VOLUME II

CLINICAL COMPONENT: CLINICAL PRACTICE REPORTS

BY

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A thesis submitted to
The University of Birmingham
For the degree of
DOCTORATE OF CLINICAL PSYCHOLOGY

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The University of Birmingham
June 2009
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Overview

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (ClinPsyD) at the University of Birmingham. The thesis comprises a research component (Volume I) and a clinical component (Volume II).

Volume I consists of two papers, a literature review and an empirical research study. The literature review examines studies that investigated the assessment of hand mouthing in individuals with severe to profound intellectual or multiple disabilities. The aetiology and subsequent treatment of hand mouthing as a behaviour maintained by automatic reinforcement is discussed, with a focus on the interaction between biological and environmental determinants of hand mouthing. The empirical research study examined the prevalence and correlates of self-injurious and aggressive behaviour in children with 1p36 deletion syndrome. Results from a survey indicate that self-injury is common in 1p36 deletion syndrome and is associated with overactivity and stereotyped behaviour. Aggression was found to be associated with impulsivity and repetitive behaviour. Experimental functional analyses confirmed high levels of hand mouthing with evidence of attention maintained function of self-injury. The implications of this finding for treatment are discussed, with particular reference made to shaping precursor behaviours to have a communicative function prior to the development of self-injurious behaviour. These papers are prepared for submission to *Journal of Intellectual Disability Research*. Contrary to journal requirements, tables and figures have been integrated into the text.

Volume II contains five clinical practice reports presenting psychological work conducted during placements in the specialties of child, learning disabilities, adult and older people. The first report describes cognitive and systemic formulations of a ten year old female and her family who presented with anxiety difficulties. The second report contains a service evaluation exploring the views of looked-after young people on a psychology service. The third report is a single-case experimental design used to evaluate a behavioural intervention for toileting difficulties in an 8-year-old boy with Autism. The fourth report describes a cognitive-behavioural formulation and intervention for a 32-year-old woman with depression and anxiety. The final report is an oral presentation that describes a cognitive-behavioural formulation and life story work with a 93-year-old male suffering from low mood.
Acknowledgements

I would like to express my thanks to the following people:

To my supervisors: Nicky Whitehead, Donna Walters, Cliff Hawkins, Clare Rose and Jacqueline Blyth, for their time and support, contributions to the development of my clinical skills and for helping to make all of my placements thoroughly enjoyable and rewarding.

Special thanks to my family and friends for all their support and encouragement throughout my many years of study. Finally, the work is finished.

Finally, to Malc, for his continuous interest, reassurance, humour and love, throughout.
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Clinical Practice Report 1: 
Psychological Models

Formulation of Anxiety Difficulties for 10-year-old Sophie, and her Family, 
from Cognitive and Systemic Perspectives.
Abstract

This paper presents two distinct formulations of the anxiety difficulties experienced by Sophie, age 10, and her family. Background information is presented along with some relevant material from initial and further assessment sessions. The presenting difficulties are then formulated from both cognitive and systemic perspectives. The cognitive perspective explores both onset and maintenance formulations of the difficulties. The systemic perspective focuses on circular causality, family scripts and levels of context that may have influenced the development and maintenance of difficulties within the family context. A critique of each formulation is then given, giving focus first to the usefulness of each formulation in terms of the family’s understanding of difficulties and second to the implications for intervention. All names and identifying details have been changed to maintain confidentiality.
**Background Information**

*Referral Process and Presenting Difficulties*

Sophie was referred to a district Child and Adolescent Mental Health Service by a Consultant Paediatrician after she experienced a severe stomach upset followed by some pain in the abdominal area for which no organic cause could be found. In addition Sophie’s parents felt that her social confidence had decreased after the illness and she had increased levels of anxiety about separating from parents and attending social situations.

*The Family Structure*

Sophie, aged 10 years, lives with her mother Ann, father Charlie and older brother Luke, 16 who attends college. Sophie’s eldest brother Jamie was away at University and came home to visit regularly. Sophie has close relationships with paternal grandparents, often going to stay overnight with them prior to the difficulties starting. Ann’s mother died a number of years ago due to what the family described as ‘ill health’. A genogram for the family can be seen in Figure 1 below.

**Figure 1:** Genogram depicting Sophie’s immediate family
**Initial Assessment**

Sophie attended for an initial assessment of the difficulties accompanied by her parents. At the time of initial assessment Sophie had been on a waiting list for approximately 12 months. Sophie’s parents described a real dip in her self-confidence for about the past two years following a bout of severe vomiting when she was 8 years old. Both Ann and Sophie had the stomach upset and both parents felt that the severity of the illness had frightened Sophie, particularly being sick very violently. Ann described how physically, Sophie had recovered gradually, but was left feeling very anxious separating from parents and doing the activities she was previously happy to do, such as going to Brownies, playing at friends houses, going on school trips and staying the night with grandparents. Sophie was also upset when being taken to school in the morning. Parents described that when Sophie felt anxious about something she would get very upset and cry, but on occasions when they were firm and left, she quickly began to enjoy the activity. Often the anxiety would lead Sophie to refuse to leave the house to attend social clubs etc. Additionally, at the times when Sophie was anxious about going somewhere without parents, she would describe having a ‘tummy ache’, and would seek reassurance from parents that she was not going to be sick. Both Charlie and Ann said that following the ‘tummy bug’ perhaps they had been a little too over-protective of Sophie, worrying about her continuing stomach aches and giving in to her more often than they used to when she wanted to be with them.

Sophie presented as a bright and bubbly girl, well able to express her thoughts articulately. She described feeling worried that she would be ill when her parents were not there. Sophie also described having a ‘hot flush’ and feeling sick at one friend’s house and subsequently feeling worried about going back there. Although Sophie said that she only felt worried sometimes, Charlie felt that she still worried unnecessarily, for example when losing sight of parents when out shopping or occasionally being upstairs by herself.
At the time of initial assessment the management strategies used by the family were for Ann to reassure Sophie that she was not going to be sick, and to tell her to lie down on her bed until she stopped feeling sick. Sophie felt that this strategy worked fairly well.

History
Ann’s pregnancy was unremarkable and Sophie’s birth although rushed was straightforward. Sophie was a healthy baby who met all her milestones within the normal range and often early. Sophie’s parents described her as a happy baby and the only difficulty they had was getting her off to sleep at night. She often slept in her parents’ bed and liked a parent to stay with her until she was asleep up until the age of five when she had a television put into her bedroom. Ann said that sleeping in their bed was a way they got Sophie off to sleep when she was a baby and a habit they all stayed in until the television was put into Sophie’s own room. Sophie was a happy and sociable toddler who played with other children at mother and toddler group, playgroup and school. She happily went to activities such as ballet from an early age and was always happy to separate from parents.

Education
Sophie attended a local mainstream primary school where she was achieving well academically and was on the school council. Her behaviour in school was described by the teacher as being excellent. Sophie’s attendance at school had not been affected by the difficulties nor had the teachers noticed any changes in her behaviour, other than her being a little reluctant to come into the classroom on some mornings.

The Family
Charlie and Ann described Sophie as having very close relationships with her mother and father as well as her brothers. Sophie said that at home she got on well with her brothers and in the holidays they played together and made up games on the trampoline and in the summerhouse. Luke and Jamie were described as being very fond and protective of Sophie. Parents said that both brothers were worried about Sophie’s decrease in confidence and they tried to encourage her to engage in social activities. Sophie said that she liked being the ‘little sister’ and being the only girl in the family.
Charlie and Ann described themselves as ‘older parents’, who were surprised but delighted to have a very much-wanted daughter. Charlie described himself as the ‘soft parent’ and Ann the ‘tough one’. Ann explained that being tough was hard and upsetting, particularly having to leave Sophie in distress at times. Ann expressed worries about the future such as Sophie’s transition to High school and how she would respond to her older brother Luke leaving for University around the same time. Ann said that Sophie was not the only ‘worrier’ in the family and that she too worried over many things, as had her own mother.

Further assessment
Further assessment was carried out with Sophie on an individual basis. Sophie described the physical sensations when she felt nervous as feeling warm on her cheeks, having a full and tight headache, and having butterflies in her ‘tummy’. On exploration it became apparent that her description of a ‘tummy ache’ was not associated with pain, but with a fluttery and churning feeling (labelled by Sophie as butterflies). Sophie said that when she worried about being sick she then often started to feel sick. This ‘nervous feeling’ typically happened after tea in the evening and Sophie said this was nearly always before she would be supposed to be going to Brownies, swimming etc. Sophie described her current coping strategies at these times as laying on her bed, watching The Simpsons on TV, and thinking about being with her best friend, Lily. Sophie’s picture of ‘nervous Sophie’ can be found in Appendix 1.

Sophie rated this difficulty (feeling ‘nervous’) on a scale of 1-10 as a 2 out of 10 level problem (where 0 was ‘not at all’ and 10 was a ‘whole lot’). On further exploration Sophie said that the problem preventing her from being away from mum and dad was a fear that she would be sick when they were not around. She described this as being ‘the very worst thing’. The pattern of thoughts occurring when this fear is around can be seen in Figure 3 below and original illustrations found in Appendix 2 (Thoughts leading to ‘the very worst thing’) and Appendix 3 (Thoughts leading from ‘the very worst thing’).
Figure 2: Thoughts leading to and from ‘the very worst thing’

Even if I am sick I’ll be ok, mum and dad will come

BUT, I might be ill, I might be sick....

I’ll miss out if I don’t go and I’ll be left out.....

I won’t want to leave....

I might not know the grown ups....

I’ll have a really good time....

I know I will be fine.....

This is my very worst thing

BUT, I’m being silly.....

As can be seen in Figure 3, in addition to being able to identify the thoughts that lead Sophie to worry about ‘the very worst thing’, she was also able to identify some of the thoughts she had which helped her to worry less.

Developing a Formulation

Presenting a formulation to a child and family not only serves an important psycho-educational function, but also provides a current working hypothesis, which in turn informs a planned intervention. For Sophie and her family it was useful to develop a formulation to provide enough information to help Sophie and her parents understand how the difficulties may have developed and how the plan for intervention stemmed from these ideas. The following formulations are presented in the same way as they were to Sophie and her family.
Cognitive Formulation

The main focus of the cognitive model of human behaviour is on how individuals interpret or construe the events they experience around them: it is the meaning assigned to an event that is important rather than the event itself (Ellis, 1962, in Weerasekera, 1996). According to the cognitive perspective, thinking affects feeling and behaviour, therefore any changes in feeling or behaviour are attributed to a change or disturbance in thinking. The most widely used cognitive model of anxiety is that proposed by Wells (1997) who provides a useful way of unravelling the different levels of cognitive processes by dividing them into a number of key elements. Beliefs are ‘core’ constructs that are unconditional in nature and self-relevant, for example ‘I am a bad person’ or ‘I’m worthless’. Early experiences, such as family, medical and social factors, relationship and educational issues and trauma are hypothesised to be central to the development of these core beliefs.

Assumptions people make about themselves, their performance and their future, are conditional, can be thought of as operationalising the person’s cognitive framework and describe the relationship between the thought and behaviour. They are often expressed as ‘if-then’ propositions; for example, ‘If I spend a lot of time on my homework then I will be successful’. Automatic thoughts can be thought of as the most accessible level of cognitions or thoughts that accompany problematic situations and uncomfortable feelings e.g. ‘What if I get this wrong?’ or ‘I can’t do this’. They arise from activating events that are often referred to as ‘triggers’ or ‘triggering events’, and can come in the form of words or images. Finally, there are emotional responses or feelings that are generated, which can include physiological changes associated with, for example, anxiety or anger. The behaviour that follows is said to maintain the core beliefs and assumptions, for example, a child continually correcting their homework and then getting good grades might maintain the assumption that ‘If I spend a lot of time on my homework then I will be successful’.

Stallard (2005) distinguishes between an onset formulation and a maintenance formulation. An onset formulation provides an historical account of the child’s difficulties by highlighting important experiences and their role in shaping the child’s cognitive framework. Wells’ cognitive model provides a helpful way of structuring an onset formulation. A maintenance formulation uses the key components of the general cognitive model to organise and structure the formulation whilst focusing on
individual triggering events and resulting thoughts, feelings and behaviours. Both types of formulation are presented in order to gain a comprehensive picture of the development of the anxiety difficulties and how they may have persisted.

*The Formation of Sophie’s Core Beliefs*

As the youngest child and only daughter it was evident that Charlie and Ann had always been protective of Sophie, and spoiled her in terms of attention and meeting her needs, reinforcing Sophie’s feeling of being ‘special’. When Sophie experienced the stomach upset when she was eight, Ann stated that she was perhaps even more overprotective of Sophie, and would worry about Sophie’s continuing stomach aches. These early experiences of being over-protected by parents could have led Sophie to form the core belief ‘I must never be unsafe’ i.e. being kept close and safe by her parents at all times, made being away from her parents in difficult situations (such as feeling sick) feel uncomfortable and unsafe for Sophie.

The experience of the stomach upset can be thought of as a ‘critical incident’ for Sophie, as although it is possible that the core beliefs were already being formed due to earlier life experience, the critical incident acted to reaffirm those beliefs and allowed them to become more rigid for Sophie. Previous life experience of being over-protected by her parents, followed by the critical incident may have led to Sophie developing the core belief ‘I cannot look after myself’. Following the critical incident Charlie and Ann made some allowances in terms of being with Sophie when she requested, for example, staying with her at a friend’s house whilst she was playing, just in case she didn’t feel well. At other times they allowed Sophie to opt out of attending social situations such as Brownies or Youth Club as she had a tummy ache and needed to be with them. These experiences of being provided with reassurance, together with the lifelong experience of being special, little, the only girl and overprotected may have served the function of Sophie reinforcing the core belief ‘I cannot look after myself’. The belief could have been further strengthened by Ann providing the suggestion to Sophie that she should lie down and relax to stop her from having stomach ache and feeling sick, and giving reassurance to Sophie that she was not going to be sick.
Development of Sophie’s Assumptions

There are two assumptions that Sophie was making that lead coherently on from the core beliefs identified. Clark (1986, in Wells, 1997), proposed that dysfunctional assumptions may not pre-date the first time an experience of anxiety or panic occurs, but may develop as a consequence of how the event was dealt with. In addition, once Sophie had experienced the physical sensations of anxiety on one occasion, she may then have become worried about the anxiety itself, as it felt so uncomfortable (and was perceived as feeling sick). The fact that Ann worried over Sophie’s stomach aches and told Sophie that she would stay with her ‘just in case’ she became ill or was sick again could have led Sophie to the assumption that ‘If I am on my own then I can’t cope’. The assumption that ‘If I am with my parents then I will be safe’ may then have stemmed from occasions where Sophie’s parents provided her with additional reassurance (E.g. staying with her, verbal reassurance), which reduced the anxiety allowing her to feel safe again. The repetition of this scenario could then have continually reinforced the assumptions. Although both assumptions, to an extent, for a child are functional (i.e. a child needs an adult at times to keep them safe) it had become over generalised to become a dysfunctional assumption, as it was leading to over dependence in a child of ten years old.

Sophie’s Automatic Thoughts

During further assessment and exploration of the difficulties, Sophie was able to identify a chain of automatic thoughts that happened when she was feeling anxious. These can be found in Figure 2. Sophie described that these thoughts were always triggered by the thought of an approaching social event where she would be separated from parents.

Sophie was able to describe not only a chain of negative automatic thoughts, but also some positive ones she would have to counterbalance the negative thoughts. For example, she would first think ‘if I go I might be sick’ but this thought might be followed by ‘but if I do go I’ll have a good time’. Sophie expressed that although it was helpful to think of the good things, she just couldn’t stop the negative thoughts from coming. Figure 3 below shows the onset formulation of Sophie’s anxiety difficulties.
Figure 3: Onset formulation of Sophie’s anxiety difficulties

**IMPORTANT EVENTS AND EXPERIENCES**
Stomach upset at age 8, over-protection and Reassurance from parents, very ‘special’ little girl

**Lead to the development of**

**CORE BELIEFS**
I cannot look after myself
I must never be unsafe

**Lead us to make predictions about what will happen**

**ASSUMPTIONS**
If I am on my own then I can’t cope

**These are activated by events that happen**

**TRIGGERS**
Attending a social situation e.g. Brownies, Youth Club, playing with a friend, thought of separating from parents

**Thoughts rush through your head**

**AUTOMATIC THOUGHTS**
If I go out on my own I might be ill or sick, I’ll feel bad
Mum and dad won’t be there, I won’t know the grown-ups

**Produce an emotional change**

**FEELINGS**
Anxious, scared, worried, upset about missing out
Feel sick, warm cheeks, tight head, butterflies in tummy

**Affect what you do**

**BEHAVIOUR**
Lay on bed, monitor physical sensations, seek reassurance from parents, avoid going out without parents

It was useful to use a maintenance formulation with Sophie and her family to describe a specific triggering event and the associated thoughts, feelings and behaviour. Figure 4 shows a maintenance formulation of Sophie’s difficulties.
Figure 4 – Maintenance Formulation of Sophie’s Difficulties -
A four part negative trap as completed by Sophie

**What happened?**
Mum told me I was going to be going to Brownies tonight on my own

**What did you do?**
Lie on my bed, watch tv, refuse to go, ask mum and dad to say I won’t be sick (Safety behaviours)

**What did you think?**
‘If I go to Brownies I might be sick, mum won’t be there, I won’t be able to look after myself’

**How did your body change?**
Butterflies in my tummy
Feel sick, warm cheeks, tight head

**How did you feel?**
Scared, worried, upset about missing out on the fun at Brownies

**Sophie’s Feelings and Behaviour**

Sophie described her feelings and physical sensations during the further assessment when she described and drew ‘nervous Sophie’ and ‘panicked Sophie’ (illustrations can be found in appendix 1 and 2). The physical sensations Sophie described are in line with the physiological changes that are associated with anxiety, such as feeling hot and sick, with a churning feeling in the stomach. Figure 4 above explains how the feelings of anxiety are reduced by Sophie with ‘safety behaviours’ such as avoidance of attending social situations without parents, laying on her bed, monitoring physical sensations and seeking reassurance from others. The term ‘safety behaviours’ refers to the actions that people take to prevent their feared outcome from occurring (Willson & Branch, 2006). Although these behaviours seem to serve a function to Sophie of protecting against perceived danger, they prevent exposure to disconfirmatory experiences, and the non-occurrence of the feared outcome (being sick) can be attributed by Sophie to the use of the safety behaviour, rather than correctly attributed to the fact that the feared outcome will not occur. This cycle then reaffirms Sophie’s assumption that she cannot cope on her own and needs her parents to keep her safe.
Systemic Formulation

There are many theoretical models that offer a perspective on family functioning and the interactions between individuals. Common to all of these models is the relationship between family functioning and psychological well being (Weerasekera, 1996). Rather than difficulties being viewed as inherent in an identified individual (the patient), any difficulties being experienced by an individual living in a family system are considered symptomatic of wider systemic complexities. Thus the system becomes the identified patient, not the individual.

Systemic approaches consider the difficulties that people experience in the context of the relationships in which they are constructed. They take account not only of the relationships that individuals have with one another, but also the relationships that individuals have with wider issues and difficulties and how they have been socially constructed (e.g. anxiety). As well as the family system, systemic thinking can incorporate parts of the wider system that may be having an impact on the difficulties, such as the school, community, health and social services, or friends and social clubs. In addition, it also takes account of issues such as gender, race, age and ability, class, culture, ethnicity and sexuality, family and individual belief systems. Finally, central to systemic approaches is the notion that there is no one ‘truth’ about a situation or difficulty, but that it is the meaning or construction given to them by different individuals that is important. Therefore when formulating from a systemic perspective, it is useful to emphasise that suggestions given are hypotheses put forward by the author, and not necessarily those views held by the family.

Johnstone and Dallos (2006) propose that there has been a shift in systemic approaches from an emphasis on patterns and processes towards a focus on cultural contexts. They suggest that the different ‘phases’ through which systemic theories have passed have implications for formulation. These phases are reflected by Carr (2000), who puts forward three focal points for formulation:

- Repetitive problem-maintaining behaviours
- Constraining belief systems and narratives
Historical, contextual or constitutional factors e.g. family scripts and cultural values and norms.

The following formulation will follow these three phases by examining the following three systemic concepts: circular causality, family scripts, and co-ordinated management of meaning.

Repetitive Problem-Maintaining Behaviours: Circular Causality
Carr (2006) suggests that children who develop anxiety difficulties may be part of family systems where significant family members elicit, model and reinforce anxiety related beliefs and behaviours. Furthermore, anxiety difficulties can be maintained by patterns of family interaction that reinforce the child’s anxiety-related beliefs and avoidance behaviour. The concept of circular causality rejects the idea that causality in families is a simple cause and effect relationship, and propose that instead events, behaviours, and interactions are seen in a more complex way, as mutually influencing one another (Cecchin, 1987). This pattern is referred to as ‘feedback loops’ where family system events create an endless (and beginningless) circular chain. If any element were to be removed then the chain would not exist in the same way and the pattern that was currently evident would change. It is possible to think about the anxiety that was bothering Sophie in this way. As Sophie felt anxious about leaving her parents, she would cry and say that she felt unwell. This would lead Ann in particular to worry about Sophie and her health, and to subsequently stay close to Sophie just in case she was sick. This behaviour could then have reinforced the belief system within the family that Sophie was ill and needed to be protected. This feedback loop is illustrated in Figure 5.
Sophie feels anxious about leaving mum
Sophie believes she is ill and needs protecting
Sophie cries, says she has tummy ache and feels sick
Mum stays close to Sophie in case she is sick (protects)
Mum worries about the tummy aches etc

A further concept within some systemic approaches is that of highlighting exceptions to the problem (de Shazer, 1991). Proponents of this solution-focused approach insist that there are always times when the problem is less severe or even absent altogether. The suggestion is that by highlighting what different circumstances existed, or what the individuals did different, then they can repeat what worked in the past. Ann was able to describe some occasions when she was able to worry less about Sophie, remain firm, and leave Sophie in a social situation (such as at Brownies). On these occasions Sophie calmed down and enjoyed the event. It could be hypothesised that this ‘exception’ to the usual family script and set of behaviours could lead to Sophie developing a new belief that she is alright and can cope on her own. This feedback loop is illustrated in figure 6.

Sophie feels less anxious about leaving mum
Sophie believes she is ok and can cope on her own
Sophie says she will give it a try and cries only a little
Mum is firm with Sophie and leaves her
Mum doesn’t worry as she knows Sophie will be fine

Figure 5: Possible Circular Cause for Sophie’s Anxiety

Figure 6: Possible Circular Cause for an Exception
Constraining Belief Systems and Narratives: Family Scripts

Byng-Hall (1985) described family scripts as family scenarios with a common script. Family scripts can connect generations, give meaning to a pattern of interaction, and link with shared belief systems within the family. A further function is that family scripts provide ready guidance for actions; for example, a script may define what is safe for the family and what is not safe.

There are a number of possible family scripts that may have developed over time and contributed to the maintenance of Sophie’s difficulties. The script of Sophie as the ‘little sister’ and only daughter making her special to other family members seems to have been running throughout her whole life. This may be linked to a script of ‘men as protectors’, i.e. brothers being protective over Sophie, and Charlie being the ‘soft’ one. These scripts of Sophie being ‘special’ and needing to be protected or looked after, may have led to Sophie’s belief system that she could not cope on her own during illness and must be with a parent at all times. A further script within the family could be ‘women as worriers’. Not only was Sophie perceived by other family members as a worrier, but Ann also said she herself had always worried, as had her own mother who had passed away through ill health a number of years ago. Hearing the language used within the family that women ‘do the worrying’ may have further strengthened this belief system for Sophie. When Sophie was unwell with the stomach upset, the only other member of the family to be unwell was Ann. This, together with the talk of Ann’s mother passing away due to ‘ill health’, may have created a family script of ‘women as unwell/sick’, which could have been further maintained by Sophie’s continuing tummy aches and visits to the Paediatrician.

Historical, Contextual & Constitutional factors: Coordinated Management of Meaning

Embedded in The Coordinated Management of Meaning (Cronen and Pearce, 1985) is the concept that the meaning given to conversations, behaviour, and relationships are socially constructed with different levels providing a context for the interpretations of others. Cronen and Pearce suggest that there are many different levels of context, which although arranged hierarchically, can have an effect upon one another, in either direction via contextual and implicative forces. Contextual forces are said to be the strongest and come from the higher levels of context downward. Higher levels of
context will reinforce implicative forces unless an implicative force has a different impact upwards to create change. Each different level is related to both the context above and below it and the different levels of context are fluid, and can therefore alter for different individuals, at different points in time, or for different hypotheses about a given situation or difficulty.

Sophie’s and her family’s difficulties can be conceptualised using different levels of context and Figure 7 offers a possible hypothesis for the situation that occurs when Sophie becomes anxious about going out without her mother.

At the highest level, it is possible that the historical and cultural influence of roles of women as caretakers of children, and men as protectors of their families, are having an impact on the belief systems adopted by the family. In addition, the perception that children are vulnerable and must be looked after may be influencing the way Ann believes she must behave towards her children. At the next level of context, family scripts may have been created about gender, for example, ‘women as worriers’ and ‘men as protectors’, and children: ‘children should be kept safe’. At the relationship level, the relationships that women have with worry, and the relationship between mothers and children i.e. mothers protecting their children are significant. These relationships may have played a role in leading Sophie to develop the identity ‘I am special and need protecting’, and Ann ‘I need to look after Sophie’. These scripts, belief systems and identities then may lead to the behaviours that Sophie and Ann engage in when an episode happens where Sophie must attend a social event on her own. In turn the implicative forces from the behaviours may act to reinforce the relationships and belief systems and so on.
Figure 7: Multiple Levels of Context

**Culture**
Traditional roles of women as carers, men as protectors, Role of adults as caring for children who are vulnerable

**Family Scripts**
Women as ‘worriers’
Men as ‘protectors’
‘Children should be kept safe’

**Relationship**
Females do the worrying
Mothers are protective of children

**Identity**
Sophie ‘I am special and need protecting’
Ann ‘I need to look after Sophie’

**Episode**
Sophie feels anxious about parents leaving her in a social situation

**Behaviour**
Sophie experiences physical symptoms of anxiety
Ann reassures Sophie

In the context of

Contextual force Implicative Force
Critical Appraisal

One way in which a formulation can be critiqued is on the basis of how useful it is for both the therapist and the client (Johnstone & Dallos, 2006). How useful the formulation is can be further considered in terms of understanding the difficulties and implications for intervention.

For Sophie and her family, both formulations were presented, and to an extent, could be understood in the context of one another. Both formulations examine beliefs, behaviour, and situations. The cognitive formulation put forward has a very individual focus on Sophie’s thoughts, feelings and behaviour. It allowed Sophie to develop an in-depth understanding of how her thought processes and behaviour were impacting on the way she was feeling. This psycho-educational element in itself allowed for changes to begin happening. The downside of this formulation was the possibility that Sophie could have felt blamed for the difficulties occurring due to the individual perception of the difficulties. One way in which this shortcoming could be resolved would be to incorporate one or both parent’s cognitions within the formulation (Drinkwater & Stewart, 2002), which could allow for all family members to conceptualise the difficulties Sophie was experiencing with a less individual focus. In addition, parents could have been brought into the intervention as ‘co-therapists’ in implementing cognitive behavioural strategies with Sophie (Barmish & Kendall, 2005).

The systemic formulation encompasses not only other members of the family, but broader contextual factors. The formulation was far more collaborative, and hypotheses were put forward in conjunction with the family. This collaboration may have led to a greater investment in continuing engagement with therapy as the family were part of the formulation process, leading to greater ‘ownership’ of ideas presented (Carr, 2000). A further strength of the systemic formulation is the effect of taking the focus away from Sophie as being the one with the ‘problem’. This act in itself may have led to changes within the system as family members conceptualised the difficulties in a different way.

Both formulations have implications for intervention. It could be seen as an advantage to work with a cognitive framework, with Sophie alone, particularly if
other members of the family were not willing to engage. Alternatively, a more collaborative cognitive behavioural approach could have been implemented with Sophie and her parents. The systemic formulation can allow for a wider scope of intervention, as any change within the system can create a wider impact on the system. For example, changing one of Ann’s beliefs may have an impact on Sophie’s beliefs or behaviour, which could in turn alter a family script and so on. It may be that certain important influences within the system were overlooked (for example, the school, or social systems), and inclusion would have allowed for further scope for intervention. However, the nature of the systemic approach would allow for these adjustments over time.

In conclusion, it is apparent that both formulations were of value to Sophie and her family, and in practice, an integrated approach was adopted. It was then possible for cognitive strategies to be implemented with both Sophie and Ann, and for systemic thinking to allow for changes to occur within the family system.
References


Clinical Practice Report 2:
Service Evaluation

The Views of Looked-After Young People on
Psychology and Mental Health Services.
Abstract

The following service evaluation details a survey of looked after young people’s views on mental health and psychology services. Four young people aged 16+ took part in a focus group based on current research literature and national policies on looked after children’s mental health services. From this, themes were generated to inform a questionnaire that thirteen young people aged 16+ completed. The questionnaire aimed to gain their views on finding out about mental health issues, referral routes, confidentiality, location of services, and the nature of support as well as barriers to access for young people.

The results from the questionnaire were used to make recommendations for a local psychology drop-in service for looked after young people and care leavers aged 16+. In addition, suggestions are put forward for future service evaluations, with an emphasis on the importance of gaining the views of looked after young people on mental health services. All names and identifying features have been removed to maintain confidentiality.
Introduction

The Mental Health Needs of Looked After Children

‘Looked after’ is the term most commonly used to describe all children in public care, including those in foster or residential homes and those still with their own parents but subject to care orders (DoH 1989). The numbers of looked after children have increased over recent years with over 60,000 looked after children in Great Britain being recorded in 2003 (DfES 2003). Recent prevalence studies in Great Britain have revealed that children who are looked after are almost five times more likely to have mental health difficulties than children in the general population. For example, Meltzer et al 2003, looked at the health records of 1039 looked after children across 134 local authorities in England and found that 45% of these children were identified as having a mental disorder.

So why is it that this group of children are so much more likely to have greater mental health needs? Research indicates that looked after children are already vulnerable to developing mental health difficulties by the time they become looked after, often having experienced abuse and neglect, family dysfunction and absent parenting (DoH, 2001). These experiences act as risk factors that predispose looked after children to the development of mental health difficulties in the future (Richardson & Lelliot, 2003). Furthermore, it had been suggested that the public care experiences of these children may exacerbate rather than reduce existing problems and can even create new dangers (Chambers, 2002). One group, which has begun to receive considerable attention, is those young people aged 16 years and older, who may be leaving care. Outcomes for these young people have been found to be poor, with many at social disadvantage, suffering ill health, engaging in risk-taking behaviours and having poor educational achievement (Broad, 1998).

The Importance of Focusing on Looked after Young People

In 2006 Young Minds produced the report ‘Stressed Out and Struggling’ which highlighted the importance of getting services right for 16-25 year olds. This emphasised the profound changes that occur for young people in this age group, whom for most, by the time they are 25 will have made three significant transitions:
• From the world of education to work
• From dependent relationships (being parented) to being independent (and for some, to being a parent)
• From dependent living to independent living

The focus of these transitions on becoming independent highlights the need for additional support for these young people during this period. Furthermore, research suggests that the early adult years are critical for formation of self-image, social skills and impulse control (Young Minds, 2006), which can be greatly affected by having mental health difficulties.

**Relevant Health and Social Care Policy**

Current health and social care policy context is in the midst of considerable change, and with this the mental health needs of looked after children has received welcome attention. There are a number of government policies and valuable pieces of research literature that direct services to ways in which the mental and emotional well-being of looked after children can be improved. Within these documents there are recommendations for those looked after young people aged 16+ who may be in the transition of leaving care and becoming more independent.

In 2002 the Department of Health produced the guidance document ‘Promoting the Health of Looked After Children’, which outlined several ways in which the health inequalities experienced by looked after children should be addressed. They suggested that:

• Looked after children should:
  o Have ‘timely’ access to services
  o Give their consent when accessing health care
  o Be supported in a transition from child to adult health services
  o Be offered a variety of therapeutic approaches within youth settings as well as traditional settings
  o Be offered mental health support via drama, art and other activities
The paper also outlines the vulnerability of aged 16+ young people leaving care, and the importance of leaving care services being supported by both Adult and Child and Adolescent Mental Health Services, with easy access to referral for young people.

The Green Paper ‘Care Matters: Transforming the Lives of Children and Young People in Care’ (2006) later proposed that there should be a focus on improving links between adults’ and children’s services in order to ensure an approach which continues to support looked after children as long as they need it, ensuring that young people move on in a gradual, phased, prepared and supported way.

What do the Looked After Young People Say?

Over recent years the active participation of children and young people has increasingly become a key theme across a broad range of service delivery. People have begun to acknowledge that children and young people have a right to be heard and, when listened to, can play a vital role in the planning and delivery of services (Wright et al, 2002). Following the inquiry ‘Bright Futures’ into children and young people’s mental health in 1999, The Mental Health Foundation identified a gap in service provision particularly emphasising a lack of services for young people aged 16-25 years. With this in mind, The Mental Health Foundation carried out a large-scale survey of services ‘Turned Upside Down’, and as part of this they looked into young peoples’ views on:

- The kind of mental health services they would like to be available
- Kinds of support that services would provide
- How they would like to find out about the service
- What would be most important to them

Findings from 45 young people who completed questionnaires and took part in face-to-face interviews showed that the young people:

- Would like mental health services in the form of: 24hr callout, youth projects and services, drop-ins, help lines, other young people, health services, and school based projects.
• Suggested that services should provide someone to talk to; experienced staff; emotional support; activities to be involved in; safe spaces to meet; practical help and support and to be involved in service development.

• To find out about the services through advertising, leaflets, campaigning, and directly from professionals such as their GP or the police.

• Placed importance on having someone to talk to and listen to them; understanding; receiving help and advice; staff with experience of similar problems; respect; confidentiality and support groups.

Beck (2006) explored users’ views of looked after children’s mental health services and findings mirrored those found by the Mental Health Foundation. The 29 young people who completed a survey about mental health services also placed importance on having someone available to talk to and talking to someone who had gone through similar experiences and who understood. In addition, the young people identified both physical barriers (e.g. distance to travel) and psychological barriers (e.g. only ‘mad’ people use such services) to accessing services.

**Aims of the current service evaluation**

The following service evaluation aims to elicit the views of a group of looked after young people on mental health services. Considerations of the needs of this particular group of young people will be made in light of the current research literature and the national policies that have been discussed. Outcomes from the survey will be used to make recommendations for a local ‘drop-in’ psychology service for looked after young people aged 16+, which the participants of the project all have access to. This service is currently reviewing its protocols for referral and delivery in order to improve access and utilisation of the service.
Method

Description of the Psychology Service
The psychology service for looked after young people that this survey aims to inform is a drop-in service for looked after young people aged 16 and above. The age of the young people means that many of them are in fact care leavers and no longer ‘looked after’. Figure 8 below shows an overview of the services offered locally for looked after children, to demonstrate the wider context within which the service is delivered.

Currently, the drop-in service is offered by a clinical psychologist, for one evening every three weeks, between 3pm and 6pm. The service is based at a large converted house where looked after young people and care leavers aged 16 and above can access a free meal and shower, free laundry services, social contact with other young people, and advice and support regarding housing and similar issues. At present, the young people can access one to one or group psychological support, as well as information about a range of common mental health difficulties. As suggested by the name, young people can ‘drop-in’ to access the support with no need for a referral or for making an appointment.

Figure 8: Local services for Looked After Children

Currently, the drop-in service is offered by a clinical psychologist, for one evening every three weeks, between 3pm and 6pm. The service is based at a large converted house where looked after young people and care leavers aged 16 and above can access a free meal and shower, free laundry services, social contact with other young people, and advice and support regarding housing and similar issues. At present, the young people can access one to one or group psychological support, as well as information about a range of common mental health difficulties. As suggested by the name, young people can ‘drop-in’ to access the support with no need for a referral or for making an appointment.
Design
The current service evaluation employed a survey design. The views of young people were obtained using a questionnaire devised by two Clinical Psychologists and one Clinical Psychologist in Training working within the wider looked after children’s psychology service. In addition, a focus group was held with a number of looked after young people to aid in shaping the questionnaire. The questions for the focus group were generated from current research literature and national policies on looked after children’s mental health services. As the questionnaire was designed for the current service evaluation, it was not standardised and therefore no reliability or validity data were generated. However, the Clinical Psychologists in the looked after children’s team assessed the face validity of the questionnaire and found it to be good.

Participants
The participants who took part in the focus groups were four males aged 16+ who attended the drop-in service on the day of the focus group. All of the young people attending the drop-in had been told about the focus group three weeks before it took place. On the day it took place they were then given the choice to opt-in if they wanted to. The questionnaire was offered to 60 looked after young people and care leavers aged 16+ over a 3-week period by their social worker at the 16 plus (looked after and after care) team. The participants who completed the questionnaire were 13 young people who opted-in to complete the questionnaire during an appointment with their social worker. There were 12 males and 1 female, aged between 18 and 20 years old.

Measures
The survey was designed using suggestions made by a group of looked after young people and care leavers aged 16+. The questions for the focus group were generated from the literature previously discussed and included the following:

- Access to services
  - Referral routes
  - Physical barriers
  - Psychological barriers
• Shape of services
  o What, where, when, who, how?

• Being made aware of mental health issues & services available
  o Advertising

• Confidentiality
  o What are the issues?

• Gaps in provision
  o Are there unmet needs?

Using the suggestions made by the young people during the focus group (see Appendix 5), a set of themes was developed for the survey. There were questions based around the following key areas:

• Finding out about mental health issues
• Types of mental health difficulties
• Referral routes
• Confidentiality
• Location of services
• Nature of support
• Barriers to access

The questionnaire was designed to be easy to understand, and so questions were brief and the language used was simple. The terms ‘mental health’ and ‘psychology’ services were both used as Clinical Psychologists within the looked after children’s team recognised that the young people used both terms. Some questions required the participant to tick a box to indicate agreement on an item. Other questions used a 6 item likert scale in order for the participant to indicate preferences. The final question was open and allowed for participants to add any other comments or ideas they wished to.
Procedure

Figure 9 below depicts a flow chart to demonstrate the different stages of the service evaluation.

During a regular drop-in session, young people attending the centre were told about the focus group to be taking place in three weeks time, in order to give them an opportunity to consider their own involvement and to ask questions. On the day of the focus group, those individuals wishing to take part were given an information sheet (see Appendix 4) by the lead researcher and then asked to sign a consent form (see Appendix 4). All information sheets and consent forms were explained verbally to the young people and they were given the opportunity to ask questions within the group and in private. Participants were reminded about the purpose of the study, its voluntary nature, confidentiality, and their right to withdraw at any time. Although the focus group was taped, notes were also taken by the lead researcher (see Appendix 5), and later used to generate survey questions as the sound quality of the tape did not allow for transcription. The questionnaire (See Appendix 6) was then generated using the outcomes from the focus group as well as relevant research literature and policies.
The questionnaire was then offered over a 3-week period to 60 young people by their social worker at the 16 plus looked after and after care team. Each of the social workers was asked to go through an information sheet and consent form (see Appendix 7) verbally with the young person before handing out the questionnaire for completion.
Results
The questionnaire ‘How would you like Psychology Services to be?’ was comprised of 8 questions. Due to the small number of questionnaires that were completed the results are descriptive.

Question 1: What do you think are the best ways for young people to find out about mental health issues?

This question gave a range of different ways in which young people could find out about mental health difficulties. Respondents were asked to rate each of these on a scale of 0-6 where 0 = not a good way and 6 = a really good way. Table 1 below shows that the respondents indicated the Internet, professionals, friends and magazines as the best ways in which they thought young people could find out about mental health difficulties. It also shows that the respondents felt that all the suggested ways of young people finding out about mental health difficulties were good ways rather than not so good ways. One young person suggested billboards and mobile text alerts as other ideas for young people to find out about mental health issues.

Table 1: Respondents views on the best ways to find out about mental health difficulties

<table>
<thead>
<tr>
<th>Approach</th>
<th>Mode</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internet</td>
<td>6</td>
<td>5</td>
<td>3-6</td>
</tr>
<tr>
<td>Professionals</td>
<td>5</td>
<td>4.5</td>
<td>2-6</td>
</tr>
<tr>
<td>Friends</td>
<td>5</td>
<td>4.5</td>
<td>0-6</td>
</tr>
<tr>
<td>Magazines</td>
<td>5</td>
<td>5</td>
<td>2-6</td>
</tr>
<tr>
<td>Posters</td>
<td>4</td>
<td>4</td>
<td>0-6</td>
</tr>
<tr>
<td>Leaflets</td>
<td>4</td>
<td>4</td>
<td>0-6</td>
</tr>
<tr>
<td>Television</td>
<td>4</td>
<td>4</td>
<td>1-6</td>
</tr>
</tbody>
</table>
Question 2: What kinds of mental health difficulties do you think young people need help with?

This question gave a range of different mental health difficulties for respondents to indicate those they felt young people need help with. Figure 10 shows that all 13 respondents indicated that young people need help with ‘anger’. The bar chart also shows that the majority of respondents felt that young people might need help with any of these difficulties. One young person suggested confidence as an issue that young people may need help with.

![Figure 10: Bar chart to show respondents views on common mental health difficulties](image)

Question 3: When a young person needs help from mental health or psychology services who do you think should refer them?

This question gave a range referral routes in which young people could access mental health services. Respondents were asked to rate each of these on a scale of 0-6 where 0 = not a good idea and 6 = a great idea. Table 2 shows that respondents rated the GP and social worker as the best people to refer young people to mental health services. All respondents indicated that they thought the GP, social worker, and parent/guardian were good ideas for people to refer. However, some respondents indicated that self-referral was not a good idea.
Table 2: Respondents views of referral routes to mental health services

<table>
<thead>
<tr>
<th>Referral route</th>
<th>Mode</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>6</td>
<td>5</td>
<td>4-6</td>
</tr>
<tr>
<td>Social Worker</td>
<td>6</td>
<td>5</td>
<td>3-6</td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td>4</td>
<td>4</td>
<td>3-6</td>
</tr>
<tr>
<td>Refer themselves</td>
<td>3</td>
<td>4</td>
<td>0-6</td>
</tr>
</tbody>
</table>

Question 4: We want to know what you think about keeping things private. Who do you think would need to know that you have seen a psychologist?

This question gave different suggestions for the people who may be told that a young person had seen a psychologist. Respondents were asked to rate each of these on a scale of 0-6 where 0 = not important and 6 = very important. Table 3 shows that respondents rated their social worker as the person it would be most important to be told that they had seen a psychologist. Although the modes for parent/guardian, GP and no one else show 0, the means indicate that on average, the respondents felt that it was neither unimportant nor very important to tell these individuals that a young person had seen a psychologist.

Table 3: Respondents views on keeping things private

<table>
<thead>
<tr>
<th>Who to tell</th>
<th>Mode</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0-6</td>
</tr>
<tr>
<td>GP</td>
<td>0</td>
<td>3.2</td>
<td>3.5</td>
<td>0-6</td>
</tr>
<tr>
<td>No one else</td>
<td>0</td>
<td>2.7</td>
<td>3</td>
<td>0-6</td>
</tr>
</tbody>
</table>

Question 5: Where do you think young people would feel most comfortable talking with a psychologist?

This question asked respondents to rate how comfortable they felt young people would be talking to a psychologist in different locations and at different times. Respondents were asked to rate each of these on a scale of 0-6 where 0 = not comfortable and 6 = very comfortable. Table 4 shows that the respondents rated
before drop-in sessions and at a health centre as the places where young people would feel most comfortable talking with a psychologist. The responses to this question also show that on average respondents did not feel young people would be comfortable talking with a psychologist during drop-in sessions.

Table 4: Respondents views on different places to see a psychologist

<table>
<thead>
<tr>
<th>Location</th>
<th>Mode</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before drop-in</td>
<td>6</td>
<td>4.2</td>
<td>5</td>
<td>0-6</td>
</tr>
<tr>
<td>Health centre</td>
<td>6</td>
<td>3.9</td>
<td>4</td>
<td>0-6</td>
</tr>
<tr>
<td>Connexions</td>
<td>3</td>
<td>3.9</td>
<td>3.5</td>
<td>3-6</td>
</tr>
<tr>
<td>Over the phone</td>
<td>3</td>
<td>3.6</td>
<td>3</td>
<td>1-6</td>
</tr>
<tr>
<td>During drop-in</td>
<td>0</td>
<td>2.5</td>
<td>3</td>
<td>0-6</td>
</tr>
</tbody>
</table>

Question 6: We want to know the sorts of things we could do to help young people with mental health difficulties. What kinds of things do you think would be helpful?

This question gave a range of different ways in which young people with mental health difficulties can be helped. Respondents were asked to rate each of these on a scale of 0-6 where 0 = not helpful and 6 = very helpful. Table 5 shows that the respondents felt that talking one to one with a psychologist would be the most helpful way in which young people with mental health difficulties could be helped. In addition, accessing information on mental health difficulties (posters, leaflets, websites etc) was rated as very helpful.

Table 5: Respondents views on what would help young people with mental health difficulties

<table>
<thead>
<tr>
<th>Form of help</th>
<th>Mode</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking one to one with a psychologist</td>
<td>6</td>
<td>6</td>
<td>3-6</td>
</tr>
<tr>
<td>Accessing information on mental health difficulties</td>
<td>6</td>
<td>5</td>
<td>3-6</td>
</tr>
<tr>
<td>Talking in a group with young people and a psychologist</td>
<td>5</td>
<td>3.5</td>
<td>0-5</td>
</tr>
<tr>
<td>Psychologist being around to chat with casually</td>
<td>4</td>
<td>4</td>
<td>0-6</td>
</tr>
</tbody>
</table>
Question 7: What do you think are the things that stop young people from accessing mental health/psychology services?

This question gave a number of different barriers that may prevent young people from accessing mental health services. Figure 11 shows that ‘being afraid to ask for help’ was the barrier indicated by the most respondents. At least half of the respondents felt that all five suggested barriers might prevent young people from accessing mental health services. One young person suggested that denial that there is a need for help may be one of the things stopping young people from accessing mental health services.

Figure 11: Bar chart to show respondents views on barriers to accessing mental health services

Question 8: Please tell us any other ideas you have about how we could do things better.

The respondents made several useful comments:

‘Approach young people privately and discretely’

‘Listen to what people have to say’

‘Stay close to them and let them know you care’

‘Reduce the waiting lists and make services more accessible’

‘A help book with phone numbers of services available to people, so they can ring them confidentially’
Discussion

Interpretation of Findings

This survey aimed to elicit the views of a group of looked after young people on psychology and mental health services. In addition, based on the findings from the survey, the service evaluation aimed to make recommendations for a local drop-in psychology service for looked after young people aged 16+, which is currently reviewing its protocols for referral and service delivery.

The findings from the survey show that the respondents recognised the range of different mental health difficulties that looked-after young people can experience. This awareness of different kinds of mental health difficulties perhaps reflects the research findings that looked after young people are more likely to experience greater mental health needs. In terms of finding out about mental health issues, the respondents rated the Internet as the best way to get information. In addition, respondents rated accessing information on the Internet as a good way to help young people with mental health difficulties. These findings may well reflect the rise in Internet use within this generation of young people. The suggestion for finding out about issues using text alerts also reflects the need for fast and easily accessible information. The respondents also rated finding out about mental health issues from professionals as a very good idea, an outcome also found by the Mental Health Foundation.

The finding that respondents rated talking one to one with a psychologist as the most helpful way of helping young people with mental health problems mirrors the findings by both the Mental Health Foundation and Beck, that young people would like someone to talk to and listen.

When looking at barriers to accessing mental health services, the survey found that both physical (difficulties getting there) and psychological barriers (being afraid to ask for help, embarrassment) were indicated by the majority of respondents. Again, these findings reflect those found by Beck.
Strengths and limitations of the service evaluation

Due to the small numbers of questionnaires received back it is not possible to generalise the findings beyond this small group of young people. As the questionnaire was generated solely to collect the information for the drop-in service, the method of data collection was not standardised, and was neither valid nor reliable. If future surveys are to take place then these methodological issues will need to be considered.

There were considerable difficulties with data collection during the service evaluation. Although the questionnaire was due to reach 60 young people, the method of distribution may well have hindered this. The questionnaire was distributed by the young person’s social worker, where the young person was given the option to opt-in at this stage. There are difficulties monitoring the consistency due to the distribution being carried out by a number of individuals. It may be that the young person felt that their time with their social worker was valuable and they did not want to take the time out of this to complete the questionnaire. Further, the lack of funding for the drop-in service (just one afternoon every 3 weeks) means that time allocated to research for service development would take away from direct time spent with young people.

Despite the limitations of this evaluation, there were some strengths. The inclusion of service users attempted to gain their valuable insight into the mental health difficulties of looked after young people, and the kinds of services they would find useful. The process of including young people at each stage of the research, assured their input into the generation of the survey right from the early stages. It also gave the researchers insight into the terms used by the young people, for example, for different mental health difficulties.

Recommendations

One of the primary recommendations following this survey is for future service evaluation to take place looking into the views of more looked after young people. The focus group used to generate themes for the questionnaire provided much detailed information and it is recommended that this method of data collection be utilised. Further, it is recommended that the method of distribution of any further
questionnaires should be given consideration, for example, just one researcher taking this on, to create consistency.

Although the data collected from the survey cannot be generalised, based on the findings from this group of young people, a number of recommendations for the drop-in service can be made:

- Use of the Internet to find out about mental health issues and services was indicated by the majority of respondents to be very helpful. It is recommended that the drop-in service consider setting up a website to let people know about the services offered as well as the kinds of mental health difficulties young people can experience and what can be helpful. It is also recommended that a group of young people be involved in the design and construction of such a project.

- Although self-referral was an idea generated by the focus group, and thought to be one young people would opt for in order for easy access to services, the survey did not show this finding. The GP and Social Worker were indicated as the best people to refer young people to mental health services, and this is current practice within the looked after children’s team. It is recommended that further exploration into young people’s views on self-referral take place before reviewing referral routes into the service.

- Again, an idea generated in the focus groups was that some young people might wish for complete confidentiality, suggesting that no one else know about their involvement with a service. However, findings from the survey show that the respondents did not mirror this, and indicated that the Social Worker was a very important person to know that young people had been involved with a service.

- In terms of location of service provision, interestingly, the respondents indicated ‘during drop-in’ as the option they felt young people would be least comfortable with. ‘Before drop in’ was found to be the option that the majority of respondents felt that young people would be most comfortable with. With this in mind, it is recommended that the drop-in service consider
setting aside a time specifically for seeing young people separate from the other services provided (i.e. a meal, shower, socialising). The ‘drop-in’ nature of this service supports the suggestions made by the Department of Health (2002) that looked after children should have ‘timely access’ and ‘give their consent when accessing health care’.

- The drop-in service was reviewing the different services offered, including individual and group work and access to information. Group work was not utilised by the young people attending and in addition, the young people did not often access information displayed at the centre. The survey found that talking one to one help with a psychologist was the option that most respondents felt would be most helpful to young people, as well as accessing information. However, on average group work was also rated by the respondents as a something that would be helpful. It is recommended that the drop-in service look into young people’s views of groups in more depth, in order to find out about any barriers to accessing them. Offering a range of services meets the criteria suggested by the Department of Health (2002) that looked after children should be offered a variety of approaches within youth settings as well as traditional settings.

- The respondents indicated that they felt there were a number of barriers to young people accessing mental health services, in particular, being afraid to ask for help, and difficulties getting there. In light of this, it is recommended that the drop-in service look into the current location of the service, to explore is accessibility by public transport. In addition, by increasing awareness of the service, and making it more user-friendly it would be hoped that young people would be more comfortable asking for help. Suggestions by the respondents to ‘approach young people privately and discretely’ and ‘make services more accessible’ indicate that these may be the things this group of people are looking for in a service.

- Finally, the drop-in service can be commended for providing a safe space for young people, with experienced staff and someone to talk to and listen – all needs outlined the Mental Health Foundation’s ‘Turned Upside Down.'
However, both the DoH (2002) and the DfES ‘Care Matters’ stress the importance of linking Child and Adults services for provision for looked after young people. It is therefore recommended that the drop-in service create further links with local adult services.
References


Clinical Practice Report 3:

Case Study

A Cognitive-Behavioural Formulation and Intervention for Maria, a 32-year-old Woman with Depression and Anxiety Difficulties.
Abstract

This paper presents the case study of Maria, a 32-year-old woman experiencing depression and anxiety. The presenting difficulties are introduced, followed by a discussion of the background and additional information gathered by clinical interviews and a range of psychometric measures. A formulation was put together collaboratively with Maria, and used to inform a cognitive-behavioural intervention package. An evidence-base is briefly discussed and an outline of the intervention is provided. Finally, reflections on the case follow a thorough evaluation of the intervention and therapy process. All names and identifying details have been changed to maintain confidentiality.
Presenting Difficulties

Maria, aged thirty-two years, was referred to the Primary Care Liaison Team initially by her GP, who stated that she reported having experienced low mood since the age of eighteen. The referral also stated that Maria had low self-esteem. Eight months later, after several missed appointments, the team received a second referral from a Consultant Psychiatrist. This referral stated that Maria had tendencies towards negative thinking, which she believed stemmed from her parents’ separation when she was five-years-old. It reported that she thought she was ugly, stupid, useless, worthless and selfish, and that her life was pointless. The referral detailed that Maria had poor body image, desiring plastic surgery if she had the money. An alcohol problem was referred to and said to be improving, as Maria acknowledged that this exacerbated the symptoms. Finally, the referral reported that Maria recognised that she needed to tackle her negative thinking and that she would now be willing to comply with therapy.

Initial Assessment

Assessment was carried out over four sessions; the first two were joint sessions undertaken by my supervisor and myself. During the first meeting with Maria, she described the main problem as being how she felt about herself, in particular her appearance and her weight. During this session Maria presented as very low in mood, she was tearful and cried towards the end of the session, telling us that she was consumed by negative thoughts much of the time. She said that she had no energy and struggled to get out of the bed in the morning, dreading the day ahead. Maria also described symptoms of anxiety, occurring at times when she felt others would be looking at her and feeling negative towards her. Overall, Maria said that one of the greatest difficulties was that others perceived her to be a confident individual, mainly because she was able to put on a ‘happy go lucky’ barrier in front of them.

Background Information

Over the following assessment sessions, I gradually built a comprehensive picture of Maria’s life story. She described herself as coming from a white British, working-class background. Maria’s first memory was at age five, when her parents separated. Maria had a very vivid memory of her parents arguing, and feeling confused and to blame for the separation. She remembered her childhood as being a sad and lonely
one, and found it very difficult to talk about. She described receiving no affection from any family members during her childhood. Maria had memories about her mother preventing her from seeing her father, and she felt very confused and angry about this.

Maria described hating school; she was bullied throughout high school, particularly about her appearance. Overall, Maria said about her childhood, ‘It wasn’t pleasant really, it’s like I have blocked it out completely- a numbness’. Maria said she blamed her parents for her difficult childhood and could not forgive them for this. Maria said she had been on anti-depressant medication since around the age of fifteen and she had seen a psychiatrist periodically, for monitoring.

Throughout her adolescent years Maria had difficult relationships with men, she described her first sexual experience as ‘forced upon her’. She continued in several relationships with men who at times put her down and were unpleasant towards her. Maria left school at the age of sixteen and started work on a youth training scheme which led her to work in retail for several years.

When Maria reached the age of eighteen she said she went ‘off the rails’, ‘sleeping around’ to make men like her, taking cocaine, drinking alcohol and getting into debt. Maria said she took drugs to feel better, but then the ‘come downs’ would make her feel even worse. This period lasted for several years, until Maria declared herself bankrupt, and stopped using drugs and alcohol. More than once during this period Maria said she had overdosed, however, she stated that she would never ‘have the guts’ to end her own life, as it would hurt her family too much. During this period Maria also had two pregnancies, each she chose to end in termination, finding this very hard. When asked if she ever wanted to have children, Maria said no, that she wouldn’t want them to end up like her, and if she were to split with the father, it would not be fair on the child.

From early adolescence onwards, Maria experienced gynaecological problems, mood swings that she was told were related to her menstrual cycle, as well suffering a lot of stomach and back pain and headaches. Maria felt that this had an impact on the
negative thoughts, with them being exacerbated at times when her mood was irritable and low.

At the time of assessment and throughout intervention, Maria reported no current alcohol or substance misuse, giving limited finances as the reason for this. More recently, Maria had started to binge eat, which she described as giving her the similar instant high that the drugs did. However, she then felt bad afterwards, wishing that she hadn’t eaten so much and longing to lose weight. Risk assessment was carried out during assessment and throughout intervention and Maria did not report any self-harm or suicidal ideation at any time.

After working in retail in her early twenties, Maria had just left after three years in a job working as a dental nurse. She described having applied for this job to try something different, but said that she had not enjoyed the work, feeling that she was taken advantage of by her seniors, who expected her to do tasks additional to those within her role. When we first met, Maria had just got a new job selling houses; she hoped this would be a new start. Maria was in a relationship in which she said she was unhappy, and did not want to spend the rest of her life in. Often throughout the assessment period, Maria would say that she didn’t feel she deserved to be happy, and that she felt this prevented her from doing the things she needed in order to feel better.

**Further Assessment**

To supplement the clinical interviews, and to aid evaluation post-therapy, Maria completed several psychometric questionnaires. The use of the Clinical Outcomes Routine Evaluation was a standard measure used within the Primary Care Team for all new clients. The Beck Depression Inventory and Beck Anxiety Inventory were used to gain a more detailed picture of the depressive and anxiety symptoms described by Maria. The Self-Acceptance questionnaire was used as a pre and post measure for a specific intervention. Copies of all pre-intervention questionnaires can be found in Appendix 8.
Clinical Outcomes in Routine Evaluation (CORE). The CORE is a 34-item client completed questionnaire addressing the clinical domains of subjective well-being, physical symptoms and feelings, life functioning and risk/harm (Clifford, 1998). It also provides a global index of distress, and an opportunity for therapy goals to be recorded and evaluated. The CORE has been found to be reliable and valid when used across adult mental health settings (Core System Group, 1998). Pre-intervention, Maria scored above the threshold of clinical significance on all domains as well for the global score.

Beck Depression Inventory. The BDI is one of the most widely used instruments for measuring the intensity, severity and depth of depression. It is a 21-item self-report scale that measures a range of depressive symptoms (Beck et al., 1961). The BDI has been found to be valid and reliable by numerous studies (Beck et al., 1988). Maria’s score pre intervention was 37, placing her in the ‘severe depression’ range.

Beck Anxiety Inventory. The BAI is a self-report scale comprising 21 items, each describing a common symptom of anxiety (Beck et al., 1988). The validity and reliability of the BAI has been supported by a number of studies (e.g. Beck et al., 1988). Maria’s score pre intervention was 30, placing her in the ‘severe anxiety’ range.

Unconditional Self-Acceptance Questionnaire. The USAQ is a self-report scale of unconditional self-acceptance, created as part of a study looking at self-esteem correlates (Chamberlain & Haaga, 2001). It consists of 20 statements intended to reflect the various aspects of unconditional self-acceptance philosophy and practice from the Rational Emotive Behaviour Therapy literature. When used in their study, Chamberlain & Haaga (2001) found the internal consistency of this measure to be acceptable. Maria scored 58/140 pre-intervention, which indicated poor self-acceptance.
Formulation

Maria had identified two key areas of difficulty during the assessment period; depression and anxiety, and the severity of these difficulties were supported by the outcomes on the psychometric measures. There is a sound evidence base demonstrating the effectiveness of the cognitive-behavioural approach, which is one of the most widely adopted and extensively evaluated interventions with both anxiety and depression (Fennel, 2005.). In addition, during the assessment period, Maria had expressed a need to understand more about why she experienced such intrusive negative thoughts, and why she found herself behaving in unhelpful ways. It was felt that a formulation that would clearly link past life experiences, with underlying beliefs, and resulting thoughts, feelings and behaviours, would assist Maria in this understanding. As depression had been identified as a pervasive difficulty for Maria, the formulation was based on a cognitive model of depression (Beck, 1976), which also encompassed the associated symptoms and behaviours. Beck’s cognitive model of depression suggests that the experiences we have, lead us to form ‘core’ beliefs and assumptions about ourselves and others, that are used to guide and evaluate our behaviour. However, when the assumptions become rigid, extreme and resistant to change, they become ‘dysfunctional’ (Fennel, 2005). Difficulties then come about when life events occur which either confirm or clash with the person’s belief systems. This can then lead to ‘negative automatic thoughts’. Beck suggests that these negative automatic thoughts do not cause depression, rather they are part of it, and they can lead to physical, cognitive, behavioural and motivational symptoms.

Although formulation was discussed during supervision, this was partially speculative in nature. In order to develop a more accurate formulation and to increase Maria’s understanding of the origins of her difficulties, a formulation was developed collaboratively, with the aim of using this to inform intervention. Maria expressed a wish to gain more insight into the most salient difficulties for her at the time of assessment, therefore the formulation focuses on two specific behaviours: binge eating and avoiding socialising. This formulation is presented in Figure 12.
Early experiences and the formation of core beliefs

Maria’s description of a childhood in which she felt sad and lonely, with a lack of any affection, and no friendships, led to beliefs around not being likable or lovable. Her beliefs about being unattractive, worthless, useless and stupid may be closely linked with feelings of being unlovable, and reinforced by the bullying about her appearance by her peers at school. Maria’s expression of blame towards her parents, the significance of their separation when she was young, and her first sexual experience being forced upon her, led Maria to develop beliefs around other people treating her however they wish. Furthermore, Maria consistently stated her belief that other people cannot be trusted, and she spoke about this in the context of family and relationships with men. Finally, Maria had mentioned right from the start her feeling that she did not deserve to be happy. This belief, she felt, had prevented her from taking action to help herself in the past.

Development of María’s assumptions

There are several assumptions that Maria made that lead coherently on from the core beliefs identified. Throughout the assessment, Maria expressed her assumption that if she could make herself slim and attractive, then she would be happy. She also felt that in the past, she had believed that if she had sexual relations with men, then they would like her. These two assumptions reinforce Maria’s belief about being unlovable, as she assumed that certain changes and actions would need to take place for her to be liked or loved. Maria said she believed she was worthless, and that her worth in turn depended on what other people thought about her appearance and actions. Finally, Maria consistently expressed the assumption that she was to blame for all the negative things that happened to her.

Key triggers and negative thoughts

Although Maria’s difficulties had been pervasive for a number of years, there were several recent key events or ‘triggers’ that she believed had exacerbated her symptoms. Most salient, was that Maria felt she had gained weight, reinforcing her beliefs around being unattractive. In particular, looking into the mirror, triggered automatic thoughts about being fat and ugly. Maria’s relationship with her partner had recently become difficult, and this she felt only added to her feelings of being unlovable, and not being able to trust others.
Maintenance cycles

Together, Maria and I generated two maintenance cycles; looking at the links between the thoughts, feelings and behaviours she was experiencing. Maria was able to give clear examples about her thoughts and feelings when she engaged in binge eating, and also when she avoided going out on social events. Maria explained that after binge eating she experienced a ‘rush’ or ‘high’, which was shortly followed by a ‘come down’ which she equated to that experienced after taking drugs. She felt these physical feelings continued to maintain the behaviour. We therefore incorporated this into the formulation.
Early Experiences

Parental separation (feeling confused and to blame), lack of affection during childhood, bullying about physical appearance by peers, forced first sexual experience.

Beliefs about the Self, Others and the World

‘I am unlovable’ ‘I don’t deserve to be happy’ ‘I am unattractive and worthless’
‘Other people can treat me as they wish’ ‘Other people cannot be trusted’

Assumptions or Rules for Living

‘If I am slim & attractive, then I will be happy’ ‘If I have sex with men, then they will like me’
‘I’m to blame for bad things that happen in life’ ‘My worth depends on what others think of me’

Distal Triggers

Unhappy relationship with partner; becoming bankrupt; physical health problems; weight gain – looking in the mirror

Assumptions are activated

Proximal triggers

Row with boyfriend

Invited out with friends, trying clothes on

Negative Automatic Thoughts

‘I need comfort/ a rush’
‘I need to snack to feel better’

Feelings

Anger about losing self-control; Guilt about eating; Sad/low/tearful

NAT’s

‘I’m fat’ ‘I’ll never be slim now’ ‘No one will like me if I’m not slim’ ‘It’s all my fault’

Physical symptoms

Come down/low

Rush /high

Negative Automatic

‘I look fat in all of my clothes’ ‘I’m ugly’
‘Other people will look at me’

Feelings

Depressed, sad, tearful

Feeling

Depressed, angry, sad

NAT’s

‘I have no social life’
‘I have no confidence’

Behaviour

Binge eating

Avoid going out, cry.

Figure 12: Cognitive formulation of Maria’s presenting difficulties
Intervention

Treatment Goals
Maria was asked to identify some major difficulties that she hoped therapy would help with. She said that primarily, she hoped therapy would help her to like herself, in particular her appearance, help her to be more positive and to stop ‘beating herself up all the time and being so negative’. Throughout the assessment period Maria had consistently said that she found talking about the past difficult, upsetting and not helpful to her. She said that she wanted to work in the present, and struggled to see how discussion of the past may be of benefit, despite my explanations about how this might be helpful. In order to meet Maria’s needs and take account of her wishes about the way in which she wanted to work in therapy, together we decided to focus on the negative thoughts she experienced, in particular about her appearance.

Intervention Outline
A cognitive-behavioural (CBT) intervention, which led directly on from the formulation, was therefore designed to target Maria’s negative thought patterns, and the resulting depressive symptoms. This was supported by recommendations made by the National Institute of Clinical Excellence (NICE) guidelines for severe depression, which state that CBT is the treatment of choice to be delivered by primary care, combined with anti-depressant medication (NICE, 2004). These guidelines also recommend up to eight weekly sessions of structured psychological intervention for mild/moderate depression and between sixteen and twenty sessions for severe depression. Furthermore, as anxiety was also an identified issue for Maria, the NICE guidelines for anxiety (NICE, 2004), which suggest that ‘for most people, CBT should be in weekly sessions of 1–2 hours and be completed within 4 months….it should be about 8–10 hours, should be designed to integrate with structured self-help materials, and should be supplemented with appropriate focused information and tasks’ were also considered.

After discussion with Maria about possible interventions, eight, one-hour sessions were offered on a weekly basis, together with weekly tasks and information to read. Due to the Primary Care Service limiting the maximum number of sessions to sixteen (including assessment and follow-up) it was not possible to offer more than eight
sessions for intervention. The specific areas on which Maria had chosen to focus, were binge eating and avoiding socialising, and the impact of these behaviours on her life. These she felt were affecting her life most at the time of assessment. On exploration, Maria expressed a wish to learn to like herself; to accept herself, and this she believed would have a real impact on all areas of difficulty.

In order to meet Maria’s specific goal to learn to accept herself, an intervention focusing on developing ‘Self-Acceptance’ (Chamberlain & Haaga, 2001) was put together. The sessions were developed from self-acceptance material in the Rational emotive behaviour therapy (REBT) literature (Ellis & Dryden, 1998; Dryden, 1999). Although the self-acceptance material has not been evaluated for use specifically with anxiety and depression, it has been used successfully in group settings with people experiencing depression and anxiety (Dryden, 1997). REBT has been coined ‘the original CBT approach’ (Ellis & Dryden, 1998) sharing the core tenets of cognitive behavioural approaches and has been found to be effective with a wide range of difficulties, including depression and anxiety, with people across the age ranges and both in groups and individually (Lyons & Woods, 1991; Engles, Garnefsky, & Diekstra, 1993).

The main aim of the intervention was to help Maria to change her rigid assumptions about life in order to develop a philosophy of self-acceptance. In doing so, this would allow for her belief patterns around her appearance to alter. The intervention also aimed to look at ‘unhealthy’ negative emotions such as depression and anxiety, and to develop strategies to experience more ‘healthy’ negative emotions. Below is an outline of the content of the sessions. Maria was provided with readings taken from the book ‘How to Accept Yourself’ (Dryden, 1999) to accompany each session. In addition, simplified handouts were created for each session, and samples of these can be found in Appendix 9.

**Session 1: The 10 principles of unconditional self-acceptance**

A reading entitled ‘Do you have a problem with self-esteem?’ was sent to Maria in order for her to prepare for the first session. This introduced the concept of ‘self-acceptance’, in particular how it differs from the concept of self-esteem. The session then focused on introducing the principles of self-acceptance, which were discussed in
relation to Maria’s own difficulties. Maria was pleased to have found that she could really identify with the issues discussed in the first reading, in particular, ideas around self-depreciation, as she felt this was a key issue in relation to her appearance and weight.

**Weekly task:** **Reading:** The Importance of self-acceptance.

**Session 2: Learning the ABCs**
Session two focused on healthy and unhealthy negative emotions, and identified with Maria, those which she wanted to focus on (depression and anxiety). The second objective was to work through a specific problem area using the classic ABC framework from the REBT literature, looking at the situation, thoughts and associated feelings and behaviour. Maria chose to focus on her beliefs around her appearance and weight and how this impacted on socialising. The completed ABC chart can be found in Appendix 9.

**Weekly task:** Maria was asked to complete a further ABC example for the weekly task.

**Reading:** Analyse your self-depreciation problems using the ABC framework

**Session 3: Challenging unhealthy beliefs & creating more healthy beliefs**
This session used the previous examples generated using the ABC framework to create healthy self-acceptance beliefs. Maria chose to develop self-acceptance beliefs about contributing in meetings at work. The beliefs can be found in Appendix 9.

**Weekly Task:** Maria was asked to pick two situations over the week where she experienced unhealthy self-downing beliefs and then challenge these and create healthy alternatives.

**Reading:** Question your beliefs.
Session 4: Rational-emotive imagery (REI)
Session 4 covered the rational-emotive imagery technique. Maria was asked to choose one of her ABC examples, and use this to imagine a situation where negative thoughts led to an unhealthy negative emotion. The technique then allows for rehearsal of self-acceptance beliefs with the aim of experiencing a more healthy emotion. Maria initially found this difficult, but was willing to give it a try. She chose to imagine a situation in which she would usually find herself binge eating. It was suggested that Maria try to practice the REI as much as possible over the coming week.

**Weekly task:** Reading: Strengthen your conviction in your healthy beliefs.

Session 5: Acting on healthy beliefs
As we approached the end of therapy, sessions focused on the idea of putting the thinking and imagery strategies into practice. Together we created a hierarchy of the kinds of situations in which Maria wanted to practise her self-acceptance philosophy. This hierarchy included situations such as standing in a fitness class at the gym, contributing to a meeting at work, and being surrounded by people in a pub.

**Weekly task:** We agreed for Maria to act on her healthy beliefs by working through the hierarchy of situations whilst practising her self-acceptance philosophy.

**Reading:** Act on your healthy beliefs.

Session 6: Thinking errors & Shame attacks
The penultimate session focused on reinforcing concepts and strategies introduced in previous sessions. We also discussed common thinking errors, in order to identify and challenge these. Maria identified that her most common thinking errors were mind reading, minimisation, and personalisation. Maria was guided through the concept of ‘shame-attacking’ where one purposefully puts oneself into a shameful situation in order to induce self-depreciating beliefs and practice self-acceptance beliefs.

**Weekly task:** Design and carry out a shame attack.
Session 7: Maintenance and extension of gains
Maria fed back that she had been able to carry out a shame attack, asking for the location of a building she was already in – she had been very surprised at how easy she had found this whilst practising her self-acceptance philosophy. We also worked through Maria’s ideas about how she could continue to develop her self-acceptance philosophy after therapy ceased. This included the importance of practising the techniques regularly, even when feeling well.

Weekly task: Reading: Commit yourself to maintaining and extending your developing self-acceptance philosophy.

Session 8: Follow-up
A follow-up session was provided two weeks after the final intervention session. This allowed for any questions about the self-acceptance materials, as well as completing post-therapy questionnaires, and reflecting on the therapy process. During this session Maria reflected that she felt she had benefited from the material covered during sessions, as well as having the space to come and talk to someone confidentially. We discussed the importance of continuing to work on her self-acceptance philosophy in order to maintain and increase any positive changes.
Evaluation
In terms of the effectiveness of the intervention, Maria engaged well with the self-acceptance material from the start, and was clearly able to identify with and put into practice the key principles we discussed. After the first couple of sessions, we naturally began to split the sessions into a period of reflection on the previous week, any events that had occurred and reviewing the weekly task, followed by a period of concentrating on the self-acceptance materials, and working through examples. We reviewed this and Maria said she found it helpful to allow time for reflection as well as concentrating on the planned session materials.

There were several changes throughout therapy that the psychometrics measures may not have picked up. After several sessions, Maria reported that she was regularly attending the gym. At first she spoke about hating this, particularly seeing herself in the mirror during exercise classes. However, she was very determined to lose weight and get fit, and she acknowledged that she did feel better in herself after a session at the gym. After about a month of going to the gym, Maria arrived at one session telling me that she had been to the gym and exclaimed ‘I love it!’ On exploration, Maria reported that this change had come about, as she didn’t feel so preoccupied by her appearance and negative thoughts when looking in the mirror. She described not hating her body so much anymore. Throughout the final six weeks of therapy, Maria started to go out socialising, with friends and with her partner. On her first attempt, she ended up returning home, very upset, as she felt unable to continue on to a club with her friends, as she felt she would look too fat. However, she persisted, and the next couple of outings she reported to enjoy ‘a little bit’. During the last session Maria told me she had arranged to go out with friends the following weekend, and that she was ‘really looking forward to it’. Again, this provided a context to reflect on how she felt about herself, and how the negative thoughts were no longer so intrusive. I wrote Maria an ending letter (which can be found in Appendix 10) before our final session. She said that this had impacted upon her, leading her to realise how different she now felt in comparison to the way she was feeling at the start of therapy. Reflecting my thoughts back to Maria became a key part of therapy, as she didn’t always make links about shifts that I could see may be happening.
Shortly before therapy ended, Maria had to attend an appointment regarding her gynaecological problems. She described having been told that she could have surgery to reduce her pain, but that this would leave her infertile. When faced with this choice she said she felt differently about having children now, that she would want to have that option in the future. She viewed this issue very differently to how she had when therapy commenced.

Another change that happened towards the end of therapy was that Maria began to have more difficulties in her relationship with her partner. She spoke about constant rows, and in one session told me that she had come to realise that he didn’t like the fact that she was more confident now; she felt he was holding her back. Maria had made some attempts throughout the therapy to end the relationship, but had always retracted these for fear of being alone. The day before our final session Maria asked her partner to leave and he moved out. She described feeling numb about this, but not fearing being alone, as she had come to realise that she could enjoy time being with herself. We talked about this in the context of self-acceptance, and Maria agreed that she had come to accept herself more than previously, and that in fact she quite liked herself now, and was starting to feel that she did deserve to be happy. Maria’s insight about changes that were happening during therapy had seemed limited, but towards the end she was able to appreciate the impact her relationship with her partner was having on her well-being.

**Psychometric Outcomes**

During the last session, Maria returned the post-therapy questionnaires, which can be found in Appendix 11. Together we compared the questionnaires and differences were visible even before scoring, which allowed us to explore specific changes. Figure 13 below demonstrates an observable difference in Maria’s pre and post therapy psychometric scores. She moved from the ‘severe depression’ range to the ‘minimal depression’ range on the BDI, and the ‘severe anxiety’ range to the ‘mild anxiety’ range on the BAI. At the start of therapy, Maria had scored above the cut off for clinical significance on all domains as well as the global index of the CORE. Post therapy all of Maria’s scores on the CORE other than ‘risk/harm’ had reduced (indicating lower levels of distress) and her scores in the domains of well-being and physical symptoms fell below the clinical cut off. Although the difference in pre and
post scores is significant, it is possible that Maria was aware that I would be looking for any changes, particularly in a positive direction, and that her responses reflected this.

![Figure 13: Bar chart to show Maria’s pre and post scores on psychometric measures.](image)

Interestingly, the post therapy score on the domain of risk had slightly increased. This reflected higher scores on statements to do with harm towards others, e.g. ‘I have been physically violent to others’ and ‘I have threatened or intimidated another person’. This may have been related to Maria’s relationship with her partner, which she reported to have become more and more acrimonious towards the end.

Maria’s score on the USAQ increased slightly on the post-therapy questionnaire, possibly indicating a change in how she felt about herself. However, interpretation of this shift must be taken with caution, as the USAQ is not a widely used or tested tool. Yet when discussing the USAQ statements and responses with Maria in our final session, it was evident that her thinking about accepting herself had changed,
particularly with regards to considering herself to have worth as a person, regardless of what others may think of her.

At the end of therapy Maria revisited her goals using the CORE form ‘helpful aspects of therapy’, which can be found in Appendix 11. Maria indicated on this form that she had found therapy ‘moderately helpful’, but that there were still issues that remained unresolved, which she found to be ‘slightly hindering’. When discussing the goals, Maria commented that she still could not trust people and that this may be something she would think about working on at another time. On reflection, after therapy had ceased, I wondered whether it would have been helpful to explore the trust relationship between Maria and myself, as this was not something we focused on.

Like the issue with completing the questionnaires, Maria was aware that she was required to return the goal attainment form, to me, in our session, and that we would in all likelihood be discussing this. This may well have created an additional pressure or demand for her to feel she should indicate some progress, and also would have made it difficult for her to indicate any dissatisfaction with the therapy, our relationship or my approach. In order to address this issue of confidentiality, all clients discharged from the Primary Care Team are sent an anonymous satisfaction questionnaire post therapy, and I made Maria aware of this additional opportunity to give feedback.
Reflections

Due to the fact that my supervisor was present to carry out the first two assessment sessions with Maria, I felt that I hadn’t formed an immediate relationship with her at the start. I felt that the difficulties Maria was experiencing were the most complex of all my clients, and this led me to feel some anxiety around working with her. This perhaps also impacted on the development of the relationship. Throughout the time I worked with Maria, I felt that minimal progress was being made, and this perhaps also reflected Maria’s feeling that this was the case. It was only towards the very end of therapy that I was able to see much more change in Maria, not just in terms of the changes in her day-to-day life, but also in the way she presented in sessions. She came across as more confident and described things with enthusiasm and humour. I also didn’t realise until the end of therapy just how important the therapeutic relationship had been in this case. Although Maria had taken the self-acceptance materials on board, it seemed to me that the impact of having my support, encouragement and hearing my reflections had been far greater than I had anticipated. Although the relationship, to me, had felt very difficult at the start, gradually, Maria became more relaxed, and it seemed that the relationship not only reflected this change but also influenced it.

Delivering REBT was new to me, and this led me to really focus on the terminology with a feeling of needing to ‘get it right’ for Maria. I was surprised by how readily Maria engaged with the reading materials, given that they had a strong theoretical element and covered many new concepts. It seemed that Maria’s enthusiasm for our sessions increased as she was able to identify with the self-acceptance literature and the examples given of others’ thoughts and beliefs. On reflection, more time to deliver the intervention would have been desirable, due to the complexity of some of the concepts and techniques.

In terms of supervision, I found it useful that my supervisor had met Maria in person. This gave me the feeling that my supervisor was able to identify well with the session dynamics I described to her. However, as the sessions continued, and I further developed my relationship with Maria, I felt that my supervisor might still think about Maria in the way she presented at the start, rather than the very different individual I
now experienced. On reflection, because of this, I wonder whether I tried too hard to justify to my supervisor how much progress I felt Maria had made.

On a more personal level, looking back, I think I shared Maria’s feelings of hopelessness at the start of therapy. This perhaps stemmed from an urge to ‘fix’, while feeling that her difficulties were so embedded and persistent that the effects of therapy were likely to be limited. This feeling was also perpetuated by my anxieties around working with a new client group, as well as feeling that my supervisor, who had taken part in the assessment, could do a ‘better job’ than me. Clinically, working with Maria has helped me to recognise two things. First, the time spent building on the therapeutic relationship is far more valuable than I had previously realised, not only for effectively working together on an intervention, but also to allow for valuable reflection with the client. Second, it is the changes that happen for the client that are important, not the changes that I might feel are necessary, for the intervention to be seen as successful.
References


Clinical Practice Report 4:

Single Case-Design

A Behavioural Approach to Toileting Difficulties for Jake,

an eight-year-old boy with Autism.
Abstract

This paper presents an evaluated intervention for Jake, an 8-year-old boy with autism and learning disabilities, who was experiencing toileting problems. The presenting difficulties are introduced, followed by a discussion of the background to the case. A behavioural formulation is presented, which was used to inform an evaluated intervention using an AB single-case experimental design. An evidence-base is briefly discussed and an outline of the intervention is provided. Graphical representation of the results suggests that the intervention successfully increased the number of times Jake used the toilet appropriately. The limitations of the study are discussed and conclusions drawn about the effectiveness of the intervention for Jake and his family. All names and identifying details have been changed to maintain confidentiality.
Case Summary

Referral Information
A referral was made for Jake, an 8-year-old boy, into the Community Learning Disability Team by his social worker, who stated that after a period of successful control of his bowels, Jake had started to ‘smear’. Jake’s parents were requesting support in managing the difficulty. Jake attended a short breaks unit for weekly respite, and the referral noted that Jake’s parents would like to work in conjunction with the unit staff on a management approach in order to provide consistency.

Assessment
Assessment was carried out over several sessions, which consisted of in-depth clinical interviews with both parents. To aid formulation, Jake’s parents completed daily ABC charts (see Appendix 12) to record any antecedents, behaviour related to toileting, and subsequent consequences. Jake’s parents completed daily fluid intake charts (see Appendix 13), in order to gather information linked to constipation.

A meeting with Jake’s schoolteacher was carried out to gain additional information about Jake’s toileting in school. In addition, a meeting was held with the Consultant Paediatrician, in order to further explore the severity and current treatment of Jake’s constipation.

Presenting Difficulties
The presenting difficulty was described as Jake opening his bowels onto the bathroom floor, rather than into the toilet. When this happened, if Jake got faeces onto his hands, he would then try to wipe this off onto anything nearby. It was hypothesised that the smearing was an attempt to wipe the faeces off himself, rather than for enjoyment or playing. Jake would sit on the toilet, but quickly become uncomfortable and want to get off again. He suffered from constipation and took regular medication for this, which allowed him to have a bowel movement approximately once a day. Jake’s parents had noted that he appeared as if he was in pain when he needed to have a bowel movement. They also reported that Jake had a tendency to withhold his stools and this could lead to him being in the bathroom for hours at a time before having a bowel movement. When in the bathroom, Jake would become distressed, whimpering or crying. If his parents tried to remove him from the bathroom or
intervene in any way, Jake would become aggressive. After having a bowel movement, Jake was taken for a bath. Jake’s parents had noticed that he seemed visibly relieved after having a bowel movement, and would appear calm and smile. At the time of referral, the short breaks unit had reported that Jake had smeared in his bedroom on several occasions.

The ABC charts completed by Jake’s parents showed a consistent pattern; Jake would show signs that he needed to have a bowel movement (becoming agitated, standing in a tense posture, breaking wind), would open his bowels onto the bathroom floor, and would then be bathed by a parent. This bath was functional and not for play. This pattern happened on most days. During this period, Jake had ceased having a bowel movement at the short breaks unit and the day on his return home tended to be the most difficult with regards to toileting, with Jake showing more distress.

**Background information**

Jake was the only child to his parents, Tanya and Chris. During the first assessment session, both parents reported that they had been having relationship difficulties for some time and had recently decided to separate. Tanya was sleeping downstairs in the lounge and the long-term plan was for Tanya to move out of the marital home, and for them to share the care of Jake equally. Both parents felt that the marriage had been put under considerable strain by having to manage a child with severe learning disabilities. They both reported Jake to be easier to manage when only one parent was present, and this had contributed to their decision to separate. On exploration, it became apparent that Tanya and Chris did not always manage Jake in the same way. For example, Tanya used the visual timetable more consistently than Chris did. They both felt that the difficulties in their relationship were impacting on Jake’s behaviour.

Jake and his parents had first received support from the community learning disability team when he was 4-years-old. At this time Jake had been diagnosed with autistic spectrum disorder, and a degree of learning disability. A referral was made to psychology in order for Jake’s parents to develop some strategies in encouraging him to walk, rather than use a buggy. This work later extended to introducing a visual timetable for Jake, in order to increase his routine and structure in the home. Jake was reported to have responded to the timetable very well.
Over the following four years, Jake’s parents gained various forms of support from different professionals within the team, including; a group for fathers of children with learning disabilities, support for aggressive behaviour, sleep difficulties, feeding difficulties, constipation and toilet training. During this time, there were periods when Jake was fairly settled and periods when his parents found his difficulties very hard to manage. They reported that there were times when they were less consistent with the use of Jake’s visual timetable and that he did not respond well to this or any other unexpected changes in routine.

At home Jake’s behaviour was reported to be stable, although there were occasions when he showed aggressive behaviour, particularly towards Tanya. Both parents felt that Jake’s aggressive behaviour was frequently related to needing to have a bowel movement.

Jake attended a school for children with severe learning disabilities. Although he was reported to be quite able in terms of literacy and numeracy, it had not been possible to carry out any ability tests with Jake, as he had not been co-operative during several attempts in the past. Therefore it was not possible to obtain an I.Q. score for Jake. In school, Jake’s behaviour was inconsistent, he could stay on task when redirected and responded really well to rewards for having completed a task. However, Jake would sometimes behave aggressively towards other children and staff and this tended to be during the afternoon. In school Jake was taken to the toilet regularly as part of a visually timetabled routine. He would use the toilet to urinate but despite sitting on the toilet for a five-minute period, (aided by a sand timer) after lunch each day, he had never had a bowel movement in school.

A meeting with the Consultant Paediatrician revealed that Jake had suffered from constipation for a number of years. This was managed by using a daily laxative. When examined by the Paediatrician, the fluid intake charts revealed that Jake was not currently drinking enough fluid to ameliorate the constipation.
Formulation

The initial referral for Jake identified smearing of faeces as being the main difficulty. However, during assessment, it became clear that there were two main difficulties for Jake and his parents, these were: constipation and opening his bowels onto the bathroom floor. The interactions of biological factors with operant factors have been identified as important considerations in both the assessment and treatment of constipation (Issenman, Filmer & Gorski, 1999). The formulation therefore aimed to consider how biological and behavioural factors might have contributed to the development and maintenance of both difficulties. This formulation is presented in Figure 14.

Predisposing factors

Constipation

A definition generally accepted for constipation is that of bowel movements less than three times a week (Bohmer, Taminau, Klinkenberg-Knol and Meiwissen, 2001). It is found to be more common in individuals with learning disabilities than within the general population, with studies finding up to 70% of those with severe learning disabilities to be constipated, or using laxatives more than three times a week (Bohmer et al., 2001). Recent studies have identified that gastrointestinal problems are more common in children with autism (Horvath, Papadimitriou, Rabsztyn, Drachenberg, and Tildon, 1999). Indeed, there is some evidence to suggest that constipation in children with autism not only results from problems encountered when toilet training, but also from a more specific disturbance of gastrointestinal motility (Afzal, Murch, Thirrupathy, Berger, Fagbemi & Heuschkel, 2003). Although this had not been investigated, it is possible that Jake was vulnerable to the biological abnormalities that have been found to be associated with having a diagnosis of autism.

Developmental Delay

The neurodevelopmental disabilities in children with autism make toileting problems very common, with constipation being one of the most frequent difficulties reported by parents (Dalrymple & Ruble, 1992). It has been found that specific and general developmental delay can lead to toileting difficulties (Clayden, Taylor, Loader, Borztskowski & Edwards, 2002). Jake experienced specific developmental delays, for example, his speech, social and motor milestones were delayed, as well as general
development delays, characterised by low IQ and a diagnosis of learning disabilities. These delays may have left him more likely to develop toileting difficulties.

**Precipitating factors**
Research evidence shows that secondary toileting difficulties (i.e. those not present from birth) may be precipitated by biological factors such as dietary change, for example, a low fibre diet and water deprivation, which may lead to chronic constipation (Carr, 2006). Reports from Jake’s parents indicated that Jake ate a very limited diet, which tended to be low in fibre. In addition, the fluid intake charts showed that Jake was not consuming enough fluid.

**Maintaining factors**
Several studies have established that children with chronic constipation withhold stools in an attempt to ease pain and discomfort (Issenman, Filmer & Gorski, 1999). The problem can begin when a child experiences pain upon passing a stool leading to the onset of ‘holding-in’ (Grey & McClean, 2007). This difficulty then maintains itself, as the act of withholding leads to formation of larger stools, resulting in more painful bowel movements. The act of withholding is negatively reinforced by the avoidance of the discomfort associated with passing a stool. This is also referred to as avoidance conditioning or avoidance learning, where an individual behaves in a way that will prevent or postpone an aversive event (Kazdin, 2001). The ABC charts indicated that Jake was withholding, for example, by adopting a tense posture and clenching his buttocks. The withholding might also explain why Jake would not stay sitting on the toilet and instead would open his bowels onto the bathroom floor, as it is more difficult to withhold whilst sitting over the toilet.

It is also possible that parental attention following Jake having a bowel movement on the floor, such as attending to Jake whilst cleaning him up, positively reinforced the behaviour, therefore increasing the likelihood of it happening again. In addition, it may have been that the sensation of the warm water in the bath provided a positive sensory experience for Jake, again acting as a positive reinforcer.
Figure 14: Formulation of Jake’s toileting difficulties.

**Predisposing factors**

- Low fibre diet
- Low fluid intake
- Neurodevelopmental disabilities
- Possible biological abnormalities

**Presenting difficulty 1:** Constipation

- Pain on passing a stool
- Withholds stools
- Avoidance of using the toilet

**Presenting difficulty 2:** Opens bowels onto the floor

- Parental attention & sensory experience from bath
- Avoidance of pain from passing a stool

**Negative reinforcement**

**Positive reinforcement**
Data Collection
The data collected in the study were in the form of ABC charts completed by Jake’s parents (see Appendix 14 for an example from the intervention phase). These monitoring forms were completed during the assessment period, and were then continued throughout the baseline and intervention phases. Due to the shared care of Jake, both parents participated in completing the monitoring forms. Baseline data were collected over a period of five weeks (this included the assessment period), to allow for a sufficient number of data points. Practical and ethical considerations did not allow for the baseline phase to be continued over a longer period of time. The difficulties were leaving the family under considerable stress and they were keen to intervene as soon as possible.

Design
The study employed an A-B design, which examines the effects of an intervention by following the baseline condition (A phase), when no intervention is in effect, with an intervention condition (B phase). The independent variable was the intervention previously described, and the dependent variable was the number of times Jake had a bowel movement in the toilet. Alternatives to this design were identified, but considered to be unsuitable. Whilst the more experimentally rigorous ABAB (where the A and B phases are repeated again) and ABA (baseline, intervention, return to baseline) designs can allow for more conclusive data, due to the element of withdrawal of treatment, they were considered ethically unacceptable in this case. Kazdin (2001) identifies that problems related to reversing behaviour can make the ABAB design and its variations undesirable in some clinical settings. Indeed, at the point of intervention, Jake was experiencing a considerable amount of distress and his parents were under high levels of stress, making a possible return to this situation an unfavourable option.
**Intervention**

Research has shown that results from using medication alone to treat constipation are often disappointing, possibly due to a failure to address other maintaining factors (Bohmer et al., 2001). Whilst there is a strong evidence base for the treatment of constipation with behavioural methods (Lancioni, O’Reilly & Basili, 2001), a combined approach, with both medical and behavioural treatment being utilised, can provide a more comprehensive intervention. The formulation was from a behavioural perspective, but also considered relevant biological factors in how the difficulties developed. The intervention, which was devised collaboratively with Jake’s parents, therefore had two main components: medical and behavioural.

**Medical component**

The aim of the medical component was to soften Jake’s stool in order to alleviate any pain he was experiencing before and during having a bowel movement. This would also make withholding more difficult. Jake’s medication was reviewed in collaboration with the Consultant Paediatrician who recommended increasing the laxative medication, particularly on the days when Jake attended the short breaks unit. Increasing roughage foods, decreasing dairy food and increasing fluid intake have all been found to alleviate constipation (O’Brien, Ross & Christophersen, 1986). Therefore, a referral was made to a dietician who supplied information about ways to provide a fibre rich diet for Jake. In addition, Jake’s parents were advised to increase Jake’s daily fluid intake to at least 8 x 150 millilitre drinks per day, in order to aid the softening of his stools.

**Behavioural component**

The behavioural component led directly on from the formulation. It aimed to address the withholding as well as the issue of Jake opening his bowels onto the bathroom floor. The intervention took place during the six-week school summer break, and was therefore designed to be applicable to the home environment. At the time of intervention, Jake had ceased to have a bowel movement at the short breaks unit, and so his parents chose to focus on toileting at home in the first instance, with the aim of generalising the intervention at a later time. It was hoped that in time, Jake would generalise the new toileting routine across other settings, such as the short breaks unit,
the school and toilets in public places. Generalisation refers to the transfer of a response to situations other than those in which training takes place (Kazdin, 2001).

The use of a visual timetable was implemented, as Jake was known to respond well and quickly to this kind of tool (see Appendix 15 for a sample of the symbols used). Symbols of this kind have been shown to help children with autism not only by presenting visual cues, but also by providing a system of communication which can foster speech (Jordan, 2007). Due to the success that the school had had in using a five minute sand timer to get Jake sitting on the toilet this was used in the intervention to provide continuity between the two environments.

Behavioural treatments for toileting difficulties typically involve scheduled toileting, laxatives, and reinforcement (Lancioni et al., 2001). It was clear from the ABC charts that Jake was already able to make the association between feeling the need to have a bowel movement, and going to the bathroom, therefore it was felt that scheduled toileting was not necessary. The intervention therefore focused on immediate reinforcement of appropriate activities, which were identified as spending no more than five minutes in the bathroom and having a bowel movement in the toilet.

To positively reinforce the first desired behaviour (staying in the bathroom for five minutes only), an activity reinforcer was employed, as this held the advantage of being low cost with the possibility of being changed over time to increase desirability. Jake’s parents were asked to select a toy or activity that they felt would be highly desirable and rewarding to him. Jake had been requesting a new space hopper and so his parents bought one to be used as a reward activity. An additional advantage of using the space hopper was that it encouraged Jake to adopt a relaxed posture, therefore inhibiting any withholding.

When Jake showed signs that he needed to have a bowel movement, or was withholding (becoming agitated, standing in a tense posture, breaking wind), Jake’s parents were instructed to show him the visual timetable and then direct him to use the toilet for five minutes only (using the sand timer) and this was followed by an opportunity to play on the space hopper. This process was then repeated until Jake had a bowel movement.
As a reward for the second desired behaviour (having a bowel movement in the toilet), Jake’s parents felt that a ‘fun’ bath would be appropriate, incorporating lots of verbal praise and attention from a parent. This was something they reported that Jake really enjoyed, but due to the fact that baths tended to be functional after Jake had smeared, the fun bath remained novel to him. Numerous studies have found that social reinforcers from a parent, such as verbal praise, attention and physical contact can exert considerable control over a behaviour (Kazdin, 2001). In addition, Jake’s parents reported that he responded very well to verbal praise and attention in other situations.

If Jake had a bowel movement on the bathroom floor, parents were instructed to give him a functional bath or wash, if necessary, with no verbal praise and limited parental attention. Written guidelines for the intervention, which were provided for Jake’s parents, can be found in Appendix 16.
Results
Table 6 shows the number of times the target behaviour of Jake having a bowel movement in the toilet occurred during the baseline and intervention phases. As can be seen from the table, the number of times Jake used the toilet increased during the intervention phase. In addition, the number of times Jake opened his bowels onto the bathroom floor decreased during the intervention phase.

Table 6: Table to show number of times Jake used the toilet during baseline and intervention phases

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used the toilet</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Used the floor</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

Although table 6 demonstrates an increase in the target behaviour, the data have been displayed graphically in figure 14 in order to examine the pattern of results in more detail. It is interesting to note a period of ten days, between days 51 and 61, where no data were recorded. On exploration, it became apparent that this had occurred when Jake suffered persistent diarrhoea and vomiting, and was not in control of his bowels. The intervention had therefore not been carried out during this period. Visual inspection of the data gives the impression of an ABAB design, where the initial baseline and intervention are repeated. The ten day period without intervention imitates a second baseline phase. This will be discussed in more detail further on. A second observation reveals an unstable baseline, where the target behaviour had already occurred just prior to the intervention phase. This will also be commented on further in the discussion section.

Analysis
As the data were binary, a test for autocorrelation was not performed. A chi square was employed to analyse the rate of change during the intervention phase. There was a significant association between the phase (baseline or intervention) and location of bowel movement (bathroom floor or toilet), $\chi^2 (1, N = 1) = 10.06, p < .01$, showing a significant difference in the use of the toilet between the baseline and intervention phases.
Figure 14: Graph showing number of times Jake used the toilet during baseline and intervention phases
Discussion

Kazdin (2001) states that the most fundamental design characteristic of a single-case experimental design is the reliance on repeated observations of performance over time. This would usually be before the intervention is applied and then continuously whilst it is in effect. Although this single case design meets this requirement, before conclusions can be drawn about the effectiveness of the intervention, it is first necessary to consider a number of limitations to the design as well as the way in which it was implemented.

Given that baseline data are used to predict how a client will behave during an intervention phase, it is important that the data are stable. If a baseline begins to show an improvement, this questions the necessity of intervening at all. Jake did carry out the target behaviour on two occasions just prior to the intervention, making the baseline unstable. Ideally, it would have been more effective in this case to record data over a longer baseline period. However, due to the considerable stress the family were under, coupled with the expectation that the planned intervention was going to begin, it was not considered appropriate to delay the intervention. In addition, although Jake had used the toilet prior to the intervention phase, he was still spending considerable periods of time in the bathroom, where he became increasingly distressed. Introducing the behavioural intervention, which aimed to reinforce Jake spending just 5 minutes at a time in the bathroom, was therefore considered to be of benefit. Furthermore, the paediatrician had recommended that Jake’s medication, diet and fluid intake be addressed as a matter of urgency and so medical intervention for the constipation at this stage was considered essential.

The issue of where the A phase (baseline) ends and B phase (intervention) begins can also be questioned in this case. It can be argued that as soon as contact is made with a client, intervention has begun. The assessment sessions and completion of monitoring forms, as well as discussions that Jake’s parents had with the paediatrician and the dietician may all have impacted on the way they approached Jake’s difficulties before the planned intervention had even begun, thus influencing the target behaviour. This may explain why Jake used the toilet before the specified intervention had begun.

As mentioned earlier, there are limitations in carrying out an AB design. The main limitation is that without returning to baseline after the initial A and B phases, it is not possible to determine whether the intervention was responsible for any observed changes. It may be that
change was coincidental, and would have happened over time whether or not the intervention had happened. This shortcoming could have been addressed by the use of a multiple baseline design, which can demonstrate the effect of an intervention across different situations. For example, if circumstances had allowed, the intervention could have been implemented in the school and at the short breaks unit. Indeed, it was planned that the intervention be applied in school after the summer break. The advantage of multiple baseline design is that it can demonstrate the effect of an intervention without a return to baseline condition, where intervention is withdrawn. Whilst two baselines (situations) are considered a minimum, three can really strengthen the demonstration (Kazdin, 2001), particularly if a stable baseline is recorded. Therefore, intervention at home, in the school and at the short breaks unit, following a longer baseline period to allow for stability, would have provided a more rigorous design allowing for more plausible conclusions to be drawn.

During the intervention phase Jake’s parents commented that there had been a reduction in stress for the whole family. This highlighted the importance of implementing more than one measure of effectiveness, and on reflection, it would have been useful to carry out a measure of stress with Jake’s parents during baseline and intervention phases. In view of reports like this from parents, the community learning disability team are subsequently routinely implementing a measure of parenting stress and a developmental behaviour checklist, at every screening appointment, during intervention and again at discharge. On discussion with Jake’s parents, it also became apparent that the reduction of stress was not only due to the increase in Jake using the toilet appropriately, but also due to the decrease in the length of time spent in the bathroom. Although this data was not recorded, verbal reports from parents indicated that prior to intervention, Jake could spend anything from an hour to several hours in the bathroom each day. Additional data collection of time spent in the bathroom, as well as whether Jake used the toilet appropriately would have allowed for trends in the data to be identified as well as further statistical analysis.

A further limitation to the case study was that the separate components of the intervention may have confounded one another. The simultaneous medical and behavioural interventions prevent conclusions from being drawn about whether one element was responsible for the change, or whether it was the combination of both that may have impacted on the difficulties. One way in which this could have been addressed would have been to carry out an ABC design, where the medical and behavioural components would have been carried out
separately following a baseline. For this to have been considered ethically acceptable, the medical component would have needed to precede the behavioural component, due to the advice from the paediatrician that changes to medication, diet and fluid intake were in Jake’s best interest. Due to the need for the medical and behavioural components to be combined in order for the intervention to be most effective, this design was not considered for this case.

A reliance on Jake’s parents to carry out the intervention and to record all data limits the reliability of the data. It is possible that the intervention was not carried out consistently, or that the data recorded did not accurately reflect events that occurred. It may be that Jake’s parents reported more change than actually occurred, due to feeling that Jake’s success reflected on their abilities to implement the intervention. However, it would be difficult to monitor an intervention of this kind in any other way. Due to the nature of the difficulties, video recording would not have been appropriate, as it would have compromised Jake’s privacy.

When drawing conclusions, it is necessary to consider the effectiveness of the intervention in light of all of the limitations discussed. Despite the limitations to the design and its application, Jake’s parents reported an improvement in his difficulties, and the results do support this claim, showing a significant difference in the use of the toilet between the baseline and intervention phases. The imitation of an ABAB design serves to further strengthen this claim, given the continued increase in Jake using the toilet appropriately even after what was in essence a withdrawal of the intervention. The reports of a reduction in stress for the whole family also suggest a clinically effective intervention. However, the future application at school and at the short breaks unit will serve to determine further the effectiveness of the intervention.
References


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Clinical Practice Report 5:
Oral Presentation

Case Study: Life Story work with Victor, aged 93 years.
Abstract

This case study details a life review intervention with Vincent, a 93-year-old gentleman with depression. Victor was referred to a Psychology Service for Older People by his GP, after having become frustrated by his declining physical health, deterioration in memory and sleep difficulties. The home manager where Victor was a resident reported that over the previous six months Victor had also withdrawn from his usual activities, isolating himself from others. Information gathered at assessment indicated that Victor was low in mood, had decreased activity levels and underlying negative thought patterns. He expressed a wish to share his life story. No formal assessment measures were used and the rationale for this is given. A speculative cognitive formulation is presented, drawing together information gathered from clinical interviews with Victor and the home manager. A brief evidence-base for life review is discussed, which gives support for the use of life story work with older people suffering from depression. This was used in conjunction with the cognitive formulation to inform an eight session life story work intervention with Victor. Additionally, four consultation sessions with the home manager were given to assist staff in supporting Victor. Conclusions are drawn about the effectiveness of the intervention for Victor, based on self-reports and observations made by staff. Following the intervention Victor had resumed his daily activities and interactions and commented on improvements in his mood. Staff noted that his mood had ‘lifted’ and that he was no longer worrying over trivial matters. Finally, reflections on the limitations of the intervention are given in light of time restrictions and appropriateness of psychology involvement. Reflections about the process are made in relation to collaborative working with other agencies and the impact of ending therapeutic relationships on both personal and professional development. Identifying details have been changed to maintain confidentiality.
References


Appendix 1:
CPR 1: Illustration of ‘nervous Sophie’
Illustration of ‘nervous Sophie’
Appendix 2:
CPR 1: Thoughts leading to ‘the very worst thing’
Thoughts leading to ‘the very worst thing’
Appendix 3:
CPR 1: Thoughts leading from ‘the very worst thing’
Thoughts leading from ‘the very worst thing’
Appendix 4:
CPR 2: Information and Consent Form for Focus Group
Please read this information carefully before you decide if you want to take part:

We are interested in what it is like for looked after young people who might want to receive help from psychology or mental health services.

**We are very interested in**
- Things you think would be helpful
- Things you think would not be so helpful
- Your ideas about how we can do things in a better way

**Why are we interested in this?**
- It will help us to understand what looked after young people want from services
- It will help us to plan and provide the right kind of services for looked after young people in the future

**What will happen?**

If you want to take part, you can take part in a group discussion with other young people about what you think about mental health services and psychology.

We are interested in hearing about the things you think might be helpful, the things you don’t think would be helpful, and your ideas for doing things in a better or different way.

We will be making a tape of the things that people say to help us remember what was said. If you take part, everything you say or do will be kept private. If we write about what was talked about then your name will not be used. No one with know that you have joined in.

If you want to leave before the end you can. If you change your mind about joining in that is ok.

*If you decide you do not want to take part then this will not affect any help you are currently receiving from psychology or mental health services*
I confirm that I have read and understood the project explanation sheet for the above study and have had the opportunity to ask questions.

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

I agree to participate in the above study.

Please fill in your name here...

Thank you 😊

FOR OFFICE USE ONLY
Signature of researcher ................................. Date..............
Focus group notes: 16+ drop in centre

- Verbal project explanation given by lead researcher
- Consent forms read and signed
- Discussion about destroying tape at end of project

- Themes given by researcher in bold.
- Ideas given by participants in italics.

- Access to services
  - Referral routes/self referral
    - Doctor, GP, social worker, mentor, college tutors, psychologist, school nurse, parent/guardian.
    - Self-referral – intimidation – talking to people you don’t know – some people can do this, others can’t.
  - Physical barriers – travel
    - Yes this can be an issue, getting lifts, bus fare
  - Psychological barriers – stigma
    - Stereotyped, ‘freak’, ‘psycho’ (if seeing a psychiatrist)
    - If people see you coming out – big worry

- Shape of services
  - What?
    - Groups? We’re bored of the classroom way (shaking of heads), not really
    - Groups? For people with the same types of problems. Some people feel alienated, have trust issues, need to be friendly, have sofas, massage chairs, bean-bags, drinks, cups of tea, get to know each other with ice-breakers & team-building, taking things slowly.
    - Being in care – problems: bullying (by foster parents); anything; depression; isolation; suicide feelings; sexually harassed; anger management
    - What would make it better? One to one, not a group.
Where? Settings/premises

- In our homes as confidential, private and no stigma, somewhere near like a local community centre.
- At college? Getting stick, people finding out and taking the mick, school would be worse than college, need to be something anonymous and discrete.
- At the GP surgery? What people may think about why you are there.

When? Crisis – 24hr, help-lines

- A 24hr helpline would be good

Being made aware of services available

Advertising?

- Yellow pages, booklets with all the info in, at Connexions, youth clubs, training schemes, library, summer groups.

Confidentiality

What are the issues?

- Professionals sharing information – don’t like it but understand why
- Telling anyone – not unless there is a risk, what about signing something the first time you come to say this is ok?
- At drop in? Need somewhere private and quiet. Could tick a box for times and then don’t have to give a name.
- Do it over the phone or at home, take the psychologist to the person.

Gaps in provision

Unmet needs?

- Need for more ‘helping’ people, counselors
- There are enough social workers
- What’s there is good
- Three most important things about a service
  1. Appearance/ environment
  2. Convenient access
  3. Self-referral possible & kept private
Appendix 6:
CPR 2: Questionnaire: How would you like Psychology Services to be?
How would you like Psychology Services to be?

Male ☐ Female ☐ Age ___________ Ethnicity______________________

1. What do you think are the best ways for young people to find out about mental health issues?

<table>
<thead>
<tr>
<th>Method</th>
<th>Not a good way</th>
<th>Neither a good nor a bad way</th>
<th>A really good way</th>
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</thead>
<tbody>
<tr>
<td>Posters</td>
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<td>Leaflets</td>
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<td>Internet</td>
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<td>Television</td>
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<tr>
<td>Magazines</td>
<td>0</td>
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<td>2</td>
</tr>
<tr>
<td>Professionals (Social workers, psychologists etc)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other – any ideas?</td>
<td>0</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

2. What kinds of mental health difficulties do you think young people need help with?

(Please tick as many as you think)

- Sleep Problems
- Low mood
- Eating Problems
- Stress
- Hurting themself
- Upsetting thoughts & feelings
- Problems getting on with people
- Other? (please tell us your ideas)

- Anger
- Substance misuse (drugs/alcohol)
- Worries
- Panic attacks
- Hurting other people
- Paranoia
- Coping with abuse

----------
3. When a young person needs help from mental health or psychology services who do you think should refer them?

<table>
<thead>
<tr>
<th>Not a good idea</th>
<th>Neither a good nor a bad idea</th>
<th>A great idea</th>
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<tbody>
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</table>

They should be able to refer themselves 0 1 2 3 4 5 6
Their Social Worker 0 1 2 3 4 5 6
Their Parent or Guardian/Carer 0 1 2 3 4 5 6
Their GP 0 1 2 3 4 5 6
Anyone else? 0 1 2 3 4 5 6

4. We want to know what you think about keeping things private. Who do you think would need to know that you have seen a psychologist?

<table>
<thead>
<tr>
<th>Not important</th>
<th>Neither unimportant nor very important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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<td>5</td>
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</tbody>
</table>

Your parent or guardian/carer 0 1 2 3 4 5 6
Your Doctor/GP 0 1 2 3 4 5 6
Your Social Worker 0 1 2 3 4 5 6
No one else 0 1 2 3 4 5 6
Other - any ideas? 0 1 2 3 4 5 6

5. Where do you think young people would feel most comfortable talking with a psychologist?

<table>
<thead>
<tr>
<th>Not comfortable</th>
<th>Neither comfortable nor uncomfortable</th>
<th>Very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>3</td>
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<td>5</td>
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<tr>
<td>6</td>
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</tbody>
</table>

Before drop-in 0 1 2 3 4 5 6
During drop-in 0 1 2 3 4 5 6
At a health centre 0 1 2 3 4 5 6
At Connexions 0 1 2 3 4 5 6
Over the phone 0 1 2 3 4 5 6
Other - any ideas? 0 1 2 3 4 5 6
6. We want to know the sorts of things we could do to help young people with mental health difficulties. What kinds of things do you think would be helpful?

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Neither helpful nor unhelpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>6</td>
<td></td>
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</tbody>
</table>

Talking one to one with a psychologist

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Neither helpful nor unhelpful</th>
<th>Very helpful</th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>6</td>
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</tbody>
</table>

Talking in a group of young people with a psychologist

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Neither helpful nor unhelpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>6</td>
<td></td>
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</tr>
</tbody>
</table>

Having the psychologist around to chat with casually at drop-in

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Neither helpful nor unhelpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>3</td>
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<td>5</td>
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<td>6</td>
<td></td>
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</tbody>
</table>

Being able to access information about mental health difficulties (posters, leaflets, website etc)

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Neither helpful nor unhelpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

7. What do you think are the things that stop young people from accessing mental health/psychology services? (Please tick as many as you think)

- Embarrassment
- Difficulties getting there
- Not knowing how to get help
- Being afraid to ask for help
- Thinking there is a long waiting list

Other __________________________

8. Please tell us any other ideas you have about how we could do things better:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you ☺
Appendix 7:
CPR 2: Information and Consent Form for Questionnaire
Please read this information carefully before you decide if you want to take part:

We are interested in what it is like for looked after young people who might want to receive help from psychology or mental health services.

**We are very interested in**

- Things you think would be helpful
- Things you think would not be so helpful
- Your ideas about how we can do things in a better way

**Why are we interested in this?**

- It will help us to understand what looked after young people want from services
- It will help us to plan and provide the right kind of services for looked after young people in the future

**What will happen?**

If you want to take part, you can fill in the questionnaire attached to this sheet. This should take no more than a few minutes. Everything that you write will be kept private. If we write about what you put on your questionnaire then your name will not be used. If you change your mind about us using your questionnaire at a later time then this is ok.

**If you decide you do not want to take part then this will not affect any help you are currently receiving from psychology or mental health services**

I confirm that I have read and understood the project explanation sheet for the above study and have had the opportunity to ask questions.

I understand that taking part in the study is voluntary and that I can request that my questionnaire be destroyed at any time without giving reason.

I agree to participate in the above study.

Please fill in your name here...............................................................

Thank you ☺
<table>
<thead>
<tr>
<th>Statement</th>
<th>Least of All</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>More or all the time</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have felt terribly alone and isolated</td>
<td></td>
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</tr>
<tr>
<td>2. I have felt tense, anxious or nervous</td>
<td>❑</td>
<td>❑</td>
<td></td>
<td></td>
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<tr>
<td>3. I have felt I have someone to turn to for support when needed</td>
<td>✓</td>
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<tr>
<td>4. I have felt O.K. about myself</td>
<td>4</td>
<td>0</td>
<td>3</td>
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<td></td>
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<tr>
<td>5. I have felt totally lacking in energy and enthusiasm</td>
<td>✓</td>
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<tr>
<td>I have been physically violent to others</td>
<td></td>
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<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>7. I have felt able to cope when things go wrong</td>
<td>✓</td>
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<td>8. I have been troubled by aches, pains or other physical problems</td>
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<td>9. I have thought of hurting myself</td>
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<td>✓</td>
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<tr>
<td>10. Talking to people has felt too much for me</td>
<td>0</td>
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<td>✓</td>
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<tr>
<td>11. Tension and anxiety have prevented me doing important things</td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>12. I have been happy with the things I have done.</td>
<td>4</td>
<td></td>
<td></td>
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<td>✓</td>
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<tr>
<td>13. I have been disturbed by unwanted thoughts and feelings</td>
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<td>✓</td>
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<td>14. I have felt like crying</td>
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Please turn over
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<td>49.</td>
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</table>

**Over the last week**

1. I have felt or been physically or mentally unwell.
2. I have thought about ending my own life.
3. I have been unable to do work or job-related activities.
4. I have been unable to do everyday activities.
5. I have had difficulty getting to sleep or staying asleep.
6. I have felt my problems were too much for me to handle.
7. I have been unable to do work or job-related activities.
8. I have been unable to do everyday activities.
9. I have had difficulty getting to sleep or staying asleep.
10. I have been physically or mentally unwell.
11. I have thought about ending my own life.
12. I have been unable to do everyday activities.
13. I have felt my problems were too much for me to handle.
14. I have been unable to do work or job-related activities.
15. I have felt my problems were too much for me to handle.
16. I have been unable to do everyday activities.
17. I have been unable to do work or job-related activities.
18. I have had difficulty getting to sleep or staying asleep.
19. I have felt my problems were too much for me to handle.
20. I have been physically or mentally unwell.
21. I have thought about ending my own life.
22. I have been unable to do everyday activities.
23. I have been unable to do work or job-related activities.
24. I have felt my problems were too much for me to handle.
25. I have been physically or mentally unwell.
26. I have thought about ending my own life.
27. I have been unable to do everyday activities.
28. I have been unable to do work or job-related activities.
29. I have felt my problems were too much for me to handle.
30. I have been physically or mentally unwell.
31. I have thought about ending my own life.
32. I have been unable to do everyday activities.
33. I have been unable to do work or job-related activities.
34. I have felt my problems were too much for me to handle.
35. I have been physically or mentally unwell.
36. I have thought about ending my own life.
37. I have been unable to do everyday activities.
38. I have been unable to do work or job-related activities.
39. I have felt my problems were too much for me to handle.
40. I have been physically or mentally unwell.
41. I have thought about ending my own life.
42. I have been unable to do everyday activities.
43. I have been unable to do work or job-related activities.
44. I have felt my problems were too much for me to handle.
45. I have been physically or mentally unwell.
46. I have thought about ending my own life.
47. I have been unable to do everyday activities.
48. I have been unable to do work or job-related activities.
49. I have felt my problems were too much for me to handle.
50. I have been physically or mentally unwell.

**Total Scores**

Mean Score: 0.0

Standard Deviation: 0.0
CLINICAL OUTCOMES in ROUTINE EVALUATION
GOAL ATTAINMENT FORM

SIDE 1: Please complete this side and return the form before therapy begins.
Do not complete SIDE 2, or the small boxes on this side, until the end of therapy.
This form will be returned to you at the end of therapy.

MAIN DIFFICULTIES

Please describe up to four major difficulties that you hope therapy will help you with:

1. help to like myself, body image

2. to be more possessive

3. stop beating myself up all the time
   being so negative

4. learn to trust people and forgive people

Therapist ID: [ ]
Site ID: [ ]
Client ID: [ ]
Date SIDE 1 given to client: 1. 6 01 2008
Date SIDE 2 given to client: [ ]

This box is for office use only...
This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>1</th>
<th>I do not feel sad.</th>
<th>8</th>
<th>I don't feel I am any worse than anybody else.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel sad.</td>
<td>1</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
</tr>
<tr>
<td>2</td>
<td>I am sad all the time and I can't snap out of it.</td>
<td>2</td>
<td>I blame myself all the time for my faults.</td>
</tr>
<tr>
<td>3</td>
<td>I am so sad or unhappy that I can't stand it.</td>
<td>3</td>
<td>I blame myself for everything bad that happens.</td>
</tr>
<tr>
<td>6</td>
<td>I am not particularly discouraged about the future.</td>
<td>8</td>
<td>I don't have any thoughts of killing myself.</td>
</tr>
<tr>
<td>1</td>
<td>I feel discouraged about the future.</td>
<td>7</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>2</td>
<td>I feel I have nothing to look forward to.</td>
<td>2</td>
<td>I would like to kill myself.</td>
</tr>
<tr>
<td>3</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
<td>3</td>
<td>I would kill myself if I had the chance.</td>
</tr>
<tr>
<td>8</td>
<td>I do not feel like a failure.</td>
<td>10</td>
<td>I don't cry any more than usual.</td>
</tr>
<tr>
<td>1</td>
<td>I feel I have failed more than the average person.</td>
<td>1</td>
<td>I cry more now than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
<td>2</td>
<td>I cry all the time now.</td>
</tr>
<tr>
<td>3</td>
<td>I feel I am a complete failure as a person.</td>
<td>3</td>
<td>I used to be able to cry, but now I can't cry even though I want to.</td>
</tr>
<tr>
<td>4</td>
<td>I get as much satisfaction out of things as I used to.</td>
<td>11</td>
<td>I am no more irritated now than I ever am.</td>
</tr>
<tr>
<td>0</td>
<td>I don't enjoy things the way I used to.</td>
<td>1</td>
<td>I get annoyed or irritated more easily than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I don't get real satisfaction out of anything anymore.</td>
<td>2</td>
<td>I feel irritated all the time now.</td>
</tr>
<tr>
<td>2</td>
<td>I am dissatisfied or bored with everything.</td>
<td>3</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
</tr>
<tr>
<td>5</td>
<td>I don't feel particularly guilty.</td>
<td>12</td>
<td>I have not lost interest in other people.</td>
</tr>
<tr>
<td>1</td>
<td>I feel guilty a good part of the time.</td>
<td>1</td>
<td>I am less interested in other people than I used to be.</td>
</tr>
<tr>
<td>2</td>
<td>I feel quite guilty most of the time.</td>
<td>2</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td>3</td>
<td>I feel guilty all of the time.</td>
<td>3</td>
<td>I have lost all of my interest in other people.</td>
</tr>
<tr>
<td>8</td>
<td>I don't feel I am being punished.</td>
<td>13</td>
<td>I make decisions about as well as I ever could.</td>
</tr>
<tr>
<td>1</td>
<td>I feel I may be punished.</td>
<td>1</td>
<td>I put off making decisions more than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I expect to be punished.</td>
<td>2</td>
<td>I have greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td>3</td>
<td>I feel I am being punished.</td>
<td>3</td>
<td>I can't make decisions at all anymore.</td>
</tr>
<tr>
<td>0</td>
<td>I don't feel disappointed in myself.</td>
<td>7</td>
<td>I am disappointed in myself.</td>
</tr>
<tr>
<td>1</td>
<td>I am disappointed in myself.</td>
<td>2</td>
<td>I am disgusted with myself.</td>
</tr>
<tr>
<td>2</td>
<td>I hate myself.</td>
<td>3</td>
<td>I can't make decisions at all anymore.</td>
</tr>
</tbody>
</table>

Subtotal Page 1

CONTINUED ON BACK
<table>
<thead>
<tr>
<th>14</th>
<th>I don't feel I look any worse than I used to.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am worried that I am looking old or</td>
</tr>
<tr>
<td></td>
<td>unattractive.</td>
</tr>
<tr>
<td>2</td>
<td>I feel that there are permanent changes</td>
</tr>
<tr>
<td></td>
<td>in my appearance that make me look</td>
</tr>
<tr>
<td></td>
<td>unattractive.</td>
</tr>
<tr>
<td>3</td>
<td>I believe that I look ugly.</td>
</tr>
<tr>
<td>16</td>
<td>I can work about as well as before.</td>
</tr>
<tr>
<td>1</td>
<td>It takes an extra effort to get started at</td>
</tr>
<tr>
<td></td>
<td>doing something.</td>
</tr>
<tr>
<td>2</td>
<td>I have to push myself very hard to do.</td>
</tr>
<tr>
<td></td>
<td>anything.</td>
</tr>
<tr>
<td>3</td>
<td>I can't do any work at all.</td>
</tr>
<tr>
<td>18</td>
<td>I can sleep as well as usual.</td>
</tr>
<tr>
<td>1</td>
<td>I don't sleep as well as I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I wake up 1-2 hours earlier than usual</td>
</tr>
<tr>
<td></td>
<td>and find it hard to get back to sleep.</td>
</tr>
<tr>
<td>3</td>
<td>I wake up several hours earlier than I</td>
</tr>
<tr>
<td></td>
<td>used to and cannot get back to sleep.</td>
</tr>
<tr>
<td>17</td>
<td>I don't get more tired than usual.</td>
</tr>
<tr>
<td>1</td>
<td>I get tired more easily than I used to.</td>
</tr>
<tr>
<td>2</td>
<td>I get tired from doing almost anything.</td>
</tr>
<tr>
<td>3</td>
<td>I am too tired to do anything.</td>
</tr>
<tr>
<td>18</td>
<td>My appetite is no worse than usual.</td>
</tr>
<tr>
<td>1</td>
<td>My appetite is not as good as it used to be.</td>
</tr>
<tr>
<td>2</td>
<td>My appetite is much worse now.</td>
</tr>
<tr>
<td>3</td>
<td>I have no appetite at all anymore.</td>
</tr>
<tr>
<td>18</td>
<td>I haven't lost much weight, if any, lately.</td>
</tr>
<tr>
<td>1</td>
<td>I have lost more than 5 pounds.</td>
</tr>
<tr>
<td>2</td>
<td>I have lost more than 10 pounds.</td>
</tr>
<tr>
<td>3</td>
<td>I have lost more than 15 pounds.</td>
</tr>
<tr>
<td>20</td>
<td>I am no more worried about my health</td>
</tr>
<tr>
<td></td>
<td>than usual.</td>
</tr>
<tr>
<td>1</td>
<td>I am worried about physical problems</td>
</tr>
<tr>
<td></td>
<td>such as aches and pains; or upset</td>
</tr>
<tr>
<td></td>
<td>stomach; or constipation.</td>
</tr>
<tr>
<td>2</td>
<td>I am very worried about physical problems</td>
</tr>
<tr>
<td></td>
<td>and it's hard to think of much else.</td>
</tr>
<tr>
<td>3</td>
<td>I am so worried about my physical problems</td>
</tr>
<tr>
<td></td>
<td>that I cannot think about anything else.</td>
</tr>
<tr>
<td>21</td>
<td>I have not noticed any recent change</td>
</tr>
<tr>
<td></td>
<td>in my interest in sex.</td>
</tr>
<tr>
<td>1</td>
<td>I am less interested in sex than I used</td>
</tr>
<tr>
<td></td>
<td>to be.</td>
</tr>
<tr>
<td>2</td>
<td>I am much less interested in sex now.</td>
</tr>
<tr>
<td>3</td>
<td>I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10</th>
<th>Subtotal Page 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Subtotal Page 1</td>
</tr>
<tr>
<td>37</td>
<td>Total Score</td>
</tr>
</tbody>
</table>

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Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Mildly it did not bother me much</th>
<th>Moderately it was very unpleasant but I could stand it</th>
<th>Severely I could barely stand it</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Numbness or tingling.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Feeling hot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Wobbliness in legs.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unable to relax.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Fear of the worst happening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dizzy or lightheaded.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Heart pounding or racing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Unsteady.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Terrified.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Nervous.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Feelings of choking.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Hands trembling.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Shaky.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Fear of losing control.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Difficulty breathing.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Fear of dying.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Scared.</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Indigestion or discomfort in abdomen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Faint.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Face flushed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Sweating (not due to heat).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Unconditional Self-Acceptance Questionnaire

**Instructions:**
Please indicate how often you feel each statement below is true or untrue of you. For each item, write the appropriate number (1 to 7) on the line to the left of the statement, using the following key:

<table>
<thead>
<tr>
<th>Almost Always Untrue</th>
<th>Usually Untrue</th>
<th>More Often Untrue Than True</th>
<th>Equally Often True And Untrue</th>
<th>More Often True Than Untrue</th>
<th>Usually True</th>
<th>Almost Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

1. Being praised makes me feel more valuable as a person.
2. I feel worthwhile even if I am not successful in meeting certain goals that are important to me.
3. When I receive negative feedback, I take it as an opportunity to improve my behaviour or performance.
4. I feel that some people have more value than others.
5. Making a big mistake may be disappointing, but it doesn’t change how I feel about myself overall.
6. Sometimes I find myself thinking about whether I am a good or a bad person.
7. To feel like a worthwhile person, I must be loved by the people who are important to me.
8. I set goals for myself with the hope that they will make me happy (or happier).
9. I think that being good at many things makes someone a good person overall.
10. My sense of self-worth depends a lot on how I compare with other people.
11. I believe that I am worthwhile simply because I am a human being.
12. When I receive negative feedback, I often find it hard to be open to what the person is saying about me.
13. I set goals for myself that I hope will prove my worth.
14. Being bad at certain things makes me value myself less.
15. I think that people who are successful in what they do are especially worthwhile people.
16. I feel that the best part about being praised is that it helps me to know what my strengths are.
17. I feel I am a valuable person even when other people disapprove of me.
18. I avoid comparing myself to others to decide if I am a worthwhile person.
19. When I am criticised or when I fail at something, I feel worse about myself as a person.
20. I don’t think it's a good idea to judge my worth as a person.
10 Principles of Self-Acceptance

1. **As a human being you cannot legitimately be given a single rating, but parts of you can be rated, as can what happens to you.**
   What makes up a person?

2. **As a human being your essence is that you are fallible and unique.**
   Can you think of someone who is perfect?

3. **You are equal to other humans in terms of shared humanity, but unequal in many specific respects.**
   Can one person be worth more than another?

4. **When you accept yourself unconditionally, you think logically and avoid over generalisation errors.**
   Does it follow that one mistake means you are a complete failure?
   
   e.g. If a person gives a poor presentation at work, does it mean that they can’t do their job and that they are a failure?

5. **Unconditional self-acceptance is closely linked with a flexible, preferential philosophy.**
   Which belief is more flexible?
   
   a. I absolutely must do well at my job and if I don’t, it means I am a failure.
   b. I would very much prefer to do well at my job, but I don’t absolutely have to do so, and if I don’t it doesn’t make me a failure.
6. When you accept yourself unconditionally, your emotions are healthy and your behaviour is constructive.  
   e.g. If you believe you are a failure for doing poorly at a task at work, you will tend to stop working at the task and turn away from searching for ways in which you can learn from your errors. You will avoid doing similar tasks in the future. However, if you accept yourself as an ordinary human with your successes and failures, rather than as a failure, you are more likely to keep working at the task and will actively search for ways of learning from your mistakes.

7. Unconditional self-acceptance promotes constructive action, not resignation.  
   Does unconditional self-acceptance mean resigning yourself to the fact that there is nothing you can do to change aspects of yourself you don’t like?  
   NO!!!! Because you do the following:  
   o You acknowledge that you have behaved negatively;  
   o You regret acting in the way that you did;  
   o You acknowledge that regrettably all the conditions were in place for you to act in the way that you did;  
   o You recognise that you can learn from this experience;  
   o You review all the relevant factors that were involved in leading you to behave negatively;  
   o You decide what you can do differently in future;  
   o You commit yourself to act differently in future.

8. You can learn to accept yourself unconditionally (but never perfectly, nor all of the time).  
   GOOD NEWS!! Self-acceptance is a way of thinking that can be learned. However, humans can never do anything perfectly every time! The best you can hope for is to work towards ever-greater self-acceptance.

9. Internalising unconditional self-acceptance is difficult and involves hard work.  
   Wouldn’t it be great if all you had to do was attend this group?! Sadly, it isn’t that easy! Developing unconditional self-acceptance involves a lot of persistent practice in challenging our unhealthy beliefs about ourselves and acting in ways that are consistent with the healthy alternative beliefs.

10. Internalising unconditional self-acceptance requires force and energy.  
    All of us have practiced putting ourselves down since we were young. Therefore, to change these habits, it requires determination and conviction. To achieve psychological change you often have to fight fire with fire!!
Learning Your ABCs

What does ABC stand for?

A = an activating event or trigger
B = a belief about that event
C = the consequence of your belief

Working it all out….

A stands for an activating event. In the episode that you have chosen to analyse there are potentially several different activating events that you can focus on. You can focus on what somebody says to you, for example, the tone in which they say it, their body language or several other factors in the situation. Your task is to identify the aspect of the situation about which you put yourself down. This is known as the ‘critical A’. You can ask yourself the following questions to identify the critical A:

- What was the aspect of the situation that I put myself down about most?
- What was the aspect of the situation that I was most disturbed about?

B stands for the beliefs you hold about the event. When you put yourself down, you generally hold two types of belief.

- First you hold a rigid demand about yourself, other people and/or the world. e.g. ‘I must be able to impress my boss’
- Then you tend to give yourself a global negative rating of yourself. We call this a self-depreciating belief. e.g. ‘I’m a failure if I can’t impress my boss’

C stands for the emotions, behaviours or thoughts that you had in response to your beliefs about the part of the event that you put yourself down for: This is why C stands for ‘consequences’ because they are consequences of your beliefs.

- Emotional C – the primary unhealthy emotion you felt (e.g. anxiety, depression, guilt, shame, hurt, unhealthy anger, unhealthy jealousy and unhealthy envy)
- Behavioural C – When you put yourself down it is likely that you act in a certain way or experience an urge to act in a certain way. Most likely, these behaviours are likely to be unconstructive and self-defeating. (e.g. ‘withdrawal into myself’)
- Thinking C – This refers to how you think once you are in a self-depreciating frame of mind. This thinking is likely to be negative, exaggerated and distorted. (e.g. ‘I will never be able to please my boss’)

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ABC Form

Situations in which I put myself down:

A (critical) =

B (demand) =

(self-depreciation belief) =

C (emotional) =

(behavioural) =

(thinking) =

General instructions for completing the abc form

Step 1 Select a specific example where you depreciated yourself and describe this situation as clearly and objectively as you can.

Step 2 Identify your major emotion, your major action or action tendency and how you subsequently thought, and write these down next to the headings C (emotional), C (behavioural) and C (thinking) respectively.

Step 3 Identify what you were most disturbed about in the episode under considerations (or what you most put yourself down for). Use your identified emotional C to do an inference chain if you need to. Write down your critical A next to A (critical) on the form.

Step 4 Identify the demand and the self-depreciation belief that you held about A which resulted in your response at C. put the demand next to B (demand) and the self-depreciation belief next to B (self-depreciation belief)
Challenging Our Self-Downing Beliefs

There are three key questions that you need to ask yourself in order to challenge your self-downing irrational beliefs. These are:

(a) Are they consistent with reality?
(b) Are they logical?
(c) Are they helpful or healthy?

It is helpful to compare both your unhealthy self-downing beliefs with your healthy rational alternative beliefs when answering the above questions.

Now that you have developed healthy alternatives, you have the choice: to maintain your conviction in your unhealthy beliefs or to work towards gaining conviction in your healthy beliefs.

The battle of the beliefs!

So, back to the questions at the top. You should have two sets of opposing beliefs:

(1) Your demands vs your full preferences;
(2) Your self-downing vs your self-acceptance beliefs.
Questioning Your Demands & Full Preferences

Step 1
Take your demand and identify the alternative full preference to this belief. Write them side by side on a sheet of paper under the following headings.

<table>
<thead>
<tr>
<th>Demand</th>
<th>Full Preference</th>
</tr>
</thead>
</table>

Step 2
Ask yourself the question ‘Which belief is true and which is false?’

Step 3
Write down the answer to this question and provide written reasons for your answer.
Step 4
Ask yourself the question ‘Which belief is sensible/logical and which doesn’t make sense or is illogical?’

Step 5
Write down the answer to this question and provide written reasons for your answer.

Step 6
Ask yourself the question ‘Which belief is helpful/yields healthy results and which is unhelpful/yields unhealthy results?’

Step 7
Write down the answer to the question and provide written reasons for your answer.
Questioning Your Self-Downing & Self-Acceptance Beliefs

Step 1
Take your self-downing and identify the alternative self-acceptance belief. Write them side by side on a sheet of paper under the following headings.

<table>
<thead>
<tr>
<th>Self-Downing Belief</th>
<th>Self-Acceptance Belief</th>
</tr>
</thead>
</table>

Step 2
Ask yourself the question ‘Which belief is true and which is false?’

Step 3
Write down the answer to this question and provide written reasons for your answer.
Step 4
Ask yourself the question ‘Which belief is sensible/logical and which doesn’t make sense or is illogical?’

Step 5
Write down the answer to this question and provide written reasons for your answer.

Step 6
Ask yourself the question ‘Which belief is helpful/yields healthy results and which is unhelpful/yields unhealthy results?’

Step 7
Write down the answer to the question and provide written reasons for your answer.
Identifying the healthy alternatives to demands and self-downing beliefs

The healthy alternative to a demand that underpins a self-downing problem is known as a full preference. When you hold a full preference you assert what you want, but acknowledge that your desire does not have to be fulfilled.

For example, Mandy may have the unhealthy belief ‘When I go on a date, I must be asked out again.’ Her full preference alternative to this demand is: ‘I would very much like it if I was asked on a second date when I go out, but I do not have to be.’ This belief is a full preference because it asserts what she wants and it negates her demand (i.e.…’but I do not have to be’). The distinction between a demand and a full preference is important.

The healthy alternative to a self-downing belief is known as a self-accepting belief. When you hold a self-accepting belief, you both assert that you are a fallible human being who is too complex to merit a single rating (or similar variant) and negate the global self-rating that you gave yourself in your self-depreciating belief.

For example, Mandy has a self-depreciating belief ‘I am unlovable and worthless if I don’t get asked out again’. Her self-acceptance alternative to this belief is: ‘I am not unlovable and worthless. I am a fallible human being who cannot be attractive to everyone’.
Acting on healthy beliefs

So far we have covered a number of thinking-based techniques to strengthen your conviction in your healthy beliefs. However, behaving in ways in which are consistent with your healthy beliefs are a crucial part of the change process:

\[
\begin{align*}
\text{SELF ACCEPTANCE THINKING} & \quad + \quad \text{CONSISTENT ACTION} \\
\quad = & \quad \text{INCREASED CONVICTION IN SELF-ACCEPTANCE PHILOSOPHY}
\end{align*}
\]

\[
\begin{align*}
\text{SELF ACCEPTANCE THINKING} & \quad + \quad \text{INCONSISTENT ACTION} \\
\quad = & \quad \text{DECREASED CONVICTION IN SELF-ACCEPTANCE PHILOSOPHY}
\end{align*}
\]

The idea is to practise thinking self-acceptance ideas to act in ways that are consistent with these ideas. If you practise thinking self-acceptance ideas, but act in ways that are consistent with your unhealthy beliefs, you will be more convinced by your actions than your thoughts.

How do I do this?

- Go back to your list of problems and goals that you developed in session two, and taking them one at a time, aim to follow the constructive forms of behaviour that you outlined there.

- Make a sensible plan to confront situations that are important to face if you are to progress along the path to self-acceptance.

- Rank these situations according to how difficult you would find it to face them.

- Work your way up this hierarchy, facing these situations while strongly rehearsing your self-acceptance ideas at the same time.

- Resist any urges to go back to your more ingrained, familiar, self-defeating behaviour.

Remember….

It is very easy for you to return to patterns of behaviour that are consistent with the self-downing beliefs that you are trying to surrender, but which give your short-term relief when you are uncomfortable. Tolerate this discomfort and show yourself strongly that it is worth tolerating this discomfort, because doing so will help you stay on the path towards self-acceptance.
Rational-Emotive Imagery (REI)

Rational-emotive imagery (REI) is a way of strengthening your conviction in your healthy belief. Here is how to use this technique:

1. Identify a situation where you put yourself down and focus on the aspect of this situation that you were most disturbed about.

2. Close your eyes and vividly imagine this situation, and focus on the most disturbing aspect.

3. Identify and get in touch with the unhealthy belief that you held about the most disturbing aspect.

4. Really get in touch with the disturbed emotion that you felt in the situation and stay with this emotion briefly (choose one from the following: anxiety, depression, shame, guilt, unhealthy anger, unhealthy jealousy, unhealthy envy, or hurt).

5. While still imagining the same situation and focusing on the same disturbing aspect, change your unhealthy belief to its healthy alternative and stay with this new belief until you experience a healthy negative emotion about the negative event (one of the following: concern, sadness, disappointment, remorse, healthy anger, healthy jealousy, healthy envy, or sorrow).

6. Keep this healthy belief in mind and keep experiencing the associated healthy negative emotion for about five minutes, all the time imagining the situation you have previously identified, and in particular focusing on the critical most disturbing aspect.

7. Practice this technique at least three times a day for about five minutes each time.
As you practice the REI technique, it is important to bear in mind the following points:

- Select a specific event to imagine, not a generalised event.

- Focus on the aspect of the event that you particularly put yourself down about. Don’t just imagine the event as such, but zero in on the bit that you found most painful.

- Keep imagining that most painful aspect of the event while rehearsing your unhealthy belief.

- Identify and experience your one predominant unhealthy negative emotion. You may have experienced more than one emotion, but get in touch with the emotion about the most disturbing aspect of the event.

- As you change your unhealthy belief to its healthy alternative, make sure that you keep focusing on the most disturbing aspect of the event.

- As you focus on your new healthy negative emotion, make it the same intensity as your unhealthy negative emotion. It is not necessarily healthy for you to experience a mild emotion about a really aversive activating event.

- As you practice the technique, spend much more time imagining yourself dealing with the event in a self-accepting way than in a self-downing way.

- After a while you can just imagine the negative event and in particular the most disturbing aspect of it; rehearse your healthy belief and experience the associated healthy negative emotion.

- Practice this technique at odd moments of the day when you have a small amount of time on your hands. Practice it while waiting for a bus, for example, or stood in a queue. After all, you have probably gained a lot of mental practice of rehearsing your unhealthy self-downing beliefs and associated demands in a variety of negative life events, so you do need a lot of corrective practice of rehearsing your healthy full preferences and self-acceptance beliefs.
**Thinking errors**

**OVERGENERALISATION**
VIEWING A SINGLE EVENT AS A DEFINITE PATTERN

‘Because I made a grave error at the interview which proves that I am a fool, I will continue to make grave errors at interviews’

**FOCUSING ON THE NEGATIVE**
EDITING OUT THE POSITIVES OF A SITUATION AND CONCENTRATING ON THE NEGATIVES

‘My tutor thought my essay was good, but it absolutely should have been excellent. As I look at it again I can only see the essay’s bad points’

**DISQUALIFYING THE POSITIVE**
BEING UNABLE TO ACCEPT POSITIVE FEEDBACK

‘My friend told me that she liked the way I looked, but since I think I am worthless for not being as attractive as I absolutely should be, I thought she was only saying this to be kind, and deep down she didn’t mean it’
BLACK AND WHITE THINKING
SEEING THINGS AS ALL GOOD OR ALL BAD

‘I just failed my oral exam as I absolutely should not have done. I think it was a complete failure’

MIND READING
BEING CONVINCED THAT OTHERS HAVE A NEGATIVE VIEW OF YOU

‘I disclosed a weakness in public which proves that I am inadequate, and I am sure that other people think I am an idiot’

ALWAYS-AND-NEVER THINKING
THINKING THAT BAD EVENTS WILL ALWAYS OCCUR AND THAT GOOD EVENTS WILL NEVER OCCUR

‘I failed my driving test, which I absolutely should have passed. This means that I will never pass it’
MINIMISATION
PLAYING DOWN YOUR OWN ACHIEVEMENTS

‘I must do much better than other people. I did well on the task, but anybody could have done the task well’

MAGNIFICATION
MAKING MORE THAN IS WARRANTED OF YOUR FAILURES

‘I fluffed my lines at the rehearsal, which proves that I am a worthless idiot. Nobody will forget what I did for a very long time’

PERSONALISING
THINKING THAT YOU ARE THE CAUSE OF SOMETHING THAT WAS OUTSIDE OF YOUR CONTROL OR THINKING THAT OTHERS’ RESPONSES ARE DIRECTED AT YOU WITHOUT EVIDENCE FOR THIS

‘I played poorly at the match yesterday, which I absolutely should not have done. A group of people were laughing when I walked past and I am sure that they were laughing at me’
NEGATIVE PREDICTION
PREDICTING NEGATIVE EVENTS

‘I am a bad person for not visiting my parents and thus God will soon punish me’

EMOTIONAL REASONING
THINKING THAT SOMETHING IS TRUE BECAUSE YOU FEEL STRONGLY THAT IT IS TRUE

‘I am worthless and feel strongly that others think so too. My strong feelings about this prove that I am right’

COGNITIVE REASONING
THINKING THAT YOUR THOUGHTS ARE INEVITABLY A TRUE GUIDE TO REALITY

‘I must know that people like me. If I think that someone dislikes me, this is proof that it is true’
Shame-attacking!

So far the work you have done to help yourself along the road to self-acceptance has been serious. Now is the time to have a bit of fun along the road. Shame-attacking exercises involve you acting ‘shamefully’ in public and practising self-acceptance beliefs as you do so. It is important for you to do shame-attacking exercises for the following reasons:

1. Shame involves self-depreciation. Consequently, ‘attacking’ your shame helps you to develop a philosophy of unconditional self-acceptance.

2. You often limit yourself significantly because you are scared of what others think of you. Doing shame-attacking exercises helps you to accept yourself in the face of public disapproval.

3. Consequently, in devising shame-attacking exercises, it is important to plan to do something that will attract the attention and disapproval of others.

4. When you do a shame-attacking exercise, remain in the situation and maintain eye contact. Leaving the situation immediately after you have done a shame-attacking exercise or avoiding eye contact with those present are two ways of helping you to feel better in the short term, but prevent you from accepting yourself in the situation concerned.

5. Take suitable action to protect yourself and others from harm. Thus, when devising a shame-attacking exercise make sure that you do not do anything that will:
   - Alarm others;
   - Offend yours and others’ moral codes;
   - Break the law;
   - Jeopardize your job or your friendships.

6. Develop and practise healthy self-acceptance beliefs and high frustration tolerance beliefs before you do the task, while doing the task and after you have done the exercise.

7. Use the emotive imagery technique before you carry out your shame-attacking exercise.

8. Identify and overcome blocks to carrying out your shame-attacking exercises.

Here are a few examples of shame-attacking exercises:

- Wearing different coloured shoes
- Asking to buy a three piece suite in a sweet shop
- Singing off key in public
- Asking for directions to a road or town you are already in
- Shouting out the stops on a train or bus
- Shouting out the time in a supermarket
Commit Yourself to Your
Self-Acceptance Philosophy

Through the course we have covered all you need to know about unconditional self-acceptance and the skills that you need to continue along the path toward greater self-acceptance. To help you to maintain and extend your developing self-acceptance philosophy there are a few things you can try…

Keep practising the skills of self-acceptance

This approach to self-acceptance is skills based in nature. This means that in order to further your journey towards greater self-acceptance you need to practise these skills regularly – even when you are feeling good. Why? Because feeling better does not necessarily mean that you are strengthening your conviction in your self-acceptance philosophy. It may just mean that you are facing positive activating events in the A of the ABC framework. Think of this in the same way as your physical well being – you wouldn’t think ‘Well I’m feeling OK today so I won’t wash myself or feed myself.’ You allocate time each day to your physical well-being – so why not allocate some to your psychological well-being?

We suggest you allocate 20 minutes a day, five days a week, to practising one or more of the skills we have covered. If you are serious about working towards greater self-acceptance then we recommend you do this for TWO YEARS!! Why? Developing self-acceptance takes time and effort, so take it a day at a time.

If and when you find yourself depreciating yourself you have a choice, either you use the skills you have developed to challenge the unhealthy beliefs, or you do nothing, and continue to put yourself down.

You have to use these techniques regularly before your feelings begin to change. It is easier to change your beliefs, behaviours and images than it is to affect a fundamental change in your feelings. Accept this rather than demanding that your feelings must change immediately.

We have tended to focus on specific unhealthy beliefs, but we have also talked about core unhealthy beliefs. A core unhealthy belief is a general belief, which takes the form of a general rigid demand and self-depreciation belief that is present across a broad range of situations related to a theme (e.g. disapproval, failure, not being liked, not being in control). Look at your ABC charts, list situations in which you put yourself down – if you find a pattern this is evidence that you may have a core unhealthy belief in this area. You can use all the techniques in the same ways with core unhealthy beliefs.

If you find yourself having a ‘lapse’ in progress, accept yourself for depreciating yourself. You can use the self-depreciation as a cue for change work. Try to develop a high frustration tolerance for the slowness and unevenness of significant personal change.
Extend your philosophy of unconditional self-acceptance

You can extend your philosophy of unconditional self-acceptance in a number of ways:

- Identify and deal with situations where you are particularly vulnerable – those in which you would easily deprecate yourself. Use your goals as a framework for this.

- Seek out situations in which you are particularly vulnerable to deprecating yourself and which you would normally avoid, and practise deprecating yourself in those situations.

- Follow the principle of ‘challenging, but not overwhelming’ as you do this. This means seeking out situations that are difficult for you to face, but not at that time overwhelming.

- It is a good idea to construct a hierarchy of situations, ranging from the easiest to face to the most difficult.

- Using the Rational Emotive Imagery technique is a good preparation for facing the situations in reality.

- When you do face the situations in reality, try and ensure that you are actively practising your healthy belief and that your behaviour is functional and does not compensate for implicit deprecation – that the way you are thinking about the situation is realistic.

What else can I do?

- Ask people what they like and dislike about you and accept yourself for what they say. You may find it difficult to accept compliments and find yourself making disqualifying statements such as ‘She is only saying that to be nice’. These are a sign that you are deprecating yourself, so look out for them and the underlying demands and self-deprecating beliefs.

- Teach others the philosophy of self-acceptance. The more you teach, these principles to others, the more practise you get at rehearsing them for yourself.

- Strive to accept others, warts and all. Again, the more you practise other-acceptance, the more likely that you will accept yourself, warts and all.

- Keep practising shame-attacking exercises.

- Do things that you have always wanted to do, but have held yourself back from doing for self-depreciating reasons.

- Admit your faults to others and show them and yourself that you can accept yourself for them.
When I first met you back in November last year, you described feeling down, with no energy at all, you said you had lost your ‘get up and go’. You told me that the problem was how you felt about yourself, your looks and your weight. You said to me ‘It’s like I don’t feel I deserve to be happy for some reason’. You said you felt that this was holding you back from doing the things you knew would make you feel better.

When you first came and met with and I, you said you really struggled to even get out of bed in the morning, as you didn’t want to face the day. You didn’t feel like you could go out with friends, because you felt so bad about your appearance, and you felt unable to go to the gym, even though you really wanted to do this. But right back then at the start I could see that you were determined to make some changes in your life, as you had turned up to the appointment, despite feeling this way. You said that you hoped that by coming to talk with me, you would find a way to like yourself, and to think in more positive ways.

In our early sessions you told me about your early years, the confusion, sadness and blame you felt when your parents separated, when you were so very little. You had some very vivid memories from this time, and found it really upsetting talking and thinking them. You told me that you looked back at this time as one without affection and that you felt alone much of the time. Despite finding it so difficult to talk about the past, you recognised that it was an important part of the process of you and I getting to know one another, and for me to build up a picture of the path your life has taken.

When you told me about the relationships you had had over the years, and some of the things you had done to try to cope with the way you were feeling, you described feeling to blame for
these things. You said you regretted this time and really didn’t want to think about it anymore. When I listened to this part of your story, I heard about a young woman who was searching for the affection she lost out on in childhood, someone who would try anything at all just to feel happy and to numb the negative thoughts and feelings. But what I heard about most was a person who has the ability to set their mind to something and absolutely stick to it. This is one of the qualities that I feel keeps you striving to make changes and to feel better about yourself - perhaps this quality feels you deserve to be happy?

When we first started to work through some of your difficulties together, you said you didn’t feel that the sessions were making a difference. However, in spite of this you did not miss a single one of our sessions. This again showed me the determination and perseverance that you have, but don’t always see.

One of the things we have talked about more recently, is the physical pain and up and downs that you have experienced for such a long time and just what an impact this can have on your psychological well being. One of the things that came with this was a discussion about having children. I remember right back at the start, you told me that you would never have children, as you wouldn’t want them to ‘end up like you’, put through a parental separation, which wouldn’t be fair. More recently, when we talked about this, I noticed a real change in the way you spoke about the future - you said that when given the choice about losing the possibility of having a family, you did not want to make this choice, as one day, in the future you may feel differently. I was so impressed to hear that you are now thinking about this in a more positive way.

Throughout our sessions I have noticed gradual changes happening, and each of these has been a reflection on the willpower you possess for making decisions and sticking to them, for making a difference in your life. Although it can be easy to downplay the progress you have made, I think it is important to be able to look back to how things were before, in order to see how different they are at this point. You now tell me about going to the gym - not only going (and that shows dedication) but ‘loving it!’ as you put it. You tell me that you no longer think all the time about how you look, that this is no longer consuming all of your thoughts and
actually I can tell: You hold yourself in a different way now, like somebody who is starting to like themselves perhaps? You are now able go out and actually enjoy the time you spend with friends without being constantly distracted and upset by negative thoughts. See this as a work in progress, with practice; feeling good about yourself will become easier over time.

One of the things that has come up throughout our sessions, is confidence - what it is, and when we know it is genuine. By getting to know you over the past few months, I have been able to see the side of you that you told me other people see - the confident person who makes people laugh. Someone once described confidence to me as 'a belief in yourself and your abilities'. I hope that by looking back over what you have achieved, you will be able to see that you possess a level of this belief, and I know that over time, this will only strengthen.

As we are coming to the end of our time working together, I see a person emerging who is more certain about what they want and don't want in life. The challenges at work and in relationships you are currently facing are ones I think you will now choose to face with strength and positivity. When I see how happy you are when you tell me about the time you spend on your own this tells me one thing: that you are happy to be with yourself, spending time with yourself. And to be content doing this, you need to be able to like yourself. I just want to say one more thing - you do deserve to be happy, and I have every faith that over time, your belief in this will continue to grow.
Appendix 11:
CPR 3: Evaluation Measures
<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the time</th>
<th>All of the time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last week</td>
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<td></td>
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<tr>
<td>2. I have felt tense, anxious or nervous</td>
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<td>3. I have felt depressed</td>
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<tr>
<td>4. I have felt O.K. about myself</td>
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<tr>
<td>5. I have been physically violent to others</td>
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<tr>
<td>6. I have been troubled by alcohol, pains or other physical problems</td>
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<td></td>
<td></td>
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<tr>
<td>7. I have been in time and in control</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>8. I have enjoyed reading</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. I have been happy with the things I have done</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. Talking to people has felt too much for me</td>
<td></td>
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<tr>
<td>11. I have smoked or drunk alcohol or other substances</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>12. I have felt like crying</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Survey: 26
Visit 1/131
### Over the last week

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Very</th>
<th>All the time</th>
<th>Did not happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 I made plans to end my life</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18 I have had difficulty getting to sleep or staying asleep</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20 My problems have been impossible to put to one side</td>
<td>✓</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>22 I have threatened or intimidated another person</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24 I have thought it would be better if I were dead</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26 I have felt others are against me</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28 I have thought I have no friends</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30 Unwanted images or memories have been distressing me</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32 I have thought I am to blame for my problems and difficulties</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34 I have hurt myself physically or taken dangerous risks with my health</td>
<td>✓</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Total Scores**

- Total score for each dimension divided by number of items completed in that dimension

**Mean Scores**

- Mean scores (M) calculated as total scores divided by number of items completed in each dimension

**Survey:** 65

---

*Thank you for your time in completing this questionnaire.*
HELPFUL ASPECTS OF THERAPY

1. Before your therapy began, you identified up to four difficulties or needs which you hoped therapy would help you with. Your original responses are on the other side of this form. By the side of each response there is a small box. To identify how much therapy has helped with each difficulty, please write the appropriate number in each box, using the guide below.

0 = Not at all  1 = A little bit  2 = Moderately  3 = Quite a bit  4 = Extremely

2. Could you please describe what you feel has been positive about your therapy. This might be an outcome, insight or experience.

It has made me think differently in certain things.

3. Looking back over your therapy, do you feel that there is anything which remains unresolved or that you still feel uncomfortable about? Please tick a box.

Yes
No

If yes, please describe what remains unresolved or what you still feel uncomfortable about and tick how hindering you feel this may be in the future.

I still worry what people think of me. I want everyone to like me only sometimes.

4. Overall, how satisfied are you with the service you have received? Please tick a box.

Very satisfied
Satisfied
Mixed feelings
Dissatisfied
Very dissatisfied

5. On the basis of your experience, would you recommend this service to a friend? Please tick a box.

NO: definitely not
NO: I don’t think so
YES: I think so
YES: definitely

6. Have you any additional comments you wish to make about the service you have received?

Thank you for your time in completing this form.
This questionnaire consists of 31 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. I do not feel sad.
   1. I feel sad.
   2. I am sad all the time and I can’t snap out of it.
   3. I am so sad or unhappy that I can’t stand it.

2. I am not particularly discouraged about the future.
   1. I feel discouraged about the future.
   2. I feel I have nothing to look forward to.
   3. I feel that the future is hopeless and that things cannot improve.

3. I do not feel like a failure.
   1. I feel I have failed more than the average person.
   2. As I look back on my life, all I can see is a lot of failures.
   3. I feel I am a complete failure as a person.

4. I get as much satisfaction out of things as I used to.
   1. I don’t enjoy things the way I used to.
   2. I don’t get as much enjoyment out of anything anymore.
   3. I am dissatisfied or bored with everything.
   4. I don’t feel particularly guilty.
   5. I feel guilty a good part of the time.
   6. I feel quite guilty most of the time.
   7. I feel guilty all of the time.

5. I don’t feel I am being punished.
   1. I feel I may be punished.
   2. I expect to be punished.
   3. I feel I am being punished.

6. I don’t feel disappointed in myself.
   1. I am disappointed in myself.
   2. I am disgusted with myself.
   3. I hate myself.

7. I don’t feel I am any worse than anybody else.
   1. I am critical of myself for my weaknesses.
   2. I blame myself all the time for my faults.
   3. I blame myself for everything bad that happens.

8. I don’t have any thoughts of killing myself.
   1. I have thoughts of killing myself but I would not carry them out.
   2. I would like to kill myself.
   3. I would kill myself if I had the chance.

9. I don’t cry any more than usual.
   1. I cry more now than I used to.
   2. I cry all the time now.
   3. I used to be able to cry but now I can’t cry even though I want to.

10. I am no more irritated now than I ever was.
    1. I get annoyed or irritated more easily than I used to.
    2. I feel irritated all the time now.
    3. I don’t get irritated at all by the things that used to irritate me.

11. I have not lost interest in other people.
    1. I am less interested in other people than I used to be.
    2. I have lost most of my interest in other people.
    3. I have lost all of my interest in other people.

12. I make decisions about as well as I ever could.
    1. I put off making decisions more than I used to.
    2. I have greater difficulty in making decisions than before.
    3. I can’t make decisions at all anymore.
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>I don’t feel I look any worse than I used to.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I am worried that I am looking old or unattractive.</td>
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<tr>
<td>16</td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
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<tr>
<td>17</td>
<td>I believe that I look ugly.</td>
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<tr>
<td>18</td>
<td>I can work about as well as before.</td>
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<tr>
<td>19</td>
<td>It takes an extra effort to get started at doing something.</td>
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<tr>
<td>20</td>
<td>I have to push myself very hard to do anything.</td>
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</tr>
<tr>
<td>21</td>
<td>I can’t do any work at all.</td>
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</tr>
<tr>
<td>22</td>
<td>I can sleep as well as usual.</td>
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</tr>
<tr>
<td>23</td>
<td>I don’t sleep as well as I used to.</td>
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<tr>
<td>24</td>
<td>I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</td>
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<tr>
<td>25</td>
<td>I wake up several hours earlier than I used to and cannot get back to sleep.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>I don’t get more tired than usual.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I get tired more easily than I used to.</td>
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<tr>
<td>28</td>
<td>I get tired from doing almost anything.</td>
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<tr>
<td>29</td>
<td>I am too tired to do anything.</td>
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<tr>
<td>30</td>
<td>My appetite is no worse than usual.</td>
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<td></td>
<td></td>
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<tr>
<td>31</td>
<td>My appetite is not as good as it used to be.</td>
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<tr>
<td>32</td>
<td>My appetite is much worse now.</td>
<td></td>
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</tr>
<tr>
<td>33</td>
<td>I have no appetite at all anymore.</td>
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</tbody>
</table>

Total Score: 12

Subtotal Page 1: 7

Subtotal Page 2: 5
Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>Mildly</th>
<th>Moderately</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Numbness or tingling.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Feeling hot.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Wobbliness in legs.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Unable to relax.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Fear of the worst happening</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Dizzy or lightheaded.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Heart pounding or racing.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>Unsteady.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Terrified.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Nervous.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Feelings of choking.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12</td>
<td>Hands trembling.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Shaky.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14</td>
<td>Fear of losing control.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>15</td>
<td>Difficulty breathing.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>16</td>
<td>Fear of dying.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>17</td>
<td>Scared.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>18</td>
<td>Indigestion or discomfort in abdomen.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td>Faint.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Face flushed.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Sweating (not due to heat).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

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Unconditional Self-Acceptance Questionnaire

Instructions:
Please indicate how often you feel each statement below is true or untrue of you. For each item, write the appropriate number (1 to 7) on the line to the left of the statement, using the following key:

<table>
<thead>
<tr>
<th>Almost</th>
<th>Usually</th>
<th>More</th>
<th>Equally</th>
<th>More</th>
<th>Almost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>Untrue</td>
<td>Often</td>
<td>Often</td>
<td>Often</td>
<td>True</td>
</tr>
<tr>
<td>Untrue</td>
<td>Than</td>
<td>True</td>
<td>Untrue</td>
<td>True</td>
<td>Untrue</td>
</tr>
<tr>
<td>True</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 2 3 4 5 6 7

1. Being praised makes me feel more valuable as a person.
2. I feel worthwhile even if I am not successful in meeting certain goals that are important to me.
3. When I receive negative feedback, I take it as an opportunity to improve my behaviour or performance.
4. I feel that some people have more value than others.
5. Making a big mistake may be disappointing, but it doesn’t change how I feel about myself overall.
6. Sometimes I find myself thinking about whether I am a good or a bad person.
7. To feel like a worthwhile person, I must be loved by the people who are important to me.
8. I set goals for myself with the hope that they will make me happy (or happier).
9. I think that being good at many things makes someone a good person overall.
10. My sense of self-worth depends a lot on how I compare with other people.
11. I believe that I am worthwhile simply because I am a human being.
12. When I receive negative feedback, I often find it hard to be open to what the person is saying about me.
13. I set goals for myself that I hope will prove my worth.
14. Being bad at certain things makes me value myself less.
15. I think that people who are successful in what they do are especially worthwhile people.
16. I feel that the best part about being praised is that it helps me to know what my strengths are.
17. I feel I am a valuable person even when other people disapprove of me.
18. I avoid comparing myself to others to decide if I am a worthwhile person.
19. When I am criticised or when I fail at something, I feel worse about myself as a person.
20. I don’t think it’s a good idea to judge my worth as a person.
Appendix 12:
CPR 4: ABC chart: assessment/baseline phase
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>What happened beforehand?</th>
<th>What happened afterwards?</th>
<th>Posters given</th>
<th>Anything else important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.07.08</td>
<td>3.00pm</td>
<td>TOILET</td>
<td>SHUT HIMSELF IN TOILET FOR 1 HOUR</td>
<td>TOILET WAS AGITATED AND RACING THE FLOOR FOR 1 HOUR</td>
<td>TOILET CLEARED</td>
<td>DAD ALONE WIPED DOWN AND WASHED HANDS, TOILET CLEANED.</td>
</tr>
<tr>
<td>16.07.08</td>
<td>4 pm</td>
<td>TOILET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.07.08</td>
<td>5.00pm</td>
<td>TOILET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 13:
CPR 4: Fluid intake chart
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>How much</th>
<th>Type of drink</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.7.08</td>
<td>7.05 am</td>
<td>150 mL</td>
<td>Milk</td>
</tr>
<tr>
<td>10.07.08</td>
<td>8.00 am</td>
<td>150 mL</td>
<td>Orange Juice</td>
</tr>
<tr>
<td>10.07.08</td>
<td>12.45</td>
<td>2x 150 mL</td>
<td>Milk</td>
</tr>
<tr>
<td>10.07.08</td>
<td>3.20 pm</td>
<td>150 mL</td>
<td>Orange Juice</td>
</tr>
<tr>
<td>10.07.08</td>
<td>4.00 pm</td>
<td>150 mL</td>
<td>Orange Juice</td>
</tr>
<tr>
<td>10.07.08</td>
<td>4.20 pm</td>
<td>150 mL</td>
<td>Milk</td>
</tr>
<tr>
<td>10.07.08</td>
<td>7.30 pm</td>
<td>150 mL</td>
<td>Milk</td>
</tr>
<tr>
<td>10.07.08</td>
<td>7.00 pm</td>
<td>150 mL</td>
<td>Milk</td>
</tr>
<tr>
<td>10.07.08</td>
<td>8.45 pm</td>
<td>150 mL</td>
<td>Milk</td>
</tr>
</tbody>
</table>
Appendix 14:
CPR 4: ABC chart: intervention phase
- Fill in the date, time and where the soiling occurred (e.g. bathroom, elsewhere etc)

- If possible, record something about what happened prior to the soiling (e.g. was playing, was eating, seemed agitated etc) and what happened during (e.g. was anyone else present?).

- Most importantly, record what happened after the soiling occurred (e.g. who cleaned up? Discussions, play, cuddles, bath, ignoring etc)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>What was happening beforehand?</th>
<th>What happened?</th>
<th>What happened afterwards?</th>
<th>Anything else important?</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.08.09</td>
<td>2.00 PM</td>
<td>Downstairs</td>
<td>Playing</td>
<td>Stripped off</td>
<td>Lots of PRAISE</td>
<td>Lots of PRAISE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toilet</td>
<td></td>
<td>Did his poo hover over the toilet</td>
<td>Mom gave bath</td>
<td></td>
</tr>
<tr>
<td>20.08.09</td>
<td>1.00 PM</td>
<td>Downstairs</td>
<td>Uncomfortable and a little grumpy for an hour</td>
<td>He did his poo over the toilet did not sit</td>
<td>Stopped clean continued playing afterwards happy</td>
<td>Lots of PRAISE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.08.09</td>
<td>6.30 PM</td>
<td>Downstairs</td>
<td>Unsettled and very uncomfortable</td>
<td>Did poo on the floor</td>
<td>Dad cleaned up then bathed</td>
<td>Mom not home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 15:
CPR 4: Symbols from the visual timetable
Appendix 16:
CPR 4: Intervention guidelines for parents
**Intervention guidelines for parents**

1) Show Jake a visual timetable incorporating the toilet symbol followed by an activity symbol.

2)

3) Tell Jake ‘*We will go to the bathroom for five minutes and then we will... chosen activity.*’

4) Take Jake into the bathroom; encourage him to sit on the toilet.

5) Show Jake the five minute sand timer and start the timer

6) Leave Jake alone for five minutes

7) Tell Jake ‘*Now we will...chosen activity, then you can go back into the bathroom*’ and show him the visual timetable.

8) If Jake does not want to leave the bathroom, enter the room and redirect him.

9) Once out of the bathroom, introduce Jake to the activity, even if only for a short period (e.g. 30 seconds) at first.

10) Repeat the above steps until Jake has had a bowel movement.

11) If Jake has a bowel movement in the toilet give him a fun bath and verbal praise.

12) If Jake has a bowel movement on the bathroom floor, give him a functional bath and no praise.