posited as suggestions for the low response rates, coupled with a short period of time in which to collect data, given that clients would not necessarily be seen weekly. Suggestions are made regarding continuing this work within the specialty and within other professions, for example Community Psychiatric Nurses. Implications for the service, Clinical Psychology, and clients are also offered. Reflections from the author and also other clinicians are offered regarding the implementation of outcome measures.

* Please note that any identifying information has been removed throughout this report
Appendices
Appendix 1

Antecedents, settings, events and conditions
1 Antecedent/setting events and conditions

Date………………  Time………………  Where …………………………………

- Who else was present?

- What was the client doing during preceding 5 minutes?

- What were others doing during preceding 5 minutes?

- Describe any interactions involving client during preceding 5 minutes

- Did anything immediately trigger the behaviour?
2  **Description of Behaviour**

- What did the client do (descriptive terms)

- Duration______________________ Intensity_____________________

3  **Consequences**

- How did you respond?

- How did others respond?

- How did the incident resolve itself?

- What was gained/avoided/delayed by the client?
Appendix 2

Motivational assessment scale
Motivational Assessment Scale (Durand & Crimmins, 1988)

NAME_______________________________________  DATE______________

BEHAVIOUR DESCRIPTION ______________________________________

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Would this behaviour occur continuously if the person was left alone for a long time?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Does this behaviour occur following a command to perform a difficult task?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Does this behaviour occur when you are talking to other persons on the room?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Does this behaviour ever occur to get an activity, food or game that he or she has been told he or she cannot have?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Does this behaviour occur repeatedly over and over, in the same way? (e.g. Rocking back and forth for five minutes).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Does this behaviour occur when any request is made of the person?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>Almost Never</td>
<td>Seldom</td>
<td>Half the Time</td>
<td>Usually</td>
<td>Almost Always</td>
<td>Always</td>
</tr>
<tr>
<td>---</td>
<td>-------</td>
<td>--------------</td>
<td>--------</td>
<td>--------------</td>
<td>---------</td>
<td>---------------</td>
<td>--------</td>
</tr>
<tr>
<td>7</td>
<td>Does this behaviour occur whenever you stop attending to him or her?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Does this behaviour occur when you take away a favourite activity or food?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Does it appear to you that he or she enjoys performing this behaviour and would continue even if no-one was around?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Does the person seem to do this behaviour to upset or annoy you when you are trying to get him or her to do what you ask?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Does the person seem to do this behaviour to upset or annoy you when you are not paying attention to him or her? (e.g. sitting in a separate room, interacting with another child).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Does this behaviour stop occurring shortly after you give the person the activity or toy he or she has requested?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>When the behaviour is occurring, does the person seem unaware of anything else going on around him or her?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>Almost</td>
<td>Seldom</td>
<td>Half the Time</td>
<td>Usually</td>
<td>Almost</td>
<td>Always</td>
</tr>
<tr>
<td>---</td>
<td>-------</td>
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<td>--------</td>
<td>---------------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>14</td>
<td>Does this behaviour stop occurring shortly after (one to five minutes) you stop working or making demands of him or her?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>Does he or she seem to do this behaviour to get you to spend some time with him or her?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>Does this behaviour seem to occur when the person has been told that he or she cannot do something he or she had wanted to do?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 3

Observations
Observations

Throughout each observation session, I was looking for triggers for any specific pica and ‘posting’ behaviours, however, I was also interested in any other interactions that were going on between Billy and both staff members and residents. The following three observations depict accounts of his behaviours, and give an idea of the situations surrounding Billy, both in the care home, and also in the communication.

Observation 1
On the initial occasion, I observed Billy in the lounge within the care home, where he was completing a jigsaw. Throughout the hour that I observed Billy, he did not engage in any of his ‘posting behaviours’, or in addition, any pica related behaviours. No staff members made any attempts to engage Billy in his activity, leaving him to entertain himself. On occasions when the lounge became noisy, due to the high volume of staff members, and residents, Billy would fold his ears, and occasionally would rub his head, before leaving the lounge. He would then return and continue his jigsaw. Billy did not complete the jigsaw during the hour that I was observing him within the care home. During my observations, one member of staff attempted to introduce the ‘postbox’ they had made for Billy. I explained that I would need to observe Billy as he usually presents without any attempt to prevent him from posting anything down the radiators.

Observation 2
On the second occasion, I had previously arranged to accompany Billy and his 1:1 care worker in the community. On my arrival, no member of staff was aware of this arrangement, and subsequently no plans had been made. I had also made arrangements to collect completed “Antecedents, settings, events and conditions” forms (see Appendix 1); however, only one member of the staff team was aware of this form, and expressed that on receipt of my letter instructing them what I would like them to do, her and Billy’s keyworker had not understood what I was asking of them. As a result, it was not communicated to other staff members that these forms were to be completed.

As the previously arranged observational opportunity was not able to go ahead, I took the opportunity to talk through the form with staff members, explaining each component. I asked staff once again to complete the forms for me. I also took the opportunity to spend the previously planned time observing Billy within the care home. Whilst talking staff through the ‘antecedents, settings, events and conditions’ form, I was observing Billy. He was sitting next to a staff member who was completing the staff rota. When she had she finished the pen out of Billy’s view, hiding it in a ringbinder; Billy stared at the ringbinder and became increasingly agitated, rubbing his hair and making noises. The staff member mentioned that Billy likes pens, but that he wasn’t allowed biros as he tends to chew them, and gets the ink all around his mouth. This staff member left the lounge, followed by Billy. Moments later, Billy returned to the lounge with 2 biros, and a different staff member made a verbal attempt to get the pens from Billy, asking him to hand them over; another resident also told Billy that he shouldn’t have the biros. Then the original member of staff returned saying that she had given Billy the biros as he had reportedly refused to leave the kitchen. Billy was left with the pens and given 2 colouring books. No attempt to engage Billy in making a decision about this activity was made by staff. Billy was sitting quietly, colouring the whole page. When
Billy had finished colouring the page, he would rip it out of the colouring book, rip it into smaller pieces, and post each piece into his postbox, which had previously been put next to him. Billy continued this routine of colouring, ripping, and posting for approximately 15 minutes. Billy then moved towards the radiator and posted one of the pens down the radiator. No staff member was present at this time.

Billy then returned to his seat and continued to colour a page, and engaged in this same colouring, ripping and posting routine once again. Billy completed this routine twice, and then as he moved towards the radiator a member of staff attempted to ask Billy for the pen. Billy posted the pen down the radiator. Staff explained to Billy that he wouldn’t have a pen now because he had posted them. Billy looked around the room for more pens and became increasingly agitated, again rubbing his head. Billy then left the room, and went to his bedroom.

**Observation 3**
On this occasion I met Billy and his carer at his care home. Billy was due to be going with another resident and his carer into town on the bus and then getting to the train to a neighbouring town. I arranged that I would accompany them on the bus, and around town.

Billy was lively, jumping around the hallway whilst waiting for the other resident to finish getting ready. No member of staff attempted to engage Billy whilst he was waiting, and no reinforcement was given as a result of him being ready.

Billy continued to make excited noises and was jumping as we headed towards the bus stop. Billy walked ahead of the other resident and appeared to turn around checking where the other resident was, whenever he had got further than 10 feet in front. Billy stood patiently at the bus stop, and continued to make excited noises. When the bus came, Billy headed straight to the back seat, whilst his carer paid. Billy did pick up a small twig, which when she reached the back of the bus, his carer took off him. Billy continued to make excited noises throughout the journey.

Once in the town centre, Billy walked ahead of his carer and the other resident and his carer. He continued to look around when he was approximately 10 feet in front. On two occasions, Billy headed towards two shops; his carer thought that he wanted to go in, but on both occasions he walked towards the baskets by the doorway, and put the handles down on the top basket, and the walked off.

Billy appeared to become restless after approximately 40 minutes walking round shops, and his care worker said that they would be going to catch the train. This observation finished here.

Throughout this observation, No aspects of Billy’s pica or posting behaviours were observed.
Appendix 4

Initial questionnaire to both intensive support team and respite care home
Below is a list of aspects of psychological need that you may face within your work. We would like you to do two things. Firstly, we would like you to rate how comfortable (or confident in your skills) you feel at work when you face these by circling the appropriate number. For example, if you are not at all comfortable, please circle number 1, if you are very comfortable, please circle number 4

<table>
<thead>
<tr>
<th>Not at all comfortable</th>
<th>Very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Secondly, when you have rated each aspect, we would like you to rank which aspects you think are most important for you as an individual to develop your psychological thinking around. Rank the 15 aspects in order from 1 to 15. For example, if you think “understanding positive communication” is the most important aspect that you would like to develop, place the number 1 under the heading ‘Ranking’. If you think “understanding positive communication” is the least important aspect, place the number 15 under the heading.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Rating</th>
<th>Ranking (1-15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding change and transition</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Contributing to the management of substance use and abuse</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Responding to people with a learning disability who self-harm</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding support needs of older people</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Contributing to the management of mental-ill health</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding epilepsy and helping service users to manage it</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding positive communication</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding and protecting people with a learning disability from abuse</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding and managing challenging behaviour</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding dementia and helping service users to manage it</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Understanding loss and bereavement</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Working as a member of a team</td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

Are there any other aspects of your work that you feel would benefit from you developing your psychological way of working? (Please indicate below)

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

Appendix 5

Feedback to respite care home
[date]

Dear colleague

Thank-you for completing the questionnaire that looked at areas you may feel you would like to develop, in order to enhance your ways of working psychologically. I am now in a position to feed back to you how comfortable the team as a whole feels when dealing with different aspects of their work and the areas that the team would like to develop.

Below I have compiled these aspects in relation to those that the team as a whole rated as feeling comfortable working with, and those that the group rated as feeling uncomfortable working with.

<table>
<thead>
<tr>
<th>Aspects uncomfortable working with</th>
<th>Aspects comfortable working with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>Understanding change and transition</td>
</tr>
<tr>
<td>Understanding support needs of older people</td>
<td>Contributing to the management of substance use and abuse</td>
</tr>
<tr>
<td>Contributing to the management of mental-ill health</td>
<td>Responding to people with a learning disability who self harm</td>
</tr>
<tr>
<td>Understanding epilepsy and helping service users to manage it</td>
<td>Understanding positive communication</td>
</tr>
<tr>
<td>Understanding dementia and helping service users to manage it</td>
<td>Understanding and protecting people with a learning disability from abuse</td>
</tr>
<tr>
<td>Understanding loss and bereavement</td>
<td>Understanding and managing challenging behaviour</td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
</tr>
<tr>
<td></td>
<td>Working as a member of a team</td>
</tr>
</tbody>
</table>

We also asked you to individually rank each aspect in order of how important you felt each aspect was to develop your ways of working psychologically. Below, the aspects have been displayed in terms of which aspects the group as a whole felt were the most important and
least important aspects to develop in terms of working psychologically.

<table>
<thead>
<tr>
<th>Aspects most important to develop</th>
<th>Aspects least important to develop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>Understanding change and transition</td>
</tr>
<tr>
<td>Responding to people with a learning disability who self-harm</td>
<td>Understanding support needs of older people</td>
</tr>
<tr>
<td>Understanding epilepsy and helping service users to manage it</td>
<td>Contributing to the management of mental-ill health</td>
</tr>
<tr>
<td>Understanding positive communication</td>
<td>Understanding dementia and helping service users to manage it</td>
</tr>
<tr>
<td>Understanding and protecting people with a learning disability from abuse</td>
<td>Understanding loss and bereavement</td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td></td>
</tr>
<tr>
<td>Understanding and managing challenging behaviour</td>
<td></td>
</tr>
<tr>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
<td></td>
</tr>
<tr>
<td>Working as a member of a team</td>
<td></td>
</tr>
</tbody>
</table>

You may feel that it is helpful to use the above information to discuss as a group, and also with [name] how you would like to use the consultation sessions. You may also have other aspects of your work that you would like to cover in the consultation session, which you can discuss with [name].

If you have any concerns about the consultancy sessions, please do not hesitate to contact either [name] or [name] via [telephone number].
Appendix 6

Feedback to the intensive support service
[date]

Dear colleague

Thank-you for completing the questionnaire that looked at areas you may feel you would like to develop, in order to enhance your ways of working psychologically. I am now in a position to feed back to you how comfortable the team as a whole feels when dealing with different aspects of their work and the areas that the team would like to develop.

Below I have compiled these aspects in relation to those that the team as a whole rated as feeling comfortable working with, and those that the group rated as feeling uncomfortable working with.

<table>
<thead>
<tr>
<th>Aspects uncomfortable working with</th>
<th>Aspects comfortable working with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributing to the management of substance use and abuse</td>
<td>Understanding change and transition</td>
</tr>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>Understanding epilepsy and helping service users to manage it</td>
</tr>
<tr>
<td>Responding to people with a learning disability who self harm</td>
<td>Understanding positive communication</td>
</tr>
<tr>
<td>Understanding support needs of older people</td>
<td>Understanding and protecting people with a learning disability from abuse</td>
</tr>
<tr>
<td>Contributing to the management of mental-ill health</td>
<td>Understanding and managing challenging behaviour</td>
</tr>
<tr>
<td>Understanding dementia and helping service users to manage it</td>
<td>Understanding loss and bereavement</td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
</tr>
<tr>
<td></td>
<td>Working as a member of a team</td>
</tr>
</tbody>
</table>

We also asked you to individually rank each aspect in order of how important you felt each aspect was to develop your ways of working psychologically. Due to the small number of responses, it was difficult to compile which aspects the group as a whole felt were the most
important and least important to develop. Therefore, you may find it more useful to look at each aspect in the table above, and discuss as a group, and also with [name] how you would like to use the consultation sessions. You may also have other aspects of your work that you would like to cover in the consultation session, which you can discuss with Sue.

If you have any concerns about the consultancy sessions, please do not hesitate to contact either [name] or [name] via [telephone number].
Appendix 7

Post-intervention questionnaire
Dear Colleague,

Following on from the work has been doing with you, I have included with this letter, a copy of two questionnaires that we would like you to complete.

The purpose of these questionnaires is to get an idea of how useful these sessions are, by repeating the group evaluation questionnaire you completed six months ago. [name] will be comparing the two sets of questionnaires for the staff group overall. In addition, [name] will use the information gathered from the second questionnaire to further evaluate the usefulness of these sessions. This information will be given to both your team and the Psychology Specialty about how much change your team feel has occurred over time, and about how between us we could further develop the consultation sessions.

We thank you in advance for allowing our service to work with your team, and hope that you will be able to complete the questionnaire. If you have any concerns, or would like to discuss the questionnaire, or anything related to the consultancy sessions, please do not hesitate to contact [name]or [name] via [telephone number].
Following your attendance at the consultancy sessions with [name] we would be grateful if you could complete the attached questionnaire, in order that we can evaluate this method of working.

Below is a list of aspects of psychological need that you may face within your work. We would like you to do two things. Firstly, we would like you to rate how comfortable (or confident in your skills) you feel at work when you face these by circling the appropriate number. For example, if you are not at all comfortable, please circle number 1, if you are very comfortable, please circle number 4.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding change and transition</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Contributing to the management of substance use and abuse</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding autistic spectrum disorders</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Responding to people with a learning disability who self-harm</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding support needs of older people</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Contributing to the management of mental-ill health</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding epilepsy and helping service users to manage it</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding positive communication</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding and protecting people with a learning disability from abuse</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding and managing challenging behaviour</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding dementia and helping service users to manage it</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Understanding loss and bereavement</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Promoting advocacy skills and opportunities with people who have a learning disability</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Supporting sexual expression and sexual health of people who have a learning disability</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Working as a member of a team</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

In addition, it will be helpful to know more information about the sessions. Below are a series of questions that we would like you to answer, providing as much information as you can, whilst protecting client confidentiality.
- Please list below the topics and discussions that took place during the session(s) that you attended

- Were any topics relevant to a particular aspect of your work? Y/N (please circle)
  If yes, please provide details below

- Has your attendance at these sessions changed the way that you would work with the aspect mentioned above? Y/N (please circle)
  If yes, please provide information of how your work would change.

- What is the most useful thing that you have learned from these sessions?

- Is there anything that you would have liked to cover in these sessions?

- Overall, has your attendance at these sessions prompted you to change the way that you work psychologically? Y/N (please circle)
If yes, please list below how the way that you work will change?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
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- Do you anticipate any barriers to making these changes Y/N (please circle)
  If yes, please list these potential barriers below

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

- Have you found these sessions useful/helpful Y/N (please circle)
  If no, please use the space below to say how these sessions could be more useful/helpful

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
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Appendix 8

Summary from one of the consultants about the process of these consultancy sessions
Consultation sessions commenced as per individual arrangements with consultant and respective service.

Mine has been 3-4 weekly meetings of approx 1 and a half hours, with 3 to 4 staff at a time, hopefully over the sessions aiming to meet different staff. Sessions have been open discussions facilitated by myself with content determined mainly by present participants. Facilitation has been around two themes that emerged from the first meeting: “dilemmas that the staff feel they face and need skills to work with” and “resources that they feel they have as individuals and as a team that they presently use to address these dilemmas”. These are written down on a sheet for reference at the end of each session by the participants themselves.

Follow-up on measures only partially achieved.

Meanwhile much learned qualitatively (at least for me – [name] you’ll have to address directly) in the meantime about progress/process of sessions to date in terms of e.g.:

- considerations of timescale and model of consultation – not to under-estimate the engagement phase (much like clinical work) (you will be able to find references to that in the consultation books I/you have come across

- when you engage with all roles and levels of staff in an organisation in the process of defining expectations of what’s needed and outcomes, opinions vary considerably

- its essential at an early stage of the consultation to pause and be aware/negotiate what might be the possibilities for your consultation in practice but particularly the boundaries of it. E.g. in a local authority setting – what are the clinical policies and procedures that people are obliged to work to; what is the access to training to support this relatively infrequent consultation; what are the perspectives that are emerging about frontline team support, gaps, management structures and support and discipline? The question needs to be – alongside what I’m doing as a consultant, who else needs to do what/be aware of what in order to: maximise the chance of success and change and : minimise chance of disappointment and false hope …….(I have two more sessions to do to capture all staff views, then I need to do this bit with respite care home)

- staff may have a variety of skills and ideas that might work with different individuals in practice, based on in many cases years of experience ‘on the job’, but there doesn’t appear to be a common language or shared model for this across staff (ideas bout key role of formulation and shared models of formulation are key to clinical psychology profession – could the introduction of that shared language and map in itself increase sense of competence/coherence/holistic approach? – any references re this would be interesting to find ….)
Lessons learned to date re: logistics of initiating and embedding new model of service into an organisation, in a service evaluation based way ….
Appendix 9

Hospital Anxiety and Depression Scale (HADS)
Appendix 1 – Hospital Anxiety and Depression Scale (HADS)

Name:____________________ Date:_________________

Clinicians are aware that emotions play an important part in most illnesses. If your clinician knows about these feelings he or she will be able to help you more. This questionnaire is designed to help your clinician to know how you feel. Read each item below and tick the reply which comes closest to how you have been feeling in the past week. Don’t take too long over your replies, your immediate reaction to each item will probably be more accurate than a long, thought-out response.

<table>
<thead>
<tr>
<th>I feel tense or ‘wound up’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>A lot of the time</td>
</tr>
<tr>
<td>From time to time, occasionally</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I still enjoy the things I used to enjoy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely as much</td>
</tr>
<tr>
<td>Not quite so much</td>
</tr>
<tr>
<td>Only a little</td>
</tr>
<tr>
<td>Hardly at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I get a sort of frightened feeling as if something awful is about to happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very definitely and quite badly</td>
</tr>
<tr>
<td>Yes, but not too badly</td>
</tr>
<tr>
<td>A little, but it doesn't worry me</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I can laugh and see the funny side of things</th>
</tr>
</thead>
<tbody>
<tr>
<td>As much as I always could</td>
</tr>
<tr>
<td>Not quite so much now</td>
</tr>
<tr>
<td>Definitely not so much now</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Worrying thoughts go through my mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>A great deal of the time</td>
</tr>
<tr>
<td>A lot of the time</td>
</tr>
<tr>
<td>Not too often</td>
</tr>
<tr>
<td>Very little</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel cheerful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Not often</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td><strong>I can sit at ease and feel relaxed</strong></td>
</tr>
<tr>
<td>---------------------------------------</td>
</tr>
<tr>
<td>I feel as if I am slowed down</td>
</tr>
<tr>
<td>I get a sort of frightened feeling like ‘butterflies’ in the stomach</td>
</tr>
<tr>
<td>I have lost interest in my appearance</td>
</tr>
<tr>
<td>I feel restless as if I have to be on the move</td>
</tr>
<tr>
<td>I look forward with enjoyment to things</td>
</tr>
<tr>
<td>I get sudden feelings of panic</td>
</tr>
<tr>
<td>I can enjoy a good book or radio or television programme</td>
</tr>
</tbody>
</table>
Appendix 10

Acceptance of Illness Scale
**Acceptance of Illness Scale**

Instructions: Please respond to each of the following items by choosing the number from 1 to 5, on the adjacent scale, which you feel best describes you. Then circle the number you have chosen. There are no right answers to any of the questions.

For example:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   |   |   |   |   |
|---|---|---|---|
| 1 | I have a hard time adjusting to the limitations of my illness |

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   |   |   |   |   |
|---|---|---|---|
| 2 | Because of my health, I miss the things I like to do most |

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   |   |   |   |   |
|---|---|---|---|
| 3 | My illness makes me feel useless at times |

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   |   |   |   |   |
|---|---|---|---|
| 4 | Health problems make me more dependent on others than I want to be |

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5 My illness makes me a burden on my family and friends

1  2  3  4  5
Strongly agree

6 My health does not make me feel inadequate

1  2  3  4  5
Strongly agree

7 I will never be self-sufficient enough to make me happy

1  2  3  4  5
Strongly agree

8 I think people are often uncomfortable being around me because of my illness

1  2  3  4  5
Strongly agree

Please check that you have answered ALL of the questions

Thank you
Appendix 11

Completed example of the Hot-cross bun Model
Situation: Jane wanted to transfer images she’s taken of her grandchildren, from her camera to the PC so that she can print them ready to draw them free-hand the following day:

**Cognitive**
- Self-criticism – I’ll have got the light wrong, I’ll be dissatisfied
- Catastrophising – I’ve not got the rest of the evening to face
- Awfulising – I can’t see any point to this

**Affective**
- Upset
- Depressed
- Disappointed

**Behavioural/Motivational**
- Jane doesn’t transfer the images

**Somatic**
- Tension in jaw/shoulders
- Panic
- Churned up feeling
- Loss of appetite
Appendix 12

Common thinking distortions
Common thinking distortions

*All or nothing thinking:* tendency to think in terms of extremes, e.g. something is a complete success or a complete failure

*Overgeneralisation:* thought characterised by a generalisation from one event to a number of other events

*Mental filter:* thinking which filters out positive information so that only negative information is processed

*Discounting the positive:* thoughts which dismiss the importance of a positive or helpful event

*Jumping to conclusions:* concluding something on the basis of no or little supportive evidence

*Magnification:* thinking which exaggerates the degree to which something is important

*Emotional reasoning:* thoughts which are the result of feelings being taken as primary source of evidence about an event or situation

*Personalisation:* thoughts which relate events or situations to be related to the self when this is not (or only partly) true

*Catastrophising:* thinking about events as if they are significantly more negative than they are, i.e. as if they were a catastrophe

*Mind reading/fortune telling:* thoughts which are based on estimations of what others are thinking/what will happen in the future
Appendix 13

Schema maintenance diagram
Schema Maintenance

Series of Events

“Worthless” Schema

I’m worthless

Cannot gain access

Obstacles to fly
Appendix 14

ABC chart of Ben’s aggressive behaviours
<table>
<thead>
<tr>
<th><strong>Antecedents</strong></th>
<th><strong>Behaviour</strong></th>
<th><strong>Consequences</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Who else was present?</td>
<td>What did the child do?</td>
<td>How did you respond?</td>
</tr>
<tr>
<td>What was the child doing in the 5 minutes before?</td>
<td>Duration and intensity</td>
<td>How did others respond?</td>
</tr>
<tr>
<td>What were others doing in the 5 minutes before?</td>
<td></td>
<td>How did the incident resolve itself?</td>
</tr>
<tr>
<td>Did anything immediately trigger the behaviour?</td>
<td></td>
<td>What was gained/avoided by the client?</td>
</tr>
</tbody>
</table>
Appendix 15

Department Guidelines on Parenting Strategies for Behavioural Problems
Appendix 16

Behaviour daily monitoring chart