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formulation – specialist
skills for psychologists
working with older people**

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Psychology Specialists Working With Older People

AIMS

- ◆ to promote opportunities for the exchange of knowledge and expertise between members;
- ◆ to promote a greater appreciation of psychological factors in ageing;
- ◆ to advise and participate in matters of teaching and training;
- ◆ to stimulate research and disseminate research findings;
- ◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
- ◆ to foster an exchange of information and ideas with other professional and voluntary groups.

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Letter from the Editor

Louisa Shirley

FIND IT difficult to remember when the word ‘formulation’ was not in my vocabulary. ‘Formulating’ other people’s actions on the basis of what I know as a psychologist has become second nature, like driving, like my two-finger typing. But we should not forget about the uniqueness of this aspect of our practice or its worth to others.

Butler (1998) quotes Frank’s (1986) description of formulation as being ‘a plausible story’ devised between therapist and client. In her definitions, she then clarifies that formulation is ‘a tool used by clinicians to relate theory to practice.’ These two descriptions encapsulate two aspects of formulation that, for me, make it something that works for us and for other people – the psychological therapist’s ‘unique selling point’ (USP). The first point is that formulation is model-driven, therefore, **evidence-based** (in so far as that model has been robustly tested). The second is that formulation is a **narrative**. This makes it both accessible and open to question from other perspectives. This edition looks at how we use formulation in its many guises – what does formulation in a specific model look like (Appleby), how do we train psychologists to use formulation (James, Clifford & MacKenzie), how do we influence other services to adopt a formulation-based approach (Dexter-Smith; Dexter-Smith, Hopper & Sharp; Craven-Staines, Dexter-Smith & Li; Bergin), what should a shared formulation process look like (Shirley), and how can formulation be used to understand the service itself (Hickman & Crawford-Docherty)?

In this edition of the *Newsletter*, a number of authors eloquently describe the process of formulation in their work with older people and how formulation is received by their colleagues. They outline the issues inherent in introducing the idea that we should

understand people (and services) – over and above their diagnosis – before we offer them treatment. Services differ immensely in the importance they attribute to psychological formulation, from basing an entire service on formulation-led interventions to lone psychologists struggling to have psychological formulation form part of their team’s understanding of their client.

Another aspect to the work of psychological therapists that does not feature for many of our professional colleagues is the importance attributed to reflective, non-managerial, clinical supervision. This edition presents articles on impressions of supervision in older adult placements gleaned from trainees by doctoral tutors (Milne, Marriman & Ormrod), a literature review looking at the ways in which clinical supervision can be delivered (Gibbons), especially helpful in the current economic climate where psychological provision is becoming increasingly thinly spread, and a paper that pulls the two threads of this edition together – a consideration of the benefits of including formulation as an integral part of the supervision of assistant clinical psychologists (Waugh, Vaughan & Andrews).

Thank you to all the contributors to this themed edition of the *Newsletter*. We look forward to our next geographical group contribution in the New Year.

Louisa

Many thanks to Sarah Dexter-Smith and Louise Bergin for their ‘editorial’ comments on my paper for this edition.

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Letter from the Chair

Don Brechin

HOPE THAT everyone has had the chance to get away over the summer and have a relaxing break – with all the pressures at work, we all need our time to get away and recharge our batteries.

It has been a busy time since I last wrote. I am pleased to say that we had a very successful annual conference at the British Psychological Society's London offices on 1 July. There was an excellent range of speakers (Polly Kaiser, Laura Sutton, Alison Roper-Hall, and Paul Salkovskis) who brought a varied range of subjects and perspectives to the event. The day was very well attended and excellent feedback was received from the delegates, so many thanks to Cath Burley and the training and development subcommittee for organising this.

We also held the AGM on 1 July. We managed to break with tradition by holding on to most of the conference delegates for the AGM, so thank you to all who attended! It was a chance to review the year and discuss plans for next year (more of which later). We said good bye to two long-standing committee members, Sinclair Lough as Outgoing Chair, and Alice Campbell as Treasurer. Both have served on the committee a long time, so we are grateful to them for their hard work for PSIGE. As some people leave, we also welcome new members to the national committee: Julia Boot, Mhairi Donaldson, Cerys Macgillivray, Louise Bergin and Lyn Sutcliffe. We also welcome back Liz Baikie to the national committee after a few years away. Many thanks to you all for coming forward and I know that you will bring energy and enthusiasm to the committee this year.

The AGM was also the opportunity to celebrate PSIGE's 30th birthday, complete with birthday cake (pictures available at www.psig.org). It was great to see how

PSIGE has grown from small beginnings to become one of the largest Faculties within the DCP, with over 550 members. It felt especially important to celebrate this landmark given the turbulent times in 2009 with the cancellation of the annual conference. A number of people took the time to come up and say how pleased they were to see the annual conference back on and that the work of PSIGE was continuing. This was very welcome feedback and a very positive way in which to start looking forward to 2010/11.

Since the summer, the national committee has held its annual strategy meeting at Parcevall Hall. It was a very productive two days and gave us an opportunity to think in detail about our activities for the next 12 months. As discussed at the AGM, we have agreed to focus our work on two topics for the year. The first of these is Dementia, and Liz Baikie has agreed to take the lead for the committee in co-ordinating our activities around this priority. We hope to deliver a number of objectives this year that will help members in working with the dementia strategies and plans across the four nations. The second topic is improving access to psychological therapies for Older People. The lack of capitilisation in this sentence is deliberate because the IAPT programme only exists formally in England, but the improving access agenda is relevant to all nations. Julia Boot has agreed to take the lead for the committee in co-ordinating our activities in this area. We will be using the national committee meeting on 8th November to develop more detailed work plans for both of these topics and we will be sending out more information after this.

The other key priority for the committee is to work with geographical groups to support them in their activities and ensure their ongoing vitality and survival. The local

GG meetings are the means by which we keep in touch with one another, and the GG networks are how PSIGE disseminates information and communicates internally. Without the GG networks and the GG meetings the Faculty would not work effectively, and we would lose a crucial means of providing support to each other. From a national committee point of view, we also need to make use of the expertise in those groups to help deliver the national work

plans described above. Therefore, the national committee will be meeting with GG group convenors on 9 November to discuss these issues and the national plans in more detail.

So, we have a busy year to look forward to!

Best wishes.

Don Brechin



Commentary

Georgina Charlesworth

PSYCHOLOGICAL formulation holds pride of place in the psychologist's skill set, and it is no wonder that it should. Examples of the perceived benefits of formulation are bountiful in this special edition including, but not limited to: increasing empathy with the client and enhance therapeutic alliances (Waugh, Vaughn & Andrews); providing a framework for organisational change (Hickman & Crawford-Docherty); being a vehicle for bringing together material from different professionals' perspectives (Dexter-Smith); improving communication and psychological mindedness within the multi-disciplinary team (Dexter-Smith); assisting staff in devising, implementing and monitoring care plans (Craven-Staines, Dexter-Smith & Li).

In this commentary, I consider what this issue tells us about teaching and learning the process of psychological formulation, and also pick up on issues raised on the status of the evidence-base for formulation and the potential harms that may arise from its practice.

How are formulations skills taught and learned?

Although it is easy to understand the purpose of formulation (viz. 'to make sense of assessment data and to form the basis of an action plan'), the process of producing formulations can be baffling. I have clear memories of the effort expended by my trainee-self in struggling with the 'how' of formulation, yet in common with the editor to this issue, formulation has become second nature. What does this edition tell us about how formulation skills can be taught and learned, and about factors that facilitate the shift from an effortful process to an automatic procedure?

A frequent starting point for teaching the formulation process is to provide a model or framework that can then be individualised by filling in exemplars of each domain or element. Frameworks cited in this edition include the 5Ps *predisposing, precipitating, predicting, protective, presenting approach*¹; the 'hot-cross bun'; Lemma's template for a psychoanalytic formulation; and, a behavioural model of hierarchical systems.

Dexter-Smith and colleagues used the 5Ps approach to psychological formulation as part of their sustained and inspiring campaign of training and support for its use in older people's services. An impressive 265 staff have attended training over three years, and the evaluation of training has been positive in terms of participant feedback. However, training in the background and use of a 'formulation template' has not been enough to result in non-psychology staff being confident in their ability to formulate, and the material covered in training days is, therefore, re-inforced and applied in weekly psychology-led supervision sessions. Although the supervision sessions are also well received, the closest that non-psychology staff have become to being independent formulators is for some of the most longstanding supervision groups to develop the confidence to meet even in the absence of the psychologist.

Psychological formulation is no longer the preserve of psychologists, but the ability to select between a number of competing formulation approaches is still more likely in a profession which aims to ensure that its trainees are competent in multiple therapeutic approaches. We expect psychologists to go beyond the use of a single generic

¹ Inflated the number of 'p's from the three we were taught in my cohort of trainees – predisposing, precipitating and perpetuating.

formulation framework and instead be able to determine the most appropriate approach for each client. James, Clifford and Makenzie outline a useful set of questions for consideration by trainees and supervisors which will hopefully ensure the appropriateness and usefulness of individually tailored formulations.

Is there any evidence of benefit from psychological formulation?

This special issue demonstrates our conviction in the benefits of individualised formulation and our enthusiasm for disseminating formulation methods to other staff groups. But is our evangelism justified? While I strongly believe strongly in the value of psychological formulation, I am aware that the evidence to support this belief is limited. Early comparisons between manual driven therapy and therapy based on individualised formulations tended to favour the manualised approach. However, the balance of the slowly increasing outcome literature on formulation is now tipping in favour of the use of individual case conceptualisation (e.g. Ghaderi, 2006) but has not been specifically studies with older populations. The use of individual case formulation and action planning is particularly encouraged for complex cases where there are multiple diagnoses and no manual for treatment, as would be applicable for many older clients.

What harm can arise from psychological formulation?

Generating psychological formulations is designed to have an impact, and unfortunately this impact can be harmful. James, Clifford and Mackenzie give a brief literature overview on the problems raised by use of formulation with older clients. Clients can report feeling pressurised by the conceptualisation for example where blame is assigned to one individual or where there is an implication that the self is weak. In addition both Dexter-Smith and Wainwright and Bergin document the ways in which staff can be adversely affected by involvement in the

development of psychological formulations. For example, staff can feel overwhelmed by clients' life-histories, for example multiple losses, and can struggle to use the formulation to generate ideas for intervention. When encouraging staff to use psychological formulation we may be intending to increase empathy, but without support some staff may feel paralysed by the 'realistic awfulness' of some clients' circumstances and revert to a position of therapeutic nihilism.

Recent literature on formulation within cognitive therapy has emphasised the need for careful consideration of the level of formulation, the need for collaboration and the benefits of including reference to strengths and resilience (Kuyken, Padesky & Dudley, 2008). These recommendations fit well with the person-centred and life review approaches taught for use with older people and the need to find a resolution to the dialectic of integrity vs despair.

Conclusions

Psychological formulation is a complex skill and a period of sustained effort and practice is required to develop the skill. One of the biggest barriers to the learning, teaching and application of psychological formulation skills is the time available for thought and reflection, and the importance of supervision time to support experiential learning is highlighted by Waugh, Vaughn and Andrews. To give an indication of the time set aside by Dexter-Smith and colleagues, the psychologists were facilitating weekly meetings for each team, and can spend up to an hour on initial formulations and half an hour on reviews. Not all managers would feel able to set aside this time investment by their staff, and formulation meetings are not necessarily recognised as legitimate clinical 'activity'. Although generic psychotherapy case formulation training can improve the quality of formulations (Kendjelic & Eells, 2007) there is a lack of evidence as to whether this can make a difference to client outcomes. Shirley demonstrates the way in which the Newcastle model is used to lead to

action plans, and this is a vital component of formulation activity if we are to create a measurable benefit in the quality of care provision.

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Integrating psychological formulations into older people's services – three years on (Part 1)

Sarah Dexter-Smith

IN 2007 I wrote about the initial ways in which psychological interventions were being integrated into the care of patients on two older people's inpatient units (Dexter-Smith, 2007) in Tees Esk and Wear Valleys NHS Foundation Trust (TEWV).

At that point, the Cognitive Behavioural Therapy (CBT, see Figure 1) model had been in place for approximately six months in the South of the trust and the North of the trust had just begun training with Ian James on the Columbo model (James & Stephenson, 2007). The CBT model has now become known in the directorate as the Roseberry Park (RP) model after the units it was initiated in, simply to distinguish it from the Columbo model that is also grounded in cognitive approaches. This left us with a legacy of needing to standardise the method of formulation employed across the trust whilst utilising the strengths of each model.

In expanding the use of the RP/CBT model to other teams in the directorate our aim has been to introduce a formulation structure that:

- Is theoretically sound and rigorous so that we raise the psychological knowledge base of the whole staff group and that the formulation model itself becomes a test of our understanding of the client.
- Is useful for, and incorporates information from, the whole multidisciplinary team. We have found the biological and behavioural aspects of the 'Hot Cross Bun' helpful in integrating medical/physiotherapy and occupational therapy assessments respectively. Leeming, Boyle and Macdonald (2009) also highlighted

the important role that biological aspects of emotional distress have for individuals and the danger of losing this with psychosocial formulation.

- Underlies and supports the core assessment and intervention process rather than being a separate piece of work that sits outside these fundamental requirements.
- Is appropriate for both functional and organic presentations. We have received comments that a CBT model in its pure form is not appropriate for organic clients. Our experience is the opposite of this. We have moved away from ABC forms and now use the Hot Cross Bun cycle to replace the 'B' (see Figure 2). We may start with a newly-admitted/referred client by filling in the bottom half of the model and working back up (rather than top down as is more typical with our functional patients), but the model has been invaluable in helping staff think about maintenance cycles, triggers in their widest sense (including internal triggers within the Hot Cross Bun), ways in which behaviour is learnt, and the role of staff and other systems in different points in this process.
- Enables staff to use one model to understand the entire continuum of complexity from basic brief assessments to complex challenging behaviour, thereby improving communication across the directorate's services by having a single model within which to formulate presentation and need.

Figure 1: The RP/ CBT Formulation Framework.

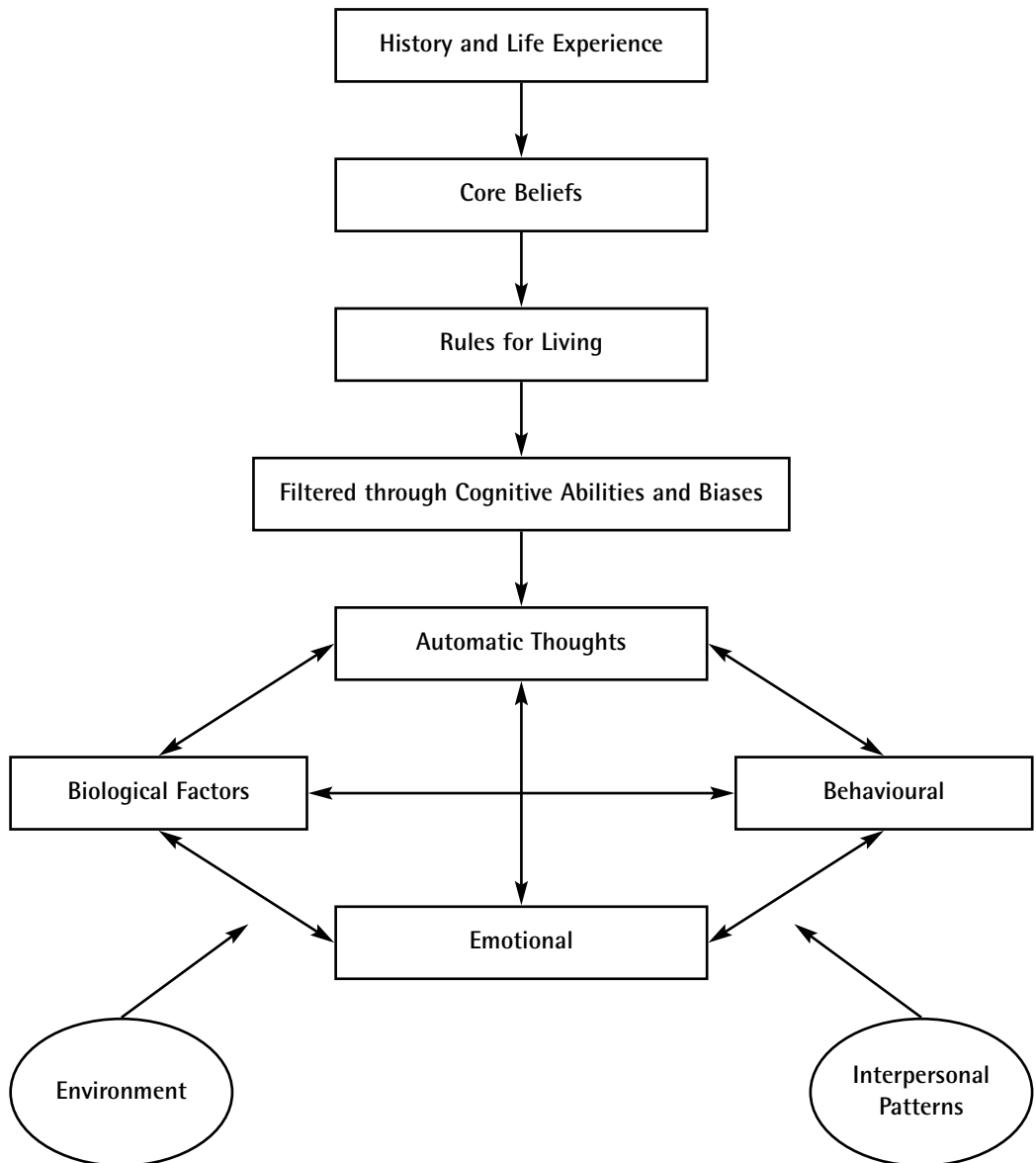
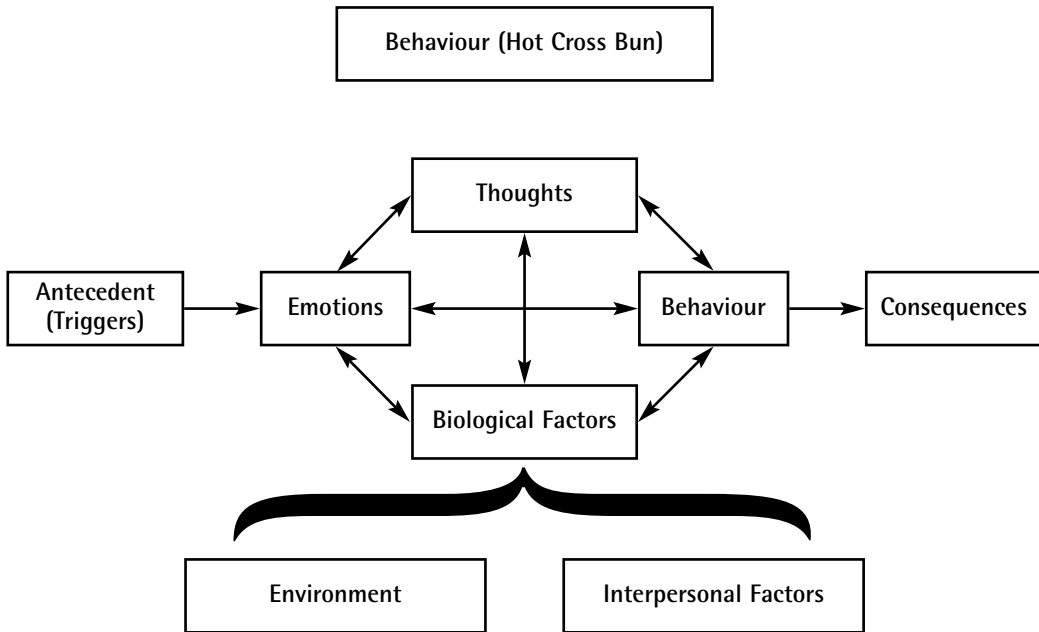


Figure 2: Replacing ABC forms with the 'Hot Cross Bun' cycle.



We have found it useful to think about whether we were trying to:

1. Just help staff do a more holistic and 'human' assessment.
2. Help them understand theory but essentially provide formulation consultation sessions that are psychology led.
3. Ensure that staff understand the theory so that the framework itself then 'tests' them to see whether the flow of information that they are putting in boxes is meaningful.

Our experience is that:

1. For this the Columbo model and the 5Ps are excellent. The 5Ps (Johnstone & Dallos, 2005) has helped staff think about the timeline of how a problem has developed and the Columbo model has helped re-humanise challenging clients. It has also been the easiest model to share with clients and families. However, it has left staff feeling overwhelmed by the amount of information about a client, for example, numbers of losses, because they have struggled to use the diagram to generate ideas for interventions.

2. This is an invaluable way of starting the process and has been essential in supporting unconfident staff to take this process on board. However, it is unsustainable in terms of psychology time and does not fundamentally enhance the knowledge and expertise of the wider staff group. It also reinforces dependency on psychology as an external expert rather than creating a more psychologically-minded culture.
3. This has been the hardest to implement in the initial stages in that it has demanded a comprehensive training package cascaded to large numbers of staff. It has also required a lot of initial input to support staff to gain confidence in utilising this model independent of psychology. However, it is the mechanism by which we have achieved the largest scale cultural change with staff from other professions owning and leading the process despite some sustained absences from psychology.

We have now integrated the Columbo and RP/CBT models within the directorate's dementia pathway, whereby Columbo is to be used for all clients in specialist community teams and the RP/CBT model within inpatient settings. This is a minimum requirement and other teams in the South of the directorate have taken the RP/CBT model as their means of conceptualising a wider range of clients, typically through their review process.

This and the following two papers focus on work related to the RP/CBT model within the directorate.

The Roseberry Park/CBT model

As shown in Figure 1, this is essentially a basic CBT framework with interpersonal and environmental aspects made explicit in terms of their contribution to the presenting and maintenance cycle. The use of the diagrammatic rather than written form has helped staff grasp patterns and engage with the material (see Moore, 2007, for a discussion of the potential consequences of which format is chosen).

We now also have a range of supporting documents such as crib sheets for staff, more accessible format documents for staff to complete with clients and families, a template to transfer the formulation to our electronic note system, etc.

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We have come a long way since that initial paper three years ago. Two-hundred-and-sixty-five members of staff across five CMHTs, a young onset dementia team, care home liaison team, and four inpatient units (functional and organic) serving a population in the region of 107,600 people over 65 years of age from five localities have been trained in the RP/CBT model and staff from the North of TEVV are beginning to attend training sessions.

In 2007, I acknowledged that this work needed evaluating and the following two papers present two parts of the audits that we have since undertaken. The first looks at the training programme that we developed to support this work. The second looks at the experiences of staff who have attended formulation meetings and used the model with their own clients.

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Integrating psychological formulations into older people's services – three years on (Part 2): Evaluation of the formulation training programme

Sarah Dexter-Smith, Sarah Hopper & Paul Sharpe

TRAINING has been defined as ‘a process which is planned to facilitate learning so that people can become more effective in carrying out their work’ (Bramley, 2003, p.4). This focus on changing the way people work and think was an important goal for us and is considered in the next paper. Training constitutes a large investment of resources with the NHS in England and Wales spending £1.2 billion per year (Audit Commission, 2001). This makes evaluation of the outcome of this investment essential and should provide feedback to establish the extent to which the training objectives are being met, and act as an aid to continuous improvement (Hackett, 1997).

The NHS Integrated Service Improvement Programme (ISIP) and the Care Services Improvement Partnership (CSIP) have both published guidance on clinical governance and principles. ISIP has published principles based on nine Care Delivery Systems (DoH, 2000) and this project falls under Principle 7: Optimised workforce capacity and capability. CSIP, in collaboration with the National Institute for Mental Health in England, have also published guidance aimed at promoting, encouraging and inspiring service improvement, entitled ‘10 high impact changes for mental health services’ (CSIP, 2006). The formulation training seeks to facilitate change No. 2, ‘improve flow of service users and carers across health and social care by improving access to screening and assess-

ment’ and No. 10, ‘Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce’. This is done indirectly by promoting the development of new skills, therefore increasing the workforce effectiveness, both in understanding current interventions and assisting or leading on new, formulation-based intervention and assessment.

The training

As the full Roseberry Park/CBT formulation is now a compulsory part of the Mental Health Services for Older People (MHSOP) directorate’s dementia pathway for inpatients, it is essential that staff have an understanding of the formulation process and the benefits it can bring, as contrasted with an approach that bases intervention on diagnostic categories. To support the integration of psychological formulation into services across the directorate we developed a two-day package of training. The first day was for all staff to attend whilst the second day gave qualified staff more opportunity to practice, given that they would ultimately be expected to develop formulations for their own clients.

Day 1 provided participants with an introduction to national and local service context, formulation, its uses and basic concepts, the collaborative nature of its development and contrasted this with approaches based on diagnosis. It outlined the 5Ps framework as

integral to all psychological formulations, and ended with a specific focus on cognitive and behavioural theories and cognitive behavioural formulation specifically. Day 2 built on this by practising formulating various different cases (including participants' own case studies, an audio play, a famous person and a contrived vignette). Qualified clinical staff are expected to attend both days and assistant staff the first day.

An interactive rather than didactic approach was taken as this has been found to be able to effect change in professional practice and, therefore, health care outcomes (Davis et al., 1999). Also, an MDT approach was taken, following from support in policy over the last 15 years for the premise that collaborative working leads to improved service delivery (Department of Health, 1998), with education and training being identified as pivotal to its implementation (Barrett, Sellman & Thomas, 2005). Teams are also one of the most effective organisational forms for bringing together the skills and abilities of the different professions, making them a lynchpin of effective care (Gorman, 1998).

Last year we evaluated this formulation training as it was delivered to MHSOP staff. Our question for this audit was: how do MSHOP staff perceive the delivery of the formulation training programme and does the training meet specific learning and development needs?

Methodology

Design

This study was a service evaluation involving analysis of quantitative and qualitative data from a standard trust evaluation questionnaire. Following each completed day of training, staff were asked to complete an evaluation form. These forms were handed out and then collected by the training staff and stored securely prior to data analysis.

Questionnaires

The Tees, Esk & Wear Valleys NHS Foundation Trust standard programme evaluation

questionnaire comprises eight items split equally between qualitative and quantitative questions. The items are designed to assess the participants' views on the training course they have completed, whether it was useful and informative, whether it met their development needs, and if there were any areas which could be improved upon.

Data analysis

The qualitative data sections of the questionnaire were initially subjected to content analysis, an approach used to interpret meaning from the content of text data (Hsieh & Shannon, 2005). A coding process was used to identify key themes emerging from the qualitative responses and their frequency of occurrence. It was then analysed using SPSS to provide descriptive statistics, in particular means and percentage frequencies. The data was analysed as a whole and also as Day 1 versus Day 2. Inferential statistics were also used, wherever appropriate, to examine any differences in the evaluation of the two training days, with *t*-tests being used for nominal categories.

Results

Participants

A total of 100 MHSOP staff had attended the training at this point, with 100 attending Day 1 and 61 also attending Day 2. Staff belonged to various MDTs and included social workers (13 per cent), physiotherapists (0.6 per cent), psychologists (2 per cent), occupational therapists (6 per cent) and both qualified (38 per cent) and non-qualified (12 per cent) nursing staff. A further 26 per cent of attendees did not specify a profession. Fourteen training days had been held, eight of Day 1 and six of Day 2, between April 2008 and February 2009 at various locations throughout the trust, with varying group sizes.

Evaluation of training

Ninety-three per cent and 95 per cent reported that Day 1 and 2 respectively had met their development needs. The

remaining respondents said it had partially met their needs. No one said that it had not met their needs.

The group/practical work was identified as most helpful on both days (especially the play and using their own client examples on Day 2) and the theoretical understanding additionally highlighted for Day 1.

Ninety-nine per cent and 93 per cent of respondents said that nothing should be removed from the course for Day 1 and 2 respectively. Responses to what should be added focused on more training/ refresher courses and some practical issues to do with refreshments and venues. Eighty-five per cent and 87 per cent said that all the content was useful (Day 1 and 2 respectively) and there was no pattern to what was nominated as least useful.

There was a high level of endorsement for positive descriptions over both days, with 'useful', 'interesting' and 'interactive' all being endorsed by over 70 per cent of attendees across both days. In addition, although all 15 positive items were selected to some degree, seven of the 12 negative items received no endorsement whatsoever.

Examination of the qualitative data reveals some key themes in the differences in perception of the two days. Coverage of theory is highlighted as a key strength of Day 1 as compared to Day 2, which is as expected given Day 2's intended function as a consolidation and expansion session. Day 2 is seen as more 'intense' but also as more 'fun', again perhaps reflecting the differences in delivery style and the increased emphasis on small group practical work rather than didactic teaching. Indeed, for both days, group work and practical examples were strongly endorsed as strengths of the course. Other strengths of the course were the chance to interact with different members of the MDTs and the practical work such as formulating an audio play.

Suggested changes to the training included reducing the theoretical content late in the afternoon, more practice, and extra training sessions.

Discussion

Overall, the quantitative and qualitative data indicate that the training has been a positive experience which has met the developmental and training needs of staff. The key strengths of the approach that have been highlighted are the use of group work and practical examples, as well as an opportunity to interact with different members of the MDT. The general theoretical background and delivery of specialist knowledge were also highlighted. With regards development of the training days, improvements of the venues and facilities provided would seem to be a key area. There is also a strong desire for increased follow-up/refresher sessions, increased group and practical work and a possible restructuring of the content of Day 2, particularly the high afternoon workload.

Since this audit was carried out, we have continued with the training and 265 members of MHSOP staff (predominantly from the South of TEWV) have now attended (at the point of writing in August 2010). We are in the process of rolling this out into the North side of the directorate. We now have increased support from psychology in the remaining localities and consistent agreement on the level of support that local psychologists will need to provide to develop and monitor these skills in the longer term. Therefore, some of the practice that Day 2 was intended to provide is now being done in practice under the supervision of the teams' psychologists. As a result, the training has now been reduced from two days to one and we have clear plans for following this up with supported service implementation in each locality. Although losing some of the practice elements of the training is a potential loss, the clearer strategic plan for implementation and support for practice in action in these latter localities should balance this out.

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Integrating psychological formulations into older people's services – three years on (Part 3): Staff perceptions of formulation meetings

Sarah Craven-Staines, Sarah Dexter-Smith & Kathy Li

PROVISION of psychological formulation meetings utilising the Cognitive Behavioural model (outlined in the introductory paper) has become a regular occurrence within the Mental Health Services for Older People in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

Formulation involves establishing the narrative of a person's life, drawing together disparate information in an attempt to see the person's difficulties from a holistic perspective, viewing their life and situation as a whole. It is 'the tool used by clinicians to relate theory to practice' (Butler, 1998, p.2) and 'provides a rationale for intervention, a process through which to organise large amounts of information in a systematic way' (Brooke, 2004, p.36, commenting on work by Kuyken, Johnstone & Dallos, 2002). For us the key feature is that formulation is person-centred and uses both theory and evidence, thereby providing a crucial balance between humanity and systematic rigor in our work. A formulation approach can be particularly valuable in dementia care, a key priority for MHSOP. It encourages the examination of underlying causes and mechanisms, taking into account the person and their life story as a whole, rather than just attending to overt behaviours and symptoms, leading to an increased understanding and specific, focused intervention. This can help avoid the malignant social psychology and environmental problems which can occur, unwittingly, in health care settings as a result of a failure to consider the individual (Kitwood & Benson, 1995). In

support of this it has been found that person-centred approaches to understanding and communicating with persons with dementia, and interpreting these in the forms of individualised care plans, can help reduce incidents of challenging behaviours in nursing homes (Moniz-Cook, Stokes & Agar, 2003).

Whilst the overarching structure of the meetings have remained the same across localities (based upon the same model, teaching framework and evidence base), the organisation of the meetings has differed depending upon the locality's development and availability of the clinical psychologist. However, they have all been led by the clinical psychologist for the locality until other identified staff were competent and confident enough to begin leading meetings themselves. Typically, they have included staff from a range of professions as appropriate such as occupational therapy, nursing (qualified and assistant), physiotherapy, and occasionally psychiatry. The aim has been to make sense of the information that we have within the theoretical model and to identify gaps in or seemingly contradictory pieces of knowledge about the client. This is then linked to a single MDT intervention plan. Meetings usually take up to an hour for a first formulation and up to half-an-hour for a review. This has been dramatically speeded up with the introduction of sheets for staff to complete with the client/family beforehand. We often work top down, partly because this makes more logical sense but also because our experience has been that leaving the session unstructured results in a dominating

focus on challenging behaviour so emotions run high before we have got to know the client (or to realise our lack of background information about the person themselves).

The following audit was carried out within two localities in the South of TEWV.

Within Locality 1, the formulation meetings have been running since mid-2006 in two inpatient settings, on a weekly basis for an hour-and-a-half on each unit. Within this weekly group, staff complete either two new formulations or four formulation reviews. Initially, the formulation meetings were led by the clinical psychologist working within the team, however, now staff within the Multidisciplinary Team (MDT) feel skilled enough to continue to hold such meetings even if the psychologist is absent.

The formulation meetings in Locality 2 have been running since April 2009. Here, formulation meetings are held on a twice weekly basis, one for the community team and one within the inpatient unit. The duration of each meeting is one-and-a-half hours, and is facilitated by the clinical psychologist within the team. Within each meeting, one hour is dedicated to a new formulation and half-an-hour is dedicated to a review.

As Locality 1 led the way in implementing the formulation meetings within their area, the meetings were initially held prior to staff attending the formulation training documented in the previous paper. As the formulation training was developed and delivered, staff from Locality 1 began to access the training sessions. By April 2009, the training package was being offered regularly and therefore staff in Locality 2 were able to access the teaching concurrently to starting their own formulation meetings.

Although the directorate has now implemented this formulation model for all inpatient clients on the dementia pathway, the future aim for these specific localities is for all inpatients to have a psychological formulation completed whether they have functional or organic presentations. During the period of writing this up, Locality 1 has now achieved this and all patients have an initial

formulation which is reviewed at appropriate intervals. This locality is now moving towards having the formulation initiated at the 72 hour CPA meeting and a full MDT formulation completed at the second MDT meeting after admission.

The following audit was designed to explore staff perceptions of the formulation meetings held within their own locality in terms of the process, impact, and theoretical understanding.

Methodology

Design

As the localities within the directorate were at different stages in terms of the delivery of the formulation meetings we took a longitudinal approach to the audit. A semi-structured interview was developed, comprising 12 open-ended questions covering understanding of the purpose of the meetings, the theoretical model, the benefits of the process, barriers to the meetings any changes that could be made to develop the meetings in the future. Participants included both qualified and assistant staff and staff who had and had not attended the formulation training. Staff were recruited through opportunity sampling.

- Phase 1 comprised staff from Locality 1 who had not attended the training (as this had not yet been developed) but had been attending formulation meetings for one year.
- Phase 2 comprised staff from Locality 1 who had attended the training and worked in a unit where the formulation meetings had been running for two to three years.
- Phase 3 comprised staff from Locality 2 whose meetings had been running for seven months and were a mix of attending/not attending the training as the set up of the meetings and the start of the training coincided for this group.

Procedure

Staff members were included on a voluntary basis. They were approached by the volunteer psychologist either directly or by e-mail.

Information was then provided to them verbally and an information sheet regarding the purpose of the audit was given if they agreed to take part. A consent form was signed by each participant. Each interview was carried out on a one-to-one basis between the volunteer psychologist and staff member, which guaranteed that the staff's identity was anonymous from the clinical psychologists and other staff members. This was important to ensure that the staff member felt comfortable in sharing their true perceptions of the formulation meetings. Given the time constraints for staff within the localities, the interview was designed to be completed within a 15- to 20-minute time frame. Interviews were tape recorded and transcribed by the volunteer.

The three authors read the transcripts individually to highlight key themes. After this process, the authors met to share these themes and to come to a consensus on superordinate and subordinate themes.

Results

A total of 20 staff were interviewed from an opportunity sample across the localities; 12 from Locality 1 (eight in Phase 1 and four in Phase 2) and eight from Locality 2/Phase 3. In Locality 1, seven were qualified and five were assistant staff. In Locality 2, seven of the eight staff were qualified. In all groups, staff came from a variety of professional backgrounds including staff nurses, occupational therapists, social workers, support workers and health care assistants.

There were a number of general themes that reflected similarities across the localities and phases.

1. Theoretical/Knowledge based statements

Naming versus explaining the model:

Fifteen of the interviewees could not name the Cognitive Behavioural model used within the formulation meetings and five were able to name it. Despite being unable to name the model, all interviewees were able to provide a description of the model, incorporating the Cognitive Behavioural

terminology into their accounts. For example:

'Basically in the groups ... what we do is ... basically gather quite a lot of information from the clients and that ... we put it all together ... it's like a jigsaw puzzle ... and we end up putting it all together ... and basically we get to know that person more in depth ... and go and see if we can put that back into their lives to give them a better quality of life.'

'We discussed the five Ps, predisposing, precipitating, predicting, protective, presenting ... looking at from the CBT approach ... looking at thought process, automatic thoughts, core beliefs, rules for living ... and then when you get all the information together ... you use that to formulate kind of a plan.'

'History, presenting problems. Look at the behaviours to see if we can identify any trigger factors and the strategies we can put in place.'

Impact of the formulation training

Those who had attended the formulation training were more articulate in their answers with regards to the theoretical underpinnings of the formulation meetings. They were more coherent in their accounts and able to elaborate more upon the process and purpose of the meetings.

2. Clinical implications

Increased understanding of the client

A number of staff mentioned the usefulness of the formulation meetings in increasing their understanding of clients. For example:

'Even when you know the patient completely, there are still some blind spots which you ignore or go unnoticed. Each person from the disciplines sees the person from a different perspective so it's more than likely that we are able to cover most of the needs the person requires.'

'I think its getting to know the person better ... I suppose what makes the person tick ... try to get an idea of the person's background, like what makes the person tick, and what influenced the person in the past ... gives us a better idea of what approach is suitable for that person, planning for the person's future care.'

'The benefits hopefully is that we get a much more accurate picture of the patient and hopefully focus on their needs and problems not necessarily the staffs.'

Care planning

Staff frequently reported the benefits of the formulation meetings in developing individualised care plans for clients. In doing so, they acknowledged the holistic approach to the formulation and the added value this provides in terms of developing MDT plans of care.

'I like the way that you end up having a clear idea of what your role is in the process. Rather than having a care plan for OT, the nurses having a care plan and psychology having a care plan, it we've all got one then we are working from the same song book.'

'I think part of it is sort of everybody getting together and looking at future care planning, or how you can apply interventions for the clients...and obviously to make staff, family and other people aware of what's going on.'

'I think the staff have become a lot more aware ... that we need to individualise care ... and we need to look at the person and particular things like ... you know when people are getting up during the night, well, was that their pattern anyway throughout their lives ... or if people have been shift workers they maybe got up at two, three, four, five o'clock in the morning and people y'know instead of saying 'oh no its six o'clock in the morning you must go back to bed' ... y'know I think its sort of ... I think in that way people are more aware that we need to sort of take on board the individual preferences.'

Implementing and monitoring care plans

In addition to recognising the usefulness of developing holistic care plans, staff also identified the positive impact on quality of care that the formulation meetings brought by the regular inbuilt monitoring of shared care plans within the team that have come from the formulation.

'The benefit of running the group is that the whole of the MDT team then has a plan to

work towards that can be reviewed and discharge planning can be made more client-centred ...'

Clear strategy for disseminating information

Staff frequently highlighted the usefulness of the formulation meetings to draw together a wealth of information about a particular client, to be able to document this and to disseminate this to other members of staff involved within the client's care.

'I did have somebody who had formulation meetings that I have acquired, and that was very helpful because they obviously have the plan that they could give to me, so when I was following up this lady in the community ... and she eventually went into care home, I was able to sort of share that with the care home staff as well, and continued that when she was discharged.'

'You get a more holistic, clear view, plus it's accessible on the [electronic record system] for other staff to quickly read through, to get the most of the person, as opposed to finding different information from separate locations, all around case notes or case files.'

Improving thought processes

Staff across the localities highlighted the usefulness of the formulation meetings to allow them to think differently with regards to their clinical work and what they are or are not able to offer.

'I have learned new skills and it has also made me think more about my approach. Maybe it's my approach that is activating some of the challenging behaviours.'

'I think doing them with the psychologist has helped me think out the box a little ... they encourage you to think out the box.'

3. Impact upon the Service

Multidisciplinary team working

The majority of staff recognised that the formulation meetings had improved the multidisciplinary team working and recognised the importance of utilising different professional skills within the context of the care for the client.

For all we work as a team, our approaches and our interventions, the way we think and everything is quite different and it just brings everything together to a more holistic approach which is totally client-centred and then you can focus on where to go, formulate a plan from that and it plans where to go with that patient.'

'I think because it gets everybody together so its multidisciplinary, everybody involved in the person's care is able to get together and look at the information ...'

Time commitments

Most staff recognised the main barrier to implementing the formulation meeting as the amount of time needed in to prepare for, gather information and conduct the meeting. For Locality 2 community staff, this may have been a potential reason as to why staff had been unable to attend.

'The major problem here is actually getting the time to do it ... I mean it's something that we know we have to do and set aside time for but because of the demands of this ward and the demands of the patients on this ward, it's actually finding that time ...'

'I think probably the time. I think getting everybody together, and workload, and time commitment.'

Greater knowledge of own and others roles

Staff felt that, through implementation of the formulation meetings, they have been able to recognise in more depth and define their own skills and roles that can be offered in a client's care, alongside that of other professionals.

'It gave you quite clear, defined roles about how you'd deal with her ... who would deal with her ... who would not deal with her ... cause we did have cases where we'd have to say who wouldn't.'

4. Specific themes and differences across localities

It became apparent through analysis of the transcripts as a whole, that some distinct themes occurred within Locality 1 as

opposed to Locality 2. Staff interviewed from Locality 1 more readily provided service based knowledge in relation to formulation, the role of leadership in driving the formulation meetings forward, the importance of delegating roles to different members of staff and the impact that staff can have in maintaining problematic cycles for clients. Such themes may have been due to staff in Locality 1 having used formulation meetings for a longer period of time and, therefore, having worked through some of the longer term issues about leadership, sustainability, and integration into ward culture and practice.

It appeared that these staff members were also able to provide more in depth responses overall and were thinking more broadly in terms of the utilisation of the formulation meetings. It seems that, over time, staff do become more confident in facilitating and making use of the formulation meetings, alongside requesting the attendance of family members at such meetings.

Discussion

In general, staff were positive about the formulation meetings in both localities and were able to be constructively critical about the process of the meetings. For example:

- Staff recognised the benefits of the meetings, such as increasing their knowledge base about the client, developing shared care plans, facilitating MDT working and increasing dissemination of information.
- But they also talked about potential barriers to implementation such as the time constraints to facilitating the sessions, not having the families routinely involved, and needing more involvement from non-qualified staff. Such barriers are important to identify in order to consider alternate approaches to the delivery and continued implementation of the formulation meetings.

Interviewing staff from two neighbouring localities at different stages of implementation of the formulation meetings was also

useful to provide an informed account of developmental changes in staff members' involvement and understanding. In particular it seems that with time, staff feel more confident in recognising the strengths and weaknesses of the formulatory process, leading this themselves, and acknowledging their own potential role in the maintenance of challenging behaviours.

Overall summary

Staff have responded positively about the training and the formulation meetings. It has been a time-consuming process, but has increased in momentum and become a standard aspect of care within many of our teams.

However, there are many other ways of implementing the use of formulations in older people's services and we know that there are other pieces of work ongoing round the country. The following is a brief summary of some of the things we wish we had known or been prompted to think about at the outset.

- There is sometimes a temptation to try and start these initiatives in teams that are already running well and successful in their own right, in the belief that they have the structures and skills necessary to build the momentum. However, we have found that the opposite has worked. The changes outlined in these papers originated in a unit that, at the time, was struggling to work effectively and have since been most resisted by the teams and units that feel they already work well. As Wooton (2007, p.255) commented 'Resistance to innovation is usually most deeply entrenched in those institutions that feel they have the most to lose'.
- Similarly, it helps to go for the most complex patients that the staff are stuck with and have faith that the formulations (and you) will help. These early wins create a story or narrative that you can build on that staff can easily identify with.
- Don't feel rushed into providing ad hoc training – step back and think about the

overall change that you're trying to create.

- Stay simple – it's tempting to think about all the other formulation models that you could use for different patients, but that's the work for you to continue to do on a consultation basis (e.g. we do CAT-based consultation and supervision groups, especially for their work with people diagnosed with personality disorders). If you're aiming for large-scale change you can't afford to try and train staff in too many models. Although 'we do not know which kind of formulation is best' (Butler, 2006, p.11), to create widespread change in ways of thinking of staff at all levels, they need to have a single coherent framework around which to organise these thoughts.
- Get the supporting documentation ready so that staff have a range of tools to use with clients and families depending on their own confidence/competence and the complexity of the client presentation, that will gather information directly relevant to the formulation structure.
- Make sure assistant staff are in the meetings; they have all the seemingly small bits of information that bring a client to life in the meeting.
- Buy a projector for each team that you are going to work with so that you can type the formulation up as it is discussed rather than having to transfer it from the paper sheets.
- Remember to step away enough to let others take over some ownership of the process. It can feel daunting to let go of something so central to our professional identity but some of the most striking changes in our teams have been when one of us has set up the work, done the training, supported staff to embed it and then left for a period of time such as maternity leave.

We are excited that the use of psychological formulations is becoming near routine in this and other services and that the benefits are being seen in the way that staff from

other professions are able to conceptualise and respond to complex needs. A valuable by product has been an increasing clarity about the wider roles of psychology and the increased understanding of some of the fundamental tenets of our profession. Our future plans are to think about the impact of formulations on risk perception and management and to build on the way in which we share the process with patients and their families

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Psychodynamic formulation with older adults: A case example

Claire Appleton

THERE IS increasing recognition that psychodynamic psychotherapy with older adults is effective and that the later years can be associated with emotional growth.

Waddell sums it up as the following:

‘Development, at whatever age, is founded in the capacity to go on engaging with the meaning of experience with imagination, courage and integrity. Freud’s exhortation that ‘one must try to learn something new from every experience’ remains as true in the last part of life as it has ever been.’ (1998, p.195, para one).

Despite this, for many clinical psychologists who may not have received extensive psychotherapy training, the process of psychodynamic formulation can at times seem elusive and daunting. In the following article I will describe the application of a formulation template provided by Lemma (2003). In reality I have not felt it necessary to adapt this for work with older adults but have merely attended to cohort and contextual factors (see Bob Knight et al.’s, 2008 work in adapting psychotherapies for older adults).

Psychodynamic formulation

Most clinical psychologists working with older adults will be working within an NHS setting rather than specialist psychodynamic

psychotherapy services. As such they are usually required to gather information during the course of the assessment regarding the specific needs of this client group (e.g. information about neurological status, physical health needs, medication etc). This will inevitably change the *tone* of the initial sessions and by default, in my experience, will lead to the use of considerably more structure (and at least initially, less use of silences) than a client might experience for example in either specialist psychodynamic services or private practice.

In terms of content Davenhill (2007, p.51) describes the utility of various aide memoirs to have in mind throughout the assessment process, this gives the assessor some structure to work with whilst allowing the therapist to move from concept to concept without feeling completely at sea. These include reference to Hinshelwood’s work (1991) and Malan’s two triangles of person and conflict (1979).

Lemma’s (2003, p.171) template provides a framework for understanding how early care giving relationships can lead to the development of particular problems and associated defences. This template maps neatly onto object relations (e.g. Klein, 1975) and attachment theory (Bowlby, 1969) which I have found particularly relevant in my work with older adults.¹

¹Another useful point of reference is Waddell’s work (1998). She makes links between the ‘states of mind’ in infancy and childhood and the later years. Consistent with Klienian theory she believes that any one state of mind in the present can have its roots in an earlier developmental phase. As such it is entirely possible that some of our older clients as they face the challenges of loss, separation and dependency will regress to states of mind associated with an earlier phase of development. Importantly Waddell notes that the key question is whether or not the client can view this as an opportunity to work through an earlier difficulty or whether it is to be avoided altogether.

Assessment information

When trying to build up a psychodynamic formulation information can be gathered from the following broad areas:

1. **Detailed history of object relations:** See Table 1.
2. **Transference phenomena:** i.e. is the client relating to you 'as if' you were their mother, father, grandmother, sibling, etc.
3. **Countertransference phenomena:** What feelings are being evoked in you? This may represent projected feelings from the client with which you in some way identify with (projective identification).
4. **Unconscious communication:** Unconscious material may be expressed in various verbal and non-verbal ways.
5. **Observation and inference of defences:** Examples include incompleteness in the client's accounts, vagueness, pre-occupation with excessive detail, tangentiality.
6. **Responses to trial interpretations:** For example, do they seem to promote integration?

In addition to the above I need to consider what specific factors about the ageing process may have precipitated the client's current difficulties (e.g. deteriorating mobility and health) and what cohort factors are relevant in terms of the genesis and interpretation of their difficulties?

The Case

Mrs B was 68-years-old at the time of the referral which was made by a psychiatrist working in older adult services. The referral was asking for input with regard to helping Mrs B work through the bereavement process.

I saw Mrs B and over a period of two years on a fortnightly basis for a total of 35 sessions. The formulation evolved continually over a period of time as the therapeutic relationship deepened and Mrs B became

more able to use particular components of a psychodynamic approach (i.e. ability to work in the transference, to discuss openly thoughts and dreams).

In the following section I will illustrate how I used Lemma's template (as described in 2007, pp.169–171) to formulate my client's difficulties.

Psychodynamic formulation

Step One: Describe the problem

The problems as seen by the patient: What are or who is the patient reacting to?

What is the patient's 'core pain': what is she the most afraid of/trying to avoid?

In Mrs B's case, her perception of her difficulties was in the first instance her sense of grief following her husband's death, however, over time it became apparent that one of her main concerns was her future and in particular her own failing health. This can be thought about as her difficulty in separating from her husband which may also relate to earlier difficulties in separating from her mother as a feature of their attachment status.²

Linked to this was a fear about being cared for by others, that she would be somehow 'too much'. *Her core pain could be formulated as a fear of rejection by others if she were to openly display her vulnerability and her care needs.* Although these were longstanding fears they had perhaps been accentuated following the loss of her husband.

Another feeling or emotional state that Mrs B was perhaps trying to avoid was an overwhelming sense of anger that she harboured against her mother whom she felt had rejected her continually throughout her life. Again, she had defended against this in various ways (see section four on defences) which were now becoming more difficult to use (for example, excessive cleaning of her house and washing rituals).

²Winnicott (1965) in his publication *The capacity to be alone* discusses how the child's ability to be alone is inextricably linked with a secure bond with the mother which facilitates such separation. If this bond is not sufficiently secure then the child may have difficulties separating or being alone throughout their life.

Table 1: Some prompts for assessing the quality of object relationships
(from Lemma, 2003, p.152).

<p>Be curious about the nature of the object relationships by asking the patient:</p> <ul style="list-style-type: none">● What is your earliest memory?● What kind of person was your mother/father/sister, etc?● Can you recall a time in your childhood when you needed help? Who did you turn to?
<p>When assessing object relationships think about:</p> <ul style="list-style-type: none">● The flexibility, adaptiveness and maturity of representations of self and other.● The degree of differentiation/relatedness of self and object representations. For example, whether there is evidence of ...<ul style="list-style-type: none">– self/other boundary compromise (i.e. basic sense of integrity is lacking/breached as in psychosis);– self/other boundary confusion (i.e. self and other are represented as physically intact/separate but feelings are confused/undifferentiated);– cohesive/individuated self and other representations.● The maturity of representations of self and other:<ul style="list-style-type: none">– people are described primarily in terms of the gratification or frustration they provide;– people are described in concrete, literal terms (usually on the basis of physical attributes);– people are described primarily in terms of their manifest activities/functions;– descriptions integrate external appearances and behaviour with internal dimensions, i.e. contradictions can be managed.● The thematic content of the descriptions of others, for example, are others experienced as:<ul style="list-style-type: none">– affectionate;– withholding;– successful;– strong/weak;– ambitious;– malevolent/benevolent;– cold/warm;– intellectual;– judgemental;– nurturing;– punitive.

Step Two: Describe the psychic cost of the problem

What limitations in the patient's functioning or distortions in his perceptions of others and self have resulted from the problem?

Over her lifetime Mrs B has found it difficult have her own emotional needs met and has expended a great deal of energy in caring for others, often to the neglect of her own wants or desires. For example, when her husband was dying of cancer she continued to find it difficult to say no to a domineering female

friend who in many regards was similar to her mother in that she made considerable demands on Mrs B (e.g. she asked her to wallpaper her entire house despite her husband's more pressing needs). In addition to this pattern Mrs B finds it difficult to express her sense of vulnerability in her relationships. She does not share her worries or concerns with close friends or family members for fear that she will be a burden or somehow 'too much'. This is very reminiscent of her experience as a child whereupon

her feelings of fear and anxiety are left undigested without either a robust internal container or the opportunity of them being worked through with the support of a trusted person.

Step Three: Contextualise the problem- identify relevant predisposing factors

Ask yourself: How do the environmental and biological givens relate to the presenting problem? (E.g. how do they modulate or exacerbate it?)

Several aspects of Mrs B's early relationships, in particular her relationship with her mother, may have predisposed her to develop difficulties with separation and dependency.

Mrs B is an only child, born just before the onset of the Second World War.

Relationship with mother: Mrs B in the initial sessions described her mother as 'lovely', but as time went on she described a very impoverished relationship. Her mother openly stated throughout Mrs B's childhood that she had always wanted a boy. Mrs B had been a difficult birth and she recalled that her mother was very unaffectionate. Mrs B noted that her mother fell pregnant before she married, which in her generation would have been associated with stigma.

Mrs B's mother showed some obsessional tendencies with regard to keeping the house and her person clean. For example, all furniture in the house would be covered in plastic and new carpets would be bought every six months for the sake of cleanliness. Her mother's views regarding personal hygiene were quite extreme and would include extensive hand washing. She would stipulate the same routines for Mrs B. There was also a sense that these routines were somehow linked with intimate relations and relations to men. Mrs B's mother demanded particular standards with regard to her general behaviour and demeanour which seemed linked to a general distrust of men. For example, if sitting Mrs B would always have to sit crosslegged as to not do so would be considered 'indecent'.

Mrs B recalls many attempts to find acceptance from her mother in her actions throughout her life. Unfortunately she felt that she never received the approval or unconditional regard she desired from her mother. Mrs B notes as a child that she was given many presents but that these felt like symbols of status devoid of any genuine affection and she recalled a deep sense of loneliness as a child. She recalls that comments were made from other people in the family about the lack of affection from her mother. This evoked a number of reactions in Mrs B. On the one hand she wished to deny this and to protect the possibility of her mother being a 'good' mother and someone who would eventually come round to loving her. In this sense she never gave up on the hope that there would be reparation between them and that somehow magically her mother would realise that she was loveable. On the other hand she would feel angry and let down but unable to express this.

Relationship with father: Mrs B spoke in very warm terms about her father, stating that after his return from the Second World War, they developed a close relationship and one of which her mother was somewhat jealous. Her perception of her mother and father is somewhat split in that her mother is regarded as hostile, unloving, manipulative whereas her father is perceived as kind, warm, gentle and loving. Furthermore the description of her father was considerably less rich, which made me wonder about the use of idealisation.

Relationship with her children: Mrs B has two sons, the eldest she rarely sees and the second with whom she has a very close relationship. Although this relationship is a close one it is very much one way from the point of view of care. She was reluctant to ask for any help from him regarding the maintenance of her house which is now becoming rather cumbersome, or emotionally in terms of discussing her worries and concerns about her health and future. Over the years Mrs B

has spent a great deal of time looking after her own children, other relative's children (nieces, nephews, etc.) and grandchildren. She notes that after her husband's death she has wondered whether their relationship suffered as a result of the amount of time and effort they both put into caring for others.

Why now?

The loss of Mrs B's husband may represent a loss of containment. The many physical health problems she has experienced over recent years and a general decrease in mobility heightened her sense of vulnerability.

Step Four: Describe the patient's most dominant and recurrent object relationship.

Ask yourself how does the patient experience herself in relation to others?

Mrs B fears rejection and desires approval to such an extent that she has often gone beyond what has been required of her in her interpersonal relationships. This repeating pattern has been evident with regard to her relationship with her mother, with other domineering female friends, and with her own children. One interpretation is that because Mrs B was so fearful of the experience of being cared for she split off her own emotional needs in this area which were projected onto others (her mother, children, grandchildren) who she then cared for and got her needs met vicariously.

In the case of her relationship with her mother and her domineering female friend, she found it very difficult to say no to their requests or express her sense of irritation with or about them.

Step Five: Identify defences

Ask yourself: What are the possible consequences of change?

Defences

Mrs B used a variety of defences throughout the sessions. It was noticeable that earlier on in our work together she would distract from

difficult areas of conversation by talking about seemingly superfluous matters either in the media or her everyday life. After a while I began to realise that this was being used unconsciously to prevent discussion from more difficult areas, for example, her own dependency needs.

Manic/obsessive defences

Manic defences are a group of primitive defences distinguished by their aim of denying depressive anxiety and guilt.

Mrs B's excessive tidying, cleaning and buying/hoarding of objects could be thought of as a manic attempt to keep 'messy' feelings under control. These feelings might include repressed rage against her mother but also sexual urges which would have been deemed unacceptable by her mother. In addition Mrs B could be thought of as trying to control feelings regarding her fear of failing health, dependency and ultimately mortality. Tidying was a way of trying to 'keep on top' of these difficult feelings but was becoming increasingly more difficult to achieve as Mrs B's failing health meant that she had less energy for such activity.

Splitting/polarisation

In some ways Mrs B was polarised in her views regarding men and women. Women are bad (mother, lady next door, granddaughter) men are good (idealised father, husband, to lesser extent son). This kind of defence avoids keeps at bay worries about rejection. For example, if 'all women are bad' then it seems a less punishing prospect to be rejected by them.

Projection and projective identification

This involves attributing states of mind from one person to another and relating to them as if they are the embodied projection. The therapist under the force of the projection can begin acting in a manner consistent with the projection.

In Mrs B's case I became aware that at times I felt as if I was being intrusive in the

sessions or alternatively that I was being controlled by some of her comments (for example, at one point when we were working towards an ending I felt backed into a corner in terms of extending the contract). Both of these sets of emotions, that of feeling intruded upon and being controlled could be thought of as aspects of Mrs B's mental life that were difficult to tolerate and, therefore, split off and projected into me.

Step Six: Identify the aims of treatment

Ask yourself: What does the patient want and what does the patient need?

To provide a safe and containing environment within which Mrs B could explore and acknowledge the complex feelings she has regarding her mother (including her rage, intrusion and manipulation).

To assess how the above impacted on her development and led to the development of particular coping styles and to the negation of her own emotional needs.

It is of note that at those times in sessions when Mrs B expressed irritation towards her mother in the subsequent session she was very concerned about my welfare, almost 'as if' I was the mother who was having such irritation directed towards her and that furthermore I would not be able to bear this. It was very important to interpret this within the session and also any irritation she might have about the sessions ending and her sense of abandonment.

To provide the space for Mrs B to contemplate her own dependency needs within the context of her immediate and more distant future.

To be attuned to her attempts to distract from this task by 'gossip', talking about peripheral matters and trying to develop a 'friendship' tone to the quality of our relationship.

Concluding comments

Templates and aide memoire's can be useful in organising complex information into a meaningful formulation. In the above case Lemma's template provided a useful guide for treatment. Over the course of my work with Mrs B we gained a deeper understanding of the unconscious determinants of her behaviour, she gained insight into her defences and ultimately re-engaged with a more authentic sense of self. Within her interpersonal relationships Mrs B is now more able to assert her viewpoint and is considerably more realistic about her needs to obtain help as she approaches the final years of her life.

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Trainee guidance on the use of case formulations for older people

Ian A. James, Mary Clifford & Anne Lorna Mackenzie

This article summarises advice given to trainees and students on placement at the Newcastle Psychology Service regarding the use of formulation frameworks. The first section deals with the principles of formulation, and the second examines the processes involved in choosing the most appropriate framework to use. Much of the material is taken from a chapter from the first author's text on CBT for older people (James, 2010).

Principles of formulation

ONE OF THE differences between working with older versus younger people is the potential complexity of elders' formulations. Trainees are often faced with a wealth of patient information and an extensive list of theoretically based frameworks. In an attempt to simplify this process, we suggest the use of the following set of nine statements in supervision to help trainees determine the most appropriate formulation approach for their patients:

1. Identify people's formulations (whose formulation is it anyway?).
2. Ensure interventions are formulation-led.
3. Compare utility with accuracy.
4. Sharing of formulations.
5. Avoid 'kitchen-sink' formulations.
6. Acknowledge the assumptions of the formulations.
7. Recognising the therapeutic platforms embedded within some formulations.
8. Understand the differences between the model/frameworks and acknowledging their biases.
9. Recognise your own skills and knowledge base.

Before discussing the items, it is important to recognise that there is confusion about the term formulation. Hence, for purposes of clarity, when describing formulations in this section, I am referring to the framework, and not the process of producing the framework (Flitcroft et al., 2007).

1. Identifying people's formulations in their various forms: The formulation framework can be composed of *either* an elaborate model of beliefs, thoughts, links made across time, or a simple set of conceptual statements regarding the patient. At the beginning the therapist's formulation will probably be different to that of his patient and/or carer. However, these different versions need to be brought together in a form that is both helpful in relation to the goals of treatment and acceptable to all parties. An example of a simple conceptual formulation of a staff member caring for a sexually dis-inhibited older man is: 'He is a dirty old sod, who exposes himself when no-one else is around, so he knows what he is doing.' Clearly such a conceptual view needs to be worked with – otherwise it would undermine the intervention. In other scenarios patients enter therapy with a coherent conceptualisation regarding their disorder. One role of the therapist is to determine whether these formulations can be utilised in therapy. Consider a patient who viewed himself as resourceful and a good 'coper' prior to the onset of his depression- the therapist could attempt to re-establish such views (Blackburn, James & Flitcroft, 2006).

2. Ensuring the interventions are formulation-led: A defining feature of our work is the development of a conceptual understanding of the individual, which then provides the rationale for our interventions. This may sound self-evident, however, frequently one

finds that therapists conduct elaborate formulations, but routinely intervene with an unrelated, unsophisticated behavioural intervention. When one asks the therapists about how this intervention relates to the formulation, they struggle to make the link.

3. Comparing utility with accuracy: As outlined above the main function of a formulation is to provide a framework to guide and support appropriate interventions. In this sense they can be seen as ‘helpful stories’, containing various levels of detail that promote change. No matter how detailed one’s story is, clearly it can never be an accurate account of the person’s disorder or history. Therefore, the therapist’s focus should not be on the perceived accuracy of the account, but rather developing a shared parsimonious ‘story’, one that links well with change strategies.

4. Sharing of formulations: In some therapies the principle of developing a shared formulation is seen as being essential. This allows the patient to be an active ally in the therapy process. Unfortunately, this is not always possible because of the complexity of some of the frameworks or the limited capabilities of patients. Hence on occasion it may be appropriate to generate two different formulations – one to aid understanding at individual and systemic levels and a second to facilitate change (Charlesworth & Reichelt, 2004). The latter framework does not necessarily need to be accurate, and may contain material that is exaggerated or embellished in the service of promoting change.

5. Avoiding ‘kitchen-sink’ formulations: The expression ‘everything but the kitchen-sink’ concerns a tendency by some therapists to over-populate the formulation with information from their patients’ pasts; information that will never be used to direct the interventions. This problem is common in therapy in general (James, 2001a), but even more so when working with older adults because of their longer histories (see James, 2010). The skill of good therapists is often

knowing what not to include in the formulation, as well as being aware of what actually needs to be present.

6. Acknowledging the assumptions of the formulation: When working with older people there are a range of formulations to choose from (see Table 1). While they all have the same broad goal (i.e. to direct interventions), each has its own set of assumptions. Some assume that the patient can be an active agent in the change process; others assume that change occurs systemically. A number of formulations are aimed at the level of the core-belief, while others are more behaviourally focussed. Therefore, therapists must be aware of assumptions underlying the formulation, and the relevance of the patient’s suitability (Safran & Segal, 1990) when making a choice of what formulation approach to use.

7. Recognising the therapeutic platforms embedded within some formulations: Formulations are not merely concerned with conceptualising people’s difficulties in a coherent manner. Indeed, many of them are designed to create platforms for change. For example, Kunik et al.’s (2003) framework in Table 1 requires a carer to examine the potential influences concerning a person’s problematic behaviours in terms of fixed and mutable features. Hence, embedded within the conceptualisation is the notion that some potential causes of the behaviours can be changed. Therefore, an assumption of Kunik’s model is that once mutable causes have been identified, these are the key therapeutic targets. Thus it is important when utilising a formulation that one is aware of its various functions, and particularly its role in explicitly highlighting treatment areas and procedures.

8. Understanding the differences between the different therapeutic frameworks and acknowledging their biases: The work of a therapist involves identifying the nature of the problem, then applying a model to understand the difficulties in order to direct inter-

Table 1: Summary of formulation frameworks used with older people.

Name of model/framework	Brief description of the model/framework
Hot cross bun model	The standard framework used in CBT: feelings, thought, sensations and behaviours. Padesky and Greenberger, (1995) outline an older adult case in their CBT workbook.
Mini-formulations (Charlesworth & Reichelt, 2004)	These frameworks use short linear chains of appraisal and emotional response, and two or three element vicious cycles. They are based on the principle that a comprehensible formulation is more likely to be accepted by an older person than one that is comprehensive, yet incomprehensible.
Diathesis-stress model	These models extend the basic Hot Cross Bun model, by including historical factors, such as assumptions and core-beliefs (Laidlaw et al., 2004; James, 2008).
Schema-focussed approaches (Young, 1994)	Exemplified by Jeff Young's schema-focussed approach, regarding early maladaptive belief formation and maintenance. This is similar to the diathesis model, but is most often used to understand those suffering with personality disorders. More recent conceptualisations attempt to re-define the concept of schema in terms of units of memory (James, 2008).
Worth enhancing-beliefs (James, 2003)	This framework suggests that self-esteem is maintained through the constant nourishment of positive beliefs that the person holds about themselves (e.g. I am good looking; I'm a good listener). Hence, it is hypothesised that depression may occur due to the loss of activation of positive self-beliefs. This model is often used with older adults because the loss of capabilities (poor mobility) and the abilities to access resources (e.g. due to lack of transport) means that tasks that the person had previously engaged-in which nourished their self-esteem may no longer be available.
Comprehensive Conceptualisation Framework (Laidlaw et al., 2004)	CCF has the diathesis-stress framework at its heart, but also includes five other features regarding the patient. By obtaining this additional information (socio-cultural and cohort beliefs, health status, inter-generational, role investment, etc.), a better understanding of the patient's distress is gained. This is regarded as a life-span model.
Interactive Cognitive Subsystems (Teasdale & Barnard, 1993)	The ICS formulation is a complex information processing perspective, which accounts for how sensory information (tactile, olfactory, taste, language-based input) is processed and how it can lead on to changes in affect (James, 2001b).
Triadic frameworks (James, 2001c, 2010)	Based on Beck's triads (i.e. models of content specificity, Beck, 1976). It suggest that the affective disorders can be characterised by three themes, concerning perception of the self, the world and the future. In terms of depression, patients see themselves as being worthless, the world as hostile, and their future as hopeless. In contrast, those with anxiety, see themselves as vulnerable, the world as chaotic, and the future as unpredictable.

Name of model/framework	Brief description of the model/framework
	Formulations for understanding Dementia and Challenging Behaviour (CB)
Kitwood (Kitwood, 1997)	This simple linear and descriptive formulation uses five features to help therapists understand a patient's experience of dementia. The assessment requires the therapist to collect details about the patient's: premorbid personality + history + health status + intellectual impairment + environment.
Cohen-Mansfield model for challenging behaviour (2000)	This needs-led frameworks involves obtaining two types of information concerning challenging behaviours, (i) background features (history, premorbid personality, physical health status) and (ii) a comprehensive description of the CB episode. This information is used to determine the needs underpinning the behaviour. An extension of this framework is her Treatment Route for Exploring Agitation (TREA) model.
Conceptualisation of dementia (James 2010)	CoD is a functional analytic framework that examines the impact of cognitive deficits on the person's understanding of themselves and her environment. It suggests that other people's ability to cope with the person with dementia's presentation, plays an important role in terms of mood and agitation.
Psychogenic model (Stokes, 2000)	This model highlights that the term 'dementia' is a barrier to both an understanding and the treatment of CBs. Stokes' suggests that the strength of the barrier is determined by the person's cognitive and physical status, the disease, compounded by medication and sensory difficulties.
Kunik et al. (2003)	In this multidimensional model there are three aspects that one must examine when accounting for CBs, namely features associated with the person, the caregiver, and the environment. Each of these aspects is then divided further into fixed and mutable determinants. Fixed determinants are characteristics that are difficult or impossible to change, while mutable characteristics can be altered via the efforts of therapists, family and staff, etc.
Comprehensive Model of Psychiatric Symptoms of Progressive Degenerative Dementia (Volicer & Hurly, 1998)	Volicer and Hurley describe their model as integrating behavioural and psychiatric approaches in the understanding and management of CB. Visually, the model is reminiscent of a four ringed sliced onion. The outer ring contains the CBs (resistiveness, combativeness, food refusal, interference with others, etc.). At the core is the 'dementia process', which is influenced by the person's pre-morbid personality and the nature of the dementia. Each of the two inner rings describe the possible primary and secondary causes of the CBs. Primary consequences are functional impairment, mood disorders, and delusions and hallucinations. These primary consequences in combination or alone, lead to secondary consequences: inability to initiate meaningful activities, dependence in activities of daily living, spatial disorientation and anxiety.
Newcastle CB framework (James, 1999, 2010)	This clinical model is based on Kitwood and Cohen-Mansfield's frameworks. It has been used to treat over 2000 cases of people with challenging behaviour in care settings.

ventions. Thus, when using a psychodynamic approach, one filters the information through a template that focuses on a patient's early life, and identifies characteristic patterns from that period. With Interpersonal Therapy, one applies an interpersonal perspective, using a social networking template. With respect to basic CBT, one filters people's distressing experiences through the 'generic' template (feelings, behaviours, thoughts, and sensations).

However, working at this generic level is sometimes insufficient to produce lasting change. At such times one might need to look for historical patterns to explain recurrent difficulties. In cognitive therapy this is termed second generation CBT (Perris, 2000). This type of work requires more information gathering, greater pattern detection, and higher levels of therapeutic competence. But also, by its nature, it involves a lot more conjecture and thus is more likely to be influenced and biased by the therapist's own theoretical leanings.

9. Recognising one's own skills and knowledge base: It is essential that all practitioners maintain their skill-base through supervision and training (James et al., 2007; Milne, 2008). It is important to constantly reflect on one's strengths and weaknesses. Indeed, therapy can be a negative experience for those patients working with incompetent therapists (James, 2001a). Therefore, when choosing a particular formulation approach with a patient, it is important to ask oneself whether one has the required skills, and also whether one has the resources and support to undertake it competently.

Choice of formulation

When choosing the appropriate formulation, a number of features need to be borne in mind. The features, and their relationship to each other, are represented diagrammatically in Figure 1. At the first level the type of formulation selected will be influenced by the Setting in which the problem is being exhibited. For example, if someone is

displaying a psychiatric illness while in an acute hospital ward, then a 30-week schema focussed approach would not be deemed appropriate.

At level two, *Stakeholders*, one is called to examine who is involved in the patient's treatment and what each of these stakeholders brings with them to the therapy. In the case of therapists, they need to consider their knowledge, experience and skills with respect to the patient's presentation. If they are working outside their zone of competence, they will need to access extra support and supervision. In relation to the patient, the choice of which formulation approach to use can be extensive if she is physically and mentally fit, motivated, has a supportive interpersonal network, and has a non-chronic condition. Other stakeholders, such as family and friends, can also influence the type of formulation employed. Evidently, if the patient is interpersonally close to her carers then a more systemic approach may be deemed appropriate.

At the third level, *Nature of Difficulty*, one sees the type of disorder and the setting. In relation to CBT, there is an evidence-base regarding which formulation framework is best suited to a specific disorder. Thus, all of the diagnostic presentations (depression, chronic depression, PTSD, OCD, etc.) have their preferred conceptual model.

At the next level, *Therapeutic Teamwork*, the degree to which the patient and therapist are able to work together is examined. A good working alliance is necessary for undertaking comprehensive, long-term formulation-led approaches, often requiring an amount of personal information. Older patients may struggle to see the relevance of the questions, and can get upset by their perceived implications (James, Kendell & Reichelt, 1999).

At the final level, *Patient manipulation of therapeutic materials*, we are concerned about the ability of the patient to manage and manipulate therapeutic materials. This requires the patient to have the ability to reflect, conceptualise, reconceptualise,

Figure 1: Levels supporting the choice of formulation.

<p>Level 1: Setting</p> <ul style="list-style-type: none">● Family home – family carers involved.● Hospital ward – shorter stay, nurses, medical staff.● Hospice – palliative care setting.● Care home – home for life, private care, care staff (mostly unqualified).
<p>Level 2: Stakeholders</p> <p><i>(i) Therapist</i></p> <ul style="list-style-type: none">● Training; Skills; Experience; Confidence; Risk; Practice; Support; Supervision. <p><i>(ii) Patient</i></p> <ul style="list-style-type: none">● Physical issues – patient's abilities to engage in behavioural tasks and exercises.● Cognitive abilities – patient abilities to retain information from one session to the next, and ability to give an adequate history of self.● Motivation – patient's ability to self-motivation and/or use support from others.● Concurrent treatment – medication, past approaches.● Personality. <p><i>(iii) Others involved in care</i></p> <ul style="list-style-type: none">● Medical staff; Family; Friends; Advocates; Social services; Care home staff.
<p>Level 3: Nature of difficulty (disorder)</p> <ul style="list-style-type: none">● Diagnosis; Co-morbid conditions; Mental and physical health of patients.● Evidence base of model with respect to the disorder.
<p>Level 4: Therapeutic Teamwork – engagement</p> <ul style="list-style-type: none">● Patient and therapist abilities to: form a working relationship, establish joint goals, take on roles, decentre, work collaboratively.
<p>Level 5: Patient Manipulation of therapeutic materials (microskills)</p> <ul style="list-style-type: none">● Patient abilities to: reflect, problem-solve, conceptualise within the session, work with abstract concepts.

demonstrate insight, etc. If the patient is unable to carry out these tasks, a simpler and more concrete approach will be required (e.g. Mini-formulations), and may need the assistance of others (e.g. Carers; Teri & Gallagher-Thompson, 1991).

Cautions regarding use of formulations

This paper has discussed formulations under the general assumption that they are powerful and positive therapeutic tools. However, as discussed by a number of authors (Leeming, Boyle & Macdonald, 2009; James, 2001a), they can often be problematic. In Leeming et al.'s qualitative study, which included patients from two older adult community teams, it was noted that some patients felt pressurised by their conceptualisations. For example, if the formulation suggested that a person's disorder was associated with an abusive upbringing, then it implied blame should be attributed to a key person(s) in her life. Further, the use of the formulation resulted in some patients perceiving themselves to be inherently weak, for example, individual siblings in a shared family environment becoming depressed. Thus, attempting to provide an explanatory model for disorders is likely to have consequences, leading to reinterpretations and the development of different and not necessarily more functional autobiographical narratives. Leeming concluded that there is a need to be more sophisticated about our use of formulations. In particular, we need to be clearer about their functions and consequences (Harper & Moss, 2003).

Conclusion

This paper has provided a brief overview of using formulations with older people. In recent times, the literature has progressed considerably. It is particularly pleasing to see that there are now specific frameworks being developed for older people. This article serves as a guide for trainees in their selection and utilisation of formulations, and highlights some of the potential pitfalls.

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Introducing psychological formulations in an acute older people's inpatient mental health ward: A service evaluation of staff views

Nigel Wainwright & Louise Bergin

The formulation project

THE USE of formulations outside of the traditional one-to-one client-therapist dyad has been receiving increasing interest. A growing number of published examples have explored the use of formulation with multidisciplinary teams (MDTs) suggesting that this work can have utility beyond the function that it has in individual therapy. Lake (2008) examined the use of formulation with an MDT to develop a shared understanding among staff working with the same Service User (SU). Similarly Kerr et al. (2007) have considered the role of formulating cases in generic mental health team settings as part of a broader aim of delivering appropriate robust models of psychotherapy. This work has also extended to inpatient settings, both in working age and older people's services. Kennedy (2009) explores the use of formulation in an acute MH inpatient setting and contends that it is central to the delivery of cognitive behavioural therapeutic interventions on the ward. Dexter-Smith (2007) has also been influential in developing a model for integrating CBT psychological formulation into an OP inpatient service.

As this body of work grows, the issue of how to evaluate its efficacy throws up methodological dilemmas. These are inevitably influenced by what the aims of the formulation work are. For example, Lake (2008) recorded that his team had observed a number of advantages to the formulation work, including raising psychological awareness among team members, providing a

model for integrating multi-professional perspectives and improving the ability of the team to understand and contain uncertainty and SU's acting out behaviours. However, he noted that this was informally observed and lacked reliable measurement. Dexter-Smith (2007) reported that her team had embarked on measuring the impact of their formulation work in terms of staff knowledge, self-efficacy, incidence reporting and length of stay with results yet to be published. Summers (2006) has explored staff views of the impact of introducing psychological formulations to a high-dependency rehabilitation service and the perceived efficacy. We are aware of no evaluations to date that include staff views of psychological formulation work in an OP inpatient setting. The following service evaluation aimed to address this area.

Background to and aims of the service evaluation

The redesign of an acute inpatient mental health OP service in 2008–2009 led to a pilot project introducing psychological formulations to one inpatient mental health ward for older women. The project included a 90-minute training session for ward staff about the theory and application of cognitive behavioural formulations. The training was run six times in a two-week period to allow most staff to be trained, including night staff. Following this, for three months, any ward staff could make a referral to the psychology service for a formulation. Any SU could be referred but it was suggested that staff refer those they felt stuck with or who

presented as a particular challenge to the staff team. For the purposes of the project, formulation was defined as:

'the summary and integration of knowledge about an individual Service User to provide a framework for describing their mental health problems, how they developed and how they are maintained.'

Formulation meetings lasted for approximately an hour and were facilitated by a clinical psychologist or accredited cognitive behaviour therapist, with a clinical psychologist in training. Attendance was open to any staff member who was involved with the SU's care, although attempts were made to actively incorporate members of the primary nursing team where possible. Formulation meetings were used to discuss the presentation and history of the SU in order to facilitate the development of a diagrammatic formulation. Formulations were based on a cognitive behaviour therapy model, primarily because it was the most familiar model to a broad number of staff and also because it had been used successfully in the Middlesbrough team facilitated by Sarah Dexter-Smith. During a maximum of three meetings, formulations were developed to the point where they informed care, whether therapeutic approaches, interventions or discharge plans. It should be noted that while the full model of formulation-led care planning would ideally involve the SU, it was agreed that during the pilot, staff would not be expected to share the formulations until they developed a sense of competence and confidence in the work, and this was beyond the scope of the pilot.

The pilot project had six aims:

1. Increase staff's psychological understanding of SUs.
2. Develop a shared understanding amongst team members.
3. Increase the use of psychological thinking in care plans.
4. Help staff to feel more able to contribute their own ideas to care planning.
5. Improve relationships between staff and SUs.
6. Capture staff's views of formulation work.

Method of evaluation

Design

Semi-structured interviews were used to gain qualitative data to evaluate the pilot project. Interview questions were designed to tap the six areas above, namely staff's psychological understanding of SUs, the extent to which a shared understanding of SUs was developed, the use of psychological thinking in care plans, staff's perceived involvement with care planning, and relationships between staff and SUs. Data was collected both prior to commencement (Round 1) and at the end (Round 2) of the pilot project. This allowed rich data to be collected that might highlight the potential value of formulation meetings to the ward, possible improvements, as well as responses that directly related to staff experiences and opinion of formulation meetings. Additional questions were included in Round 2 interviews that asked specifically about staff experiences of the formulation meetings. Initial interviews were conducted by the clinical psychologist in training who then went on to be involved in some of the formulation meetings. Second interviews were, therefore, conducted by another interviewer to limit this potential confounding effect.

Participants

The sample consisted of two registered nurses, a HSW, an occupational therapist, and a staff grade doctor who worked on the ward, who volunteered to be interviewed twice.

Data analysis

Content analysis

In order to assess whether the introduction of formulation meetings had an impact on staff's psychological understanding of SUs, a content analysis of a question asking participants to provide an explanatory example of a SU's problems was conducted. This compared the number of psychological attributions made by participants in Round 1 and Round 2 interviews.

Thematic analysis

Interview data was transcribed and analysed using thematic analysis. Data was analysed between subjects across the data set under the individual interview questions. Round 1 and Round 2 interview data were initially analysed separately, before themes were collapsed, refined, and condensed.

Results

Formulation meetings

Six SUs were referred for formulation. Two SU cases resulted in one formulation meeting, two cases led to two meetings, and the other two cases resulted in three meetings being held. The range of attendance at formulation meetings was between two and five staff members. Of the staff who participated in the interviews, only one was unable to attend any formulation meetings.

Qualitative data

The results of the qualitative analysis are presented below as themes, which are organised under the interview schedule sections and the overarching questions they were designed to tap. Figure 1 displays the focus of questions asked in the interviews and an overview of themes identified.

Section A: How do staff understand SUs?

Some participants described SUs without giving any account of how they thought the SU's problems had developed. However, some participants gave detailed explanations of SU's problems and communicated their understanding of their presentation. Some also made direct reference to the formulation meetings and implicated the meetings as allowing them to take a deeper and more complex look at SUs.

'When talking to you they see more black-and-white bits, but you can get a different idea and get the complexity. I've started doing that, and now do it without thinking.'

Section B: What influences whether there is a shared understanding of SUs?

Participants implicated good team working, the use of written documentation, the team meeting/getting together, and formulation meetings as helping develop a shared understanding of SUs. However, some participants talked about boundaries to the development of a shared understanding, which included the staff not working as a team, a lack of time and resources, and concerns that formulation meetings needed further work to continue.

'I definitely think that formulation can help, but it is a process that needs some work to keep going. Needs to direct people.'

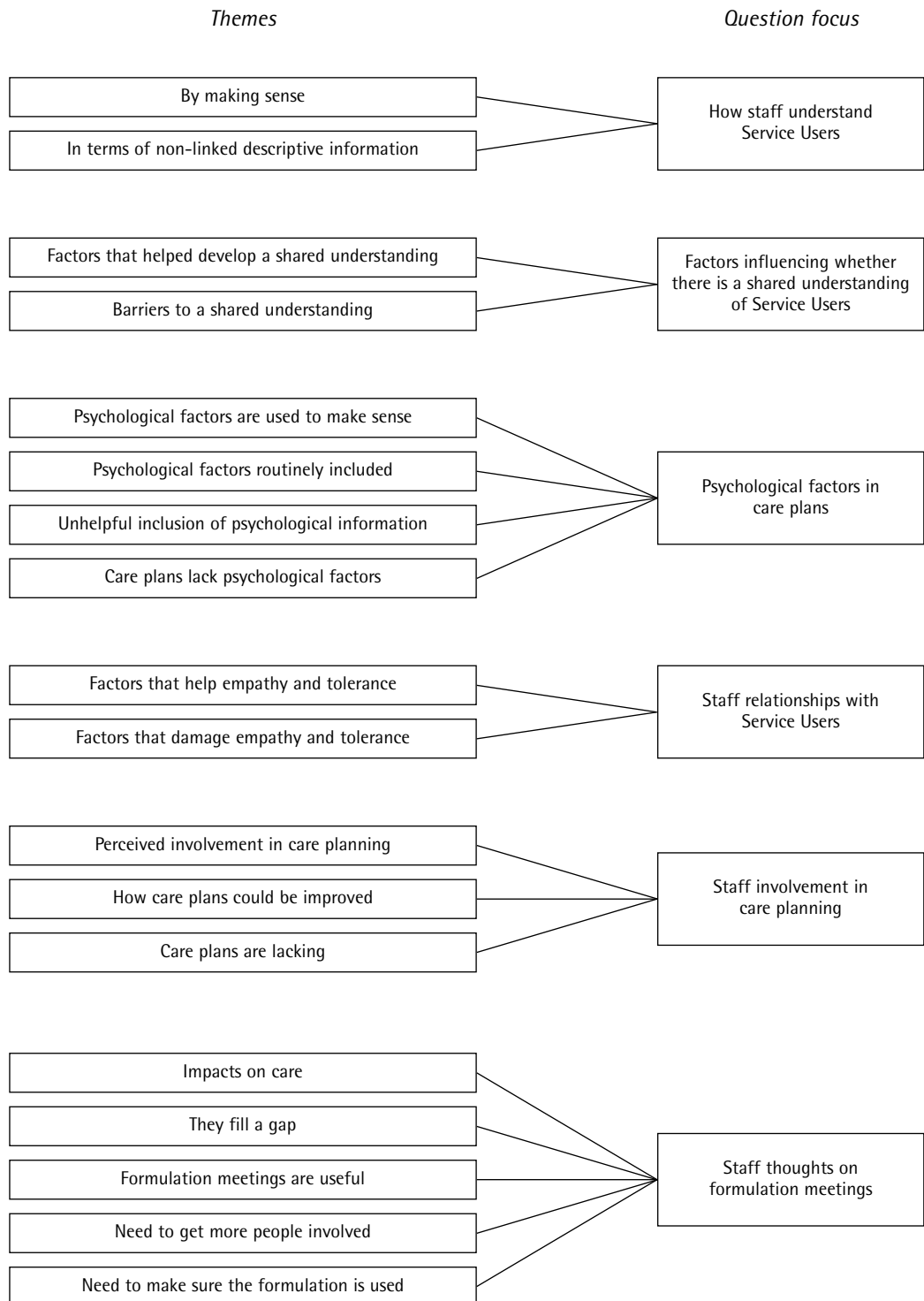
Section C: The use of psychological factors in care plans.

Some participants noted that psychological factors were used in care plans to help make sense of SU's presentations, and formulation meetings were implicated as having a positive impact upon this. Some participants simply listed a range of psychological factors that were included routinely in care plans. However, a latent inference regarding this data may be that this psychological information is *not* routinely included, but participants believe that it *should* be. Some participants gave examples of when psychological factors were included in care plans with unhelpful results. This appeared to occur when there was a lack of SU consent about sensitive material being included in care plans, or when there was a lack of staff agreement about what was important information to include. Finally, some participants stated that care plans lacked psychological thinking, with some care plans being based on diagnosis and heuristics rather than individual presentations.

Section D: What influences staff relationships with SUs?

Participants reported that being able to have an understanding of the SU's problems, staff feeling that they could move forward and help SUs, and the SU's story evoking

Figure 1: Question focus and identified themes.



emotion all helped increase feelings of empathy and tolerance.

'Her self harming was a cry for help for her.'

However there were a number of factors that appeared to damage staff feelings of empathy and tolerance. These included finding it difficult to gain an understanding of a SU's presentation, behaviour that was seen to challenge, not feeling able to help the SU, and staff encountering similar issues to a SU in their own personal life.

'Like when patients get violent and abusive for no reason (...).'

Section E: Staff involvement in care planning.

Care planning appeared to be primarily seen as a nursing-led role, and some participants did not feel involved in this process. Participants were also asked how they thought care planning could be improved. Suggestions included the need for more staff to be involved, the need for more education around care plans, and the need for care plans to be developed and used more consistently. Finally, some participants reported that a lack of time and resources was a barrier to good care planning, that care plans lacked psychological thinking, and that they are not seen as meaningful.

'They tend to have practical things in them, and are not so psychological.'

Section F: Staff thoughts on formulation meetings.

Formulation meetings were felt to be useful. They were thought to provide an important forum to discuss psychological factors and increase understanding of SUs. Some participants also noted that they thought the formulation meetings had an impact on the care of SUs.

'...staff can see why the patient is here, who is doing what, and why everyone is having the same approach.'

However, it was noted by some participants that more people needed to get involved with the formulation meetings, including more staff, SUs, and Carers. Some participants also communicated their belief that effort needs to be made to ensure that

formulations are actually used to inform continued input with the SU, rather than it being lost once a formulation had been completed.

Content analysis

A content analysis was conducted on qualitative data gained from a question asking participants to talk about a SU they had worked with and explain their problems. The number of psychological inferences made in the explanation of SU's problems was counted. Figure 2 displays the number of causal inferences made by each participant in Round 1 and Round 2.

Figure 2 shows that three of the participants (participants 1, 4, and 5) did not make any causal inferences in response to the question in Round 1. However, in Round 2 interviews, participant 1 made one causal inference, participant 4 made two, and participant 5 made three. The same number of causal inferences were made by participants 2 and 3 in both rounds.

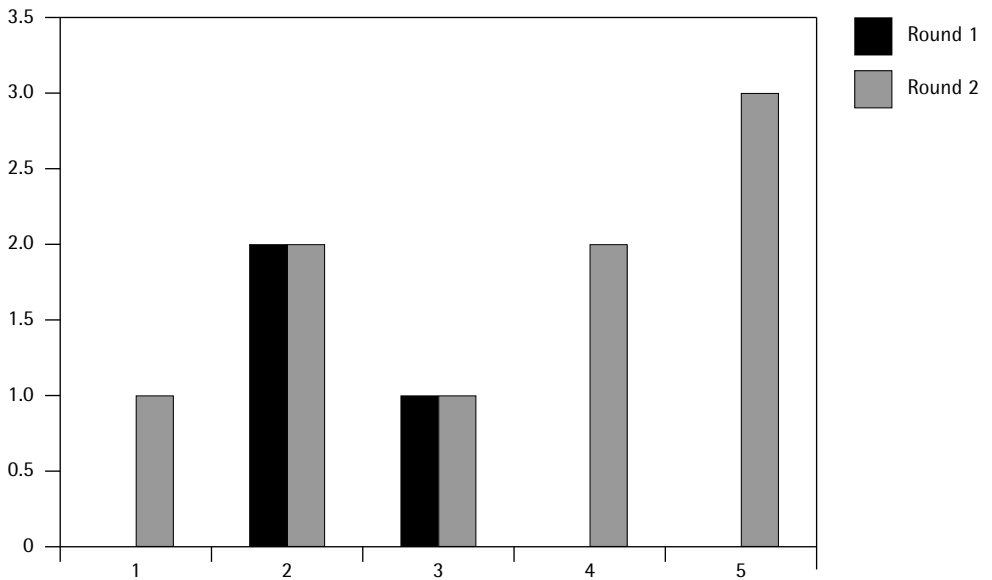
Discussion

The aim of the present evaluation was to provide an assessment of staff views on the effectiveness of introducing formulation meetings onto an acute inpatient ward for older women with functional mental health problems. It aimed to demonstrate how formulation meetings might add value to the ward, as well as report on whether staff found the introduction of formulation meetings to be useful.

Qualitative analysis

The results of the qualitative analysis lends support to the argument that the pilot met some of its aims. The results from Section A, on how staff understand SUs, implicates formulation meetings as having led to a change in thinking, allowing participants to take a more complex look at SUs, and gain understanding by trying to make sense of and explain their problems. Indeed developing an understanding and explanation of problems is fundamental to many definitions

Figure 2: Count of causal inferences made.



of formulation (Eels, 1997; Weerasekera, 1996). It was the case that some participants talked about SU's problems by just listing diagnostic features they present with while others made direct reference to the formulation work aiding their understanding of a SU. Formulation meetings may, therefore, have utility in helping these staff members develop a more psychological understanding of the people they work with, which may be evidenced by them being able to give more complex accounts of a SU's difficulties.

It was suggested in the data from Section B, relating to shared understanding of SUs, that formulation meetings did contribute to staff developing a more shared understanding of SUs. The whole team approach to formulation meetings appears to be beneficial, as a lack of such working was noted as a barrier to the development of a shared understanding.

In response to questions in Section C, on the presence of psychological factors in care plans, participants noted that psychological information was used in care planning to

make sense of a SU's presentation, and that formulation meetings led to the inclusion of more detailed psychological information in care plans. However, the listing of psychological information without elaboration, and the reports that care plans lacked psychological factors, in both Round 1 and Round 2 data, brings into question the *actual* use of psychological information in care plans. It may have been the case that the care plans of SUs who had a formulation included more psychological information, but that the care plans of SUs who had not remained unchanged. However, this was not explored in the evaluation.

Participants made no direct reference to formulation meetings in discussing their relationships with SUs, the area covered in Section D. However, being able to understand and move forward with SUs were both factors that were reported to help feelings of empathy and tolerance. Challenging behaviour and not feeling able to help appeared to damage empathy and tolerance. CBT formulation is used not only to under-

stand a SU and their presentation and problems (Meyer & Turkat, 1979), but also to inform interventions (TARRIER & Calam, 2002). Formulation would, therefore, help conditions that foster empathy and tolerance, and hopefully lead to staff having a better understanding of challenging presentations and how they might be able to help.

The results from Section E data did not highlight a direct effect of formulation meetings on participants' involvement in care planning. However, care planning was noted to need more staff involvement, and care plans were suggested to lack psychological thinking. Formulation meetings could both increase feelings of staff involvement and increase psychological thinking in care plans, but it appears that the link between formulation and care planning would need to be more explicit.

Finally, participants appeared to find the formulation meetings to be useful. They were seen as impacting on care, and providing a space to think about psychological factors, which did not appear to be present before. However, participants suggested that more people, including SUs and Carers, needed to be involved in formulation meetings, and that effort needed to be made to ensure that formulations are put to use more consistently in SU care.

Content analysis

The results from the content analysis found that three out of five participants increased the number of psychological inferences they made between Rounds 1 and 2. Also, the observation that these participants made no inferences in Round 1 provides tentative indication of a change in their psychological thinking. Although the number of inferences made by two participants did not change, these participants both made inferences in Round 1 and may, therefore, be regarded as having been more psychologically minded at

the outset. Obviously with such a small sample, caution is needed in this interpretation and although this result appears positive, it could be due to chance. More participants and statistical analysis would be needed to rule this out. However, this does provide a preliminary indication that the pilot may have impacted on the psychological understanding of some participants.

Limitations

The most significant limitation of the evaluation is the small sample size of participants. Summers' (2006) study involved 25 participants, although the analysis was not driven by a formal qualitative methodology such as thematic analysis. Nonetheless, with such small numbers in the current service evaluation, any interpretation of the data must inevitably be cautious and treated as offering indication rather than evidence *per se*. The trainee clinical psychologist who conducted the evaluation was also involved more broadly in the pilot study and this may have reduced researcher impartiality and impacted upon the interpretation of qualitative data. Unfortunately the reality of in-service research often means that clinicians are evaluating their own services and projects. Bias may have been reduced through the use of triangulated research methods, which is heavily recommended (Webb et al., 1966). However, time and resources did not allow for this. The responses of participants may have been affected by social desirability due to both the evaluation and formulation pilot project being conducted by the older people's psychology service. However, the change of interviewer between rounds was designed to reduce this bias. Finally, the evaluation cannot provide any indication of whether the formulation pilot project had any impact on SUs indirectly and this remains a highly significant area yet to be evaluated.

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Ward C: A formulation-based service development project

Gareth Hickman & Anne Crawford-Docherty

This article describes a service development project on an inpatient dementia ward, which had previously received no psychological input. A description of the assessment and formulation strategy informing the proposed intervention plan is provided. The authors' reflections on the process are offered.

Background

FOLLOWING a series of service redesigns from 2004 to 2009, Ward C was established as a 20-bed challenging behaviour unit for men and women with dementia, but with a small number of patients with significant physical health problems. The ward was staffed by Nurses, Health Care Support Workers (HCSW), and an OT Assistant; sessional input was provided by Speech and Language Therapists and OTs, and Consultant Psychiatrists reviewed patients as required. Prior to authors' involvement, the ward had received no psychology input. A Trust-commissioned quality audit had identified the need to address challenging behaviour presented by some clients, to develop psychosocial aspects of care, and to improve the ward environment. The new ward manager had requested psychology involvement.

Historically, a number of psychosocial initiatives had been introduced on Ward C, often by inspired staff working with little co-ordinated support and in isolation. Such initiatives included a Patients' Bill of Rights, Life History Work, and environmental adaptations; with limited follow-up and subsequent organisational changes, these initiatives had failed to sustain. The current imperative, therefore, was not to invest effort in further isolated training programmes and initiatives or to respond to requests for the 'psychological magic wand to fix the ward'. Instead, the focus was to be on developing a thorough understanding of Ward C, its culture, philosophy, environment, patients

and staff group, prior to any intervention – to develop a formulation of the ward as a means of informing an intervention strategy.

Assessment

From the outset, it was evident that a complete 360° perspective of Ward C was required. The target areas for assessment were, therefore: (1) The activity and engagement patterns of patients and ward staff; (2) An analysis of the ward environment with a particular focus on noise levels; (3) Identification of staffs' skills and knowledge in working with this client group; and (4) Establishing a patient group profile.

(1) Activity and engagement patterns

A naturalistic observation methodology was adopted to assess activity and engagement patterns on the ward. Three observation sessions of 16 consecutive hours were conducted, covering the 24-hour cycle of ward life. To be representative, observations were carried out at weekends (Sunday), weekday overnight (Wednesdays–Thursday), and a weekday (Friday). The observations were divided between trainee and consultant clinical psychologists, each observing alone for eight hours. A time-sampling observation methodology was used, where the behaviour of the staff and patients was (concurrently) recorded at 15-minute intervals. Behaviours were coded consistent with a set of pre-determined ward-based activities that had been utilised in similar published studies. The patient activity categories used were based

on those of Patterson et al. (2005) and the NHS Productive Wards Toolkit (2008). Two pilot observation sessions of three hours were conducted to adapt the categories to reflect Ward C's activity and to develop and pilot a recording template. These observation sessions also gave ward staff time to habituate to the presence of the observers and minimise the inherent risks of observation, such as the Hawthorne effect.

It is possible to analyse and present the observation data in ways too numerous for the scope of the present article. Figures 1 and 2 summarise the data for the Friday observation sessions, illustrating the quality of data collected.

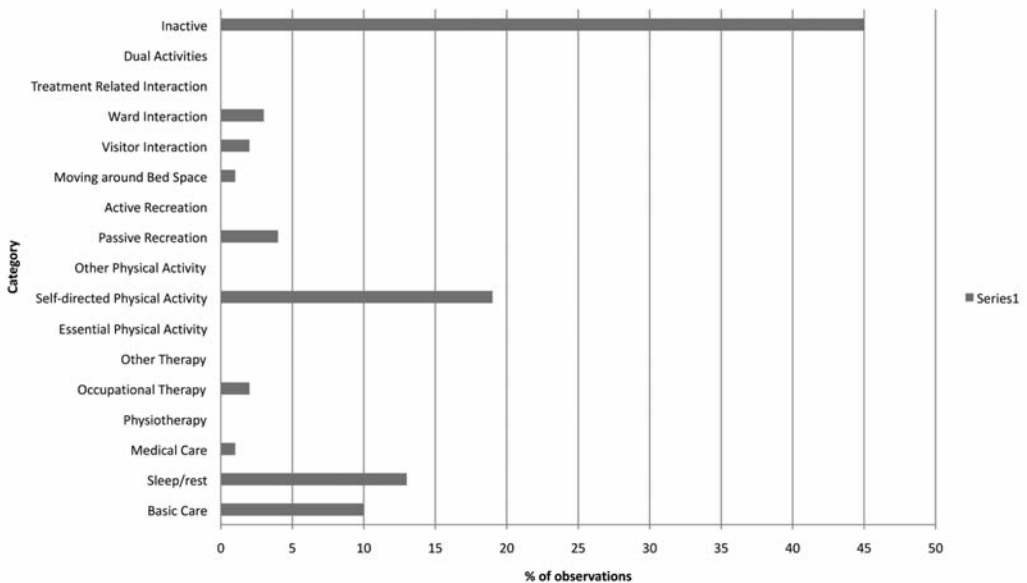
For staff, the majority of time was spent on basic care (22 to 24 per cent¹); there was a constant high level of 'task focused' activity but a lesser amount of time spent on psychosocial intervention (0 to 4 per cent); a low amount of time taking breaks (0 to 4 per cent per day); a low amount of time inactive/uncertain (4 to 7 per cent day shift,

10 per cent night shift); a large amount of time engaged in administrative and clinical administrative duties (10 to 12 per cent); a high amount of time preparing intervention (11 to 17 per cent); and limited social interaction with patients in mornings, which increased during the afternoon (a.m. interaction: 2 per cent; p.m. interaction: 14 to 16 per cent);

For patients, the majority of time was spent inactive (22 to 45 per cent); patients became more active during afternoons with greater incidence of wandering (self-directed physical activity) (a.m.: 10 to 15 per cent; p.m.: 26 to 28 per cent); and passive and active recreation was minimal (<1 per cent respectively).

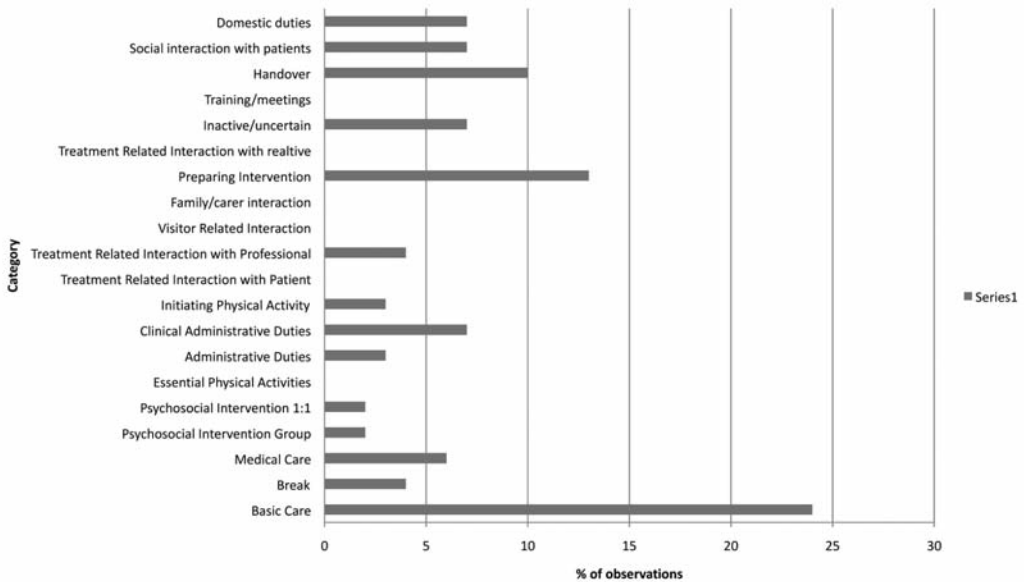
In summary, the observation sessions revealed a highly inactive patient group but a highly active staff group. However, the staff group was not active in terms of client engagement for purposes other than basic physical and medical care.

Figure 1: Patient Activity Friday observations (07.00–23.00).



¹ Note that percentages refer to percentage of observations not percentage of time.

Figure 2: Staff Activity Friday observations (07.00–23.00).



(2) Ward environment

To capture something of Ward C’s environment, noise levels during observation sessions were recorded both quantitatively, using a Data-Logger (noise in Db and Temperature in °C), and qualitatively using a Dictaphone². Figures 3 and 4 display example data from day and night recordings from the Data-Logger.

Data collected indicated that the average sound levels on the Ward fluctuated between 45 to 65db, with peaks at 87db. To give this a context, the UK Health and Safety Executive (2005) associates prolonged exposure to sound above 87db with hearing damage. Noise levels peaked during the hours of 9.00 a.m. to 12.00 p.m. and 5.00 p.m. to 9.00 p.m. Qualitative data indicated that the main source of the noise was the calling out by one particular patient.

(3) Staff knowledge and skills

To assess the existing level of Ward C staff’s skills and knowledge, an anonymous survey pack was sent to all staff members. This pack contained a questionnaire devised by the authors probing three key areas: (1) dementia knowledge related to diagnosis and presentation; (2) the current strategies used by staff for managing challenging behaviour; and (3) the skills development that staff thought they needed. Additionally staff members were also supplied with the Maslach Burnout Inventory (MBI) (Maslach, Jackson & Leiter, 1996) and an adapted version of the Challenging Behaviour Attribution scale (CHABA) (Hastings, 1997). A return rate of 36 per cent was obtained.

² Consent obtained where possible and patient next of kin informed.

Figure 3: Ward sound level (dB) Sunday.

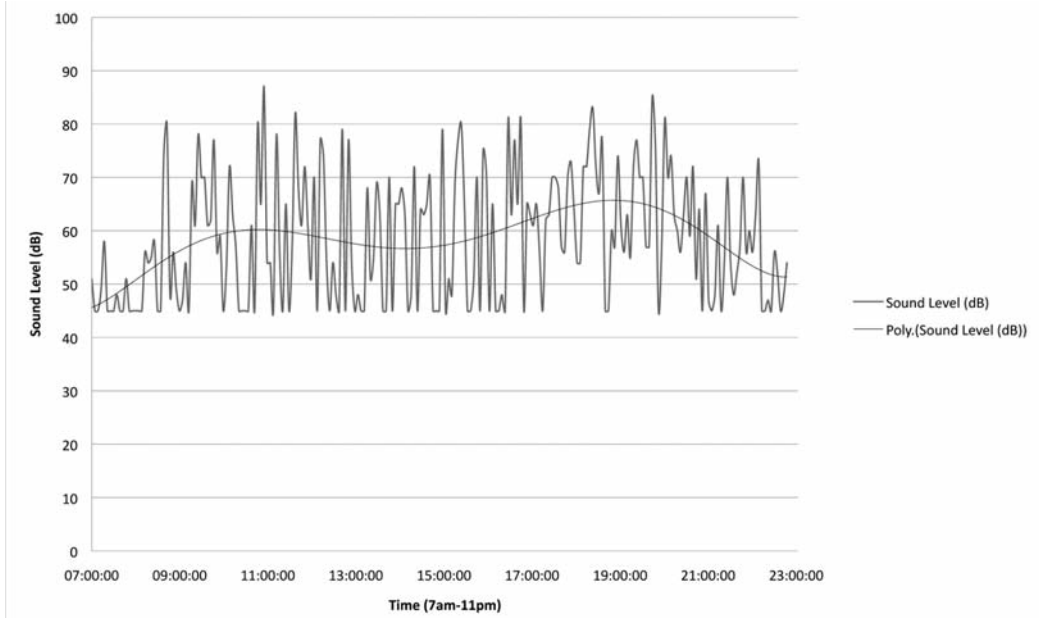
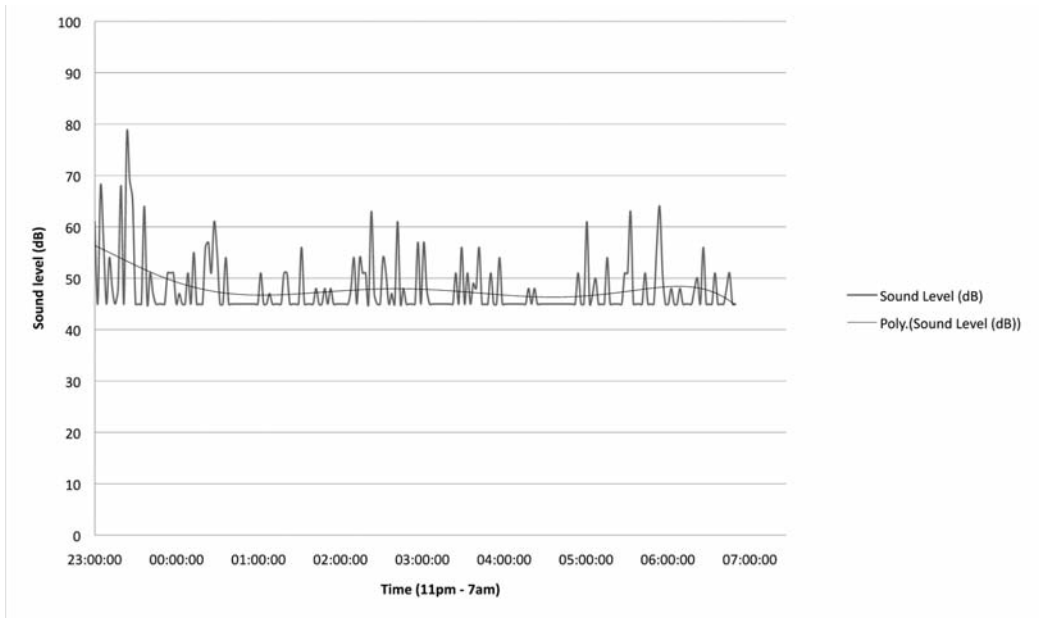


Figure 4: Ward sound level (dB) Wednesday to Thursday.



Key messages from the questionnaire feedback were that the staff group was feeling increasingly isolated, undervalued, and under-skilled.

'The largest sources of stress on [Ward C] are the shortage of staff, no thanks, poorly scheduled long shifts of 12 hours per day, and the noise levels.' (Respondent x)

Notably, only 30 per cent of respondents reported having received any dementia-related training since working on the ward, and only 10 per cent reported having received any training in managing challenging behaviour. This comprised restraint training.

Data obtained from the CHABA suggested that 'Emotional Factors', 'Physical Environment', and 'Learned Behaviour' (primarily through positive reinforcement) were viewed by the sample as the most relevant causal explanations in understanding the challenging behaviour encountered on Ward C, indicating that staff attributed limited causality to the effects of dementia *per se*.

Finally, the MBI identified that the staff group was experiencing 'High' levels of 'Emotional Exhaustion', 'Moderate' levels of 'Depersonalisation', yet 'High' levels of 'Personal Accomplishment' in their roles.

(4) Patient profile

The patient profile was explored through a review of case files on the ward. Sixteen patients reside on Ward C and present a range of challenges. The patient group comprised individuals with advanced dementias, challenging behaviour, complex physical health needs requiring constant individual support, and one inappropriately placed individual with chronic psychosis.

The file review identified an emphasis on physical-medical care with limited, mostly absent, psychosocial information. Evidence of past intervention, such as the Life History work, was largely absent, and a sense of neglected personhood was evident. In summary, the primary focus of the case notes was 'the person with DEMENTIA' and not 'the PERSON with dementia' (Kitwood, 1997).

Formulation

So how can we understand Ward C? What sense can we make of the assessment data, and how might we formulate this in order to plan appropriate interventions to address the identified needs?

Hypotheses

It was hypothesised that Ward C operated within an unwritten philosophy and purpose; 'to provide physical-medical care'. The formal remit for Ward C seemed unclear as incremental service changes had muddied the waters over time; was the focus meant to be provision of continuing care, management of challenging behaviour, working within a biopsychosocial or a biosocial model? Ostensibly, there was an absent psychosocial care philosophy, or at least one that had yet to be fully embraced by all staff. This lack of clarity around purpose was borne from the varied patient group profile; responding to a disparate set of needs with limited resource had left staff focusing primarily on 'brains and bodies' and not 'personhood'.

The staff group on Ward C was clearly informing us that the long shifts, stressful working conditions and environment, perceived lack of appreciation, and lack of investment in their professional development were leaving them feeling burnt-out. This could be hypothesised to result in depersonalising patients and becoming less focused on their psychological welfare. This appeared to leave staff investing their energy in the practical aspects of their roles (i.e. the delivery of physical-medical care), from which they derived a sense of personal accomplishment, but at the neglect of personal interaction with patients. This practical focus was necessarily time-consuming and, therefore, it had become increasingly difficult for staff to devote any additional time to psychosocial aspects of care.

Within this context, it would be highly likely that any future service development or culture change initiatives would be perceived as threat or criticism and further burden by the staff. This risk had to be addressed in designing the intervention strategy.

Organisational Formulation Framework

Chamberlain (2010) offers a model for thinking about organisations and effecting change at multiple levels. In this Behavioural Model of Hierarchical Systems, an ABC (antecedent, behaviour, consequence) framework is adopted, where, at each level (i.e. patient, key worker, manager, general manager, chief executive, commissioner) a desired behaviour (B) can only occur provided certain antecedents (A) are in place. To maintain this desired behaviour, the individual's behaviour at each stage of the hierarchy must be reinforced (C). Chamberlain asserts that as the hierarchy advances upwards in the system, each super-ordinate layer has the responsibility for putting in place the required antecedents and consequences for its directly subordinate layer. Figure 5 (overleaf) shows how this model can be adapted and applied to Ward C in order to guide an intervention strategy. In understanding Ward C, it was hypothesised that the A and C columns of the model needed development. With these near absent antecedents and consequences, the behaviours that we would wish to facilitate remain unachievable.

Intervention strategy

At the time of writing, the assessment stage has been recently completed and formulation shared with key stakeholders within the organisation. The following intervention plan has been proposed. The primary goals of intervention are to increase psychosocial input to patients and to develop a coherent culture of psychosocial care throughout the ward – in essence, introducing the necessary antecedents to facilitate desired behaviour, which must then be reinforced. A three-phase intervention programme has been proposed: (1) Maximise psychosocial input to patients; (2) Increase staff's readiness for change by addressing staff stress; and (3) Develop psychosocial skills through a triadic coaching model.

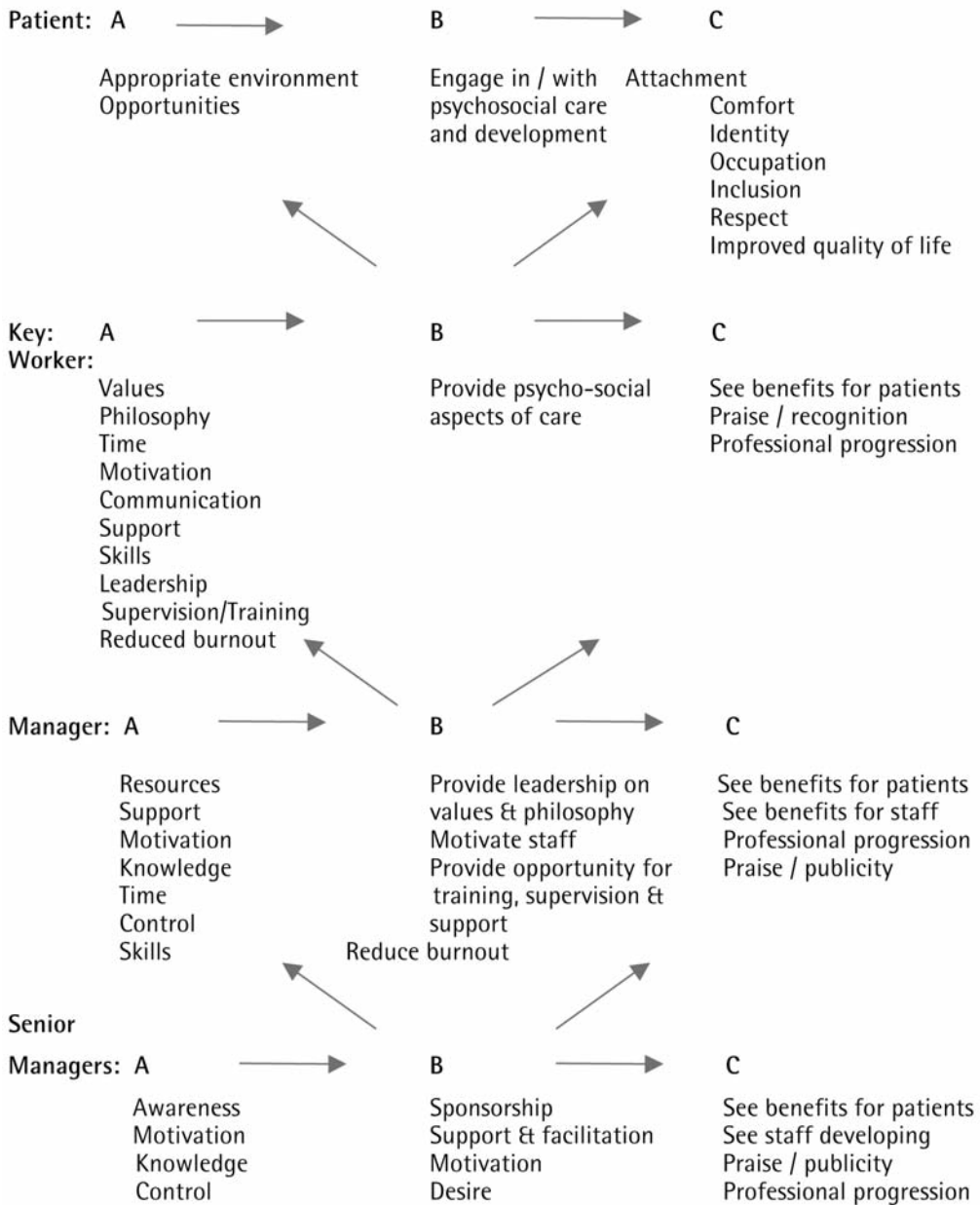
(1) Maximise psychosocial input to patients

In order to increase psychosocial interventions on Ward C, an increase in the resource of time is essential. A number of potential structural changes have been proposed, including: integrating and co-ordinating multi-disciplinary input on the ward; engaging volunteers on the ward to spend time with patients engaged in psychosocial interaction on a one-to-one basis or in small groups; bringing in resource from other areas of the hospital that are currently under-used; or staggering physical needs interventions (for example, mealtimes) where possible. Deployment of extra time will be informed by the ward observation data. Managerial antecedents will also need to be in place, such as having control of rotas and resources. Introducing this intervention first would evidence to ward staff that their high activity levels were being recognised and respected and would avoid further demands being made of them early in the project. It is hypothesised that this approach would have an impact across both the Key Worker and Client ABCs.

(2) Address staff stress

The second stage of intervention will be to address burnout and staff morale. Proposed methods include introducing facilitated staff support groups, reflective practice and/or supervision sessions, and consultation sessions with psychologists. Lake (2008) suggests that such methods, notably consultation, can help teams to reflect on their feelings about their work with service users and their difficulties, and help them to recognise how they might be acting out a particular dynamic with a service user. The target of intervention here is, therefore, to reduce burnout levels for staff and, in doing so, reduce the depersonalisation of patients, encouraging a shift in focus back to respecting personhood. It is hypothesised that this approach would begin to have an impact at a Key Worker Antecedent level.

Figure 5: Organisational Formulation Framework.



To reinforce positive staff behaviour, a culture of recognition and praise must be implemented in order to maintain gains. To this end, the findings of this piece of work have been presented in appropriate Trust clinical governance and strategic management forums. The Trust Service Director has also been included at all stages of the project and taken on a project sponsor role. It is hypothesised that in doing so, this will begin to have an impact at the Senior Management Antecedent and Behaviour level and subsequently percolate down the chain impacting Managerial, Key Worker, and Patient ABCs.

(3) Triadic coaching approach

The third stage of intervention aims to avoid generalised 'chalk and talk' training. Instead, an in-vivo 'triadic coaching' approach is suggested. This method involves identifying key clients on the ward and identifying three staff members around each of them. These nominated staff members will then receive targeted person-specific training workshops around the named patient. Initially these workshops might focus on dementia knowledge, understanding and management of challenging behaviour, and respecting personhood. Psychology staff would then support and coach ward staff in applying this training in vivo.

It is our view that this approach would not be a drain on the time of the wider staff group but would begin to enhance staff skill levels and increase confidence. It is hoped that this could be a rolling programme or be cascaded through the staff team. It is hypothesised that this approach would have an impact across both the Key Worker and Client ABCs.

None of the interventions outlined above can be effective without the following prerequisites: Effective clinical leadership within the ward, multi-disciplinary senior management sponsorship, and the control and co-ordination of deployment of resources.

Evaluation

It is proposed that, following the implementation of the intervention strategy, the assessment process will be repeated on Ward C after 12 months.

Reflections

Chamberlain (2010) recommends that prior to any organisational development, the following questions are asked of oneself: Where are you in the system? What is your credibility? And is the time right for change? These questions have served the authors well through the process thus far, and have provided guidance for ongoing reflection.

As psychologists, we have the benefit of being able to operate at all stages of the hierarchical system described, and this enabled us to involve and include the Trust Service Director throughout the process, whose support and facilitation was at times invaluable. As relative 'outsiders' to the ward, the initial obstacle to overcome involved establishing our credibility by developing relationships and asserting a 'stake' in the future of the ward. Overcoming staff suspicion and disinterest continues to be an ongoing challenge, together with negotiating relationships and isolated instances of obstruction. In addressing the timing for change, we have considered the following questions: Are staff worn out and under pressure? Is there a will for change? Will change be embraced? Who might view change badly or as punitive? Is there a moment to grab? It is our view that the present represents an ideal time for change, providing an initial focus of any change is establishing enhanced support for ward staff.

For Ward C the following is apt at this stage: *'If we continue to do what we've always done, we'll continue to get what we've always got'* (Chamberlain, 2010).

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Sharing formulation with care staff using the Newcastle Model - group problem-solving

Louisa Shirley

ALTHOUGH there is much evidence that sharing formulations is a valued and helpful function of clinical psychologists in older people's services (for example, see papers by Bergin and Craven-Staines and colleagues in this volume), it is likely that the process of delivering a formulation differs between psychologists according to what model they might follow, their confidence with the group they are sharing the formulation with, and the presentation of the client. Further, formulation is no longer the exclusive auspice of the clinical psychologist and other professional training may produce different emphases on what is highlighted in disseminating a formulation to other members of teams.

In this paper, I will discuss the way in which clinicians in the Challenging Behaviour services using the Newcastle Model (James & Stephenson, 2007) deliver formulation-sharing sessions. These teams generally, though not exclusively, work into private sector residential and nursing homes. The work of the teams has been well documented (Kennedy & McKenzie, 2007; McKenzie & Kennedy, 2008; James & Shirley, 2008; Wood-Mitchell & Milburn, 2008; Shirley, 2008)

The teams using this model stick to a specific format of facilitating a formulation session because:

- it allows nurses and care workers to whom the formulation is delivered to develop a set of expectations around, and, therefore, comfort with, a specific delivery format;
- it enables teams to train new members to produce work consistent with the model.

It is hoped that, in time, a set of criteria for effective delivery of these sessions will be produced against which we can measure the performance of team members as part of supervision and the competence of trainees. To this end, video data has been taken by the Northumberland County Challenging Behaviour Service and it is hoped this will form the basis of a small-scale project for a trainee.

This paper is largely taken from a chapter accepted for an edited book by Ian James (*Understanding behaviour that challenges: A practical guide*. London: Jessica Kingsley Publishers).

The context to providing formulation sessions for care staff

It can be difficult for psychologists to provide useful advice to care home staff who are struggling to understand the behaviour of one of the people they work with. The information received from the staff members seen can be highly subjective and usually lacking in detail. The advice from the psychologist, when given, may not match the care staff's experience of the problem and may not fit with the routines or the ethos of the home. Even good advice is unlikely to reach enough ears to be effective as the message often receives 'Chinese whispers' treatment. This is not the fault of the care staff, but is a function of the way in which information is gathered, opinions about the behaviour sought, and strategies for care developed and communicated.

The Newcastle Model provides both a framework within which to understand the clients' problems, and a process of providing

intervention that is collaborative and empowering for care staff. It follows a needs-led approach to working with challenge (Cohen-Mansfield, 2000). Pivotal to the success of this intervention is the formulation or group problem-solving session which is the focus of this paper.

The formulation meeting

The formulation meeting is held following a period of assessment from the clinician. A formulation meeting is a group meeting with people involved in the person's care (this can include staff, family, and other professionals) and is intended to refocus the group from problem to solution through increasing empathy and improving understanding of the person's distressed behaviour.

The major aims of the formulation session are to challenge some of the negative beliefs held about episodes of challenging behaviour in the light of new information and to focus on the needs of the person that are unmet and may underpin the challenging behaviour (i.e. to create some cognitive dissonance around currently held beliefs).

In this paper, I describe the detail of how the Northumberland County Challenging Behaviour Service (NCCBS) facilitates formulation sessions. I will consider the structure of sessions, and describe a number of techniques and strategies that can be used to aid the process of reframing problems to needs.

Structure of formulation sessions

There are three clear sections to the formulation sharing session:

1. Introduction and problem identification.
2. Delivery of contextual information and teaching.
3. Needs identification and care planning section.

1. Introduction and problem identification.

Introducing the concepts

Despite a growing interest in the idea of person-centred care practice (Kitwood,

1997), the concept of 'person-centredness' can be interpreted in a number of different ways and it will probably feel extraordinary to members of the formulation group to spend time sitting and considering the perspective of one client. We have found it helpful to articulate the assumptions implicit in this way of working. Firstly, our assumption that behaviour is understandable at some level and secondly, that behaviour can be seen as a communication of need, i.e. has a function. To do this we might use a common everyday example of how we try to understand the behaviour of other people in our lives (e.g. 'Why did my mum sound annoyed on the telephone?')

We have found it is also helpful to give the group some idea of what we mean by 'need'. We illustrate needs through the use of Maslow's Hierarchy of Needs (1943). Other needs can be defined by reflecting on the personal experiences of the presenter or members of the group. For example, the need to live in a tidy, ordered environment, the need for personal space, the need for family contact. These examples can also be used to think about how we all have different levels of need.

Behavioural definitions

It is helpful to start with agreeing exactly what problems the staff are experiencing. The group will often have noticed several unusual or difficult behaviours presented by the identified person. Whilst this can be helpful in learning more about their experience, it is important to identify which behaviour staff find most difficult (this is usually behaviour that poses a risk to the person themselves, to others, or to their placement).

During the assessment period, the formulation presenter would have gathered information on the key event-related components assessed in the Newcastle Model (the actual behaviour (what the person did), the way they looked at the time of the incident (appearance), and what the person says during the incident (vocalisation) (see James &

Stephenson, 2007, for more detail). The latter information enables us to make hypotheses about the emotional and cognitive state of the client during a challenging episode.

Staff are invited by the facilitator to make the links between the things they might hear a person say and what that person might be thinking at the time. Also, to make links between the person's thoughts, feelings and the behaviour that they are finding challenging. This is illustrated in Figure 1.

2. Telling the story and contextualising the behaviour

Telling the story

In the formulation session, staff are then invited to listen to the story of the identified resident's life and experiences. The session covers the areas of assessment identified in Figure 2. The facilitator continuously relates the information they are giving to the identified person's behaviour. For example, the facilitator might make special note of a physical health problem that may cause the identified person to experience pain, and

link that with a tendency for challenge to occur during times the person is being asked to mobilise.

This part of the formulation session is pivotal to the success of this type of intervention. It is a space where the care group is invited to get to know the person who they are finding challenging. Often new information comes to light that helps staff groups make sense of the way in which a person is behaving. It is especially important to have a relatively large group (five plus people) as this increases the chance of new information being introduced by group members and shared by their colleagues. In our team, the expectations between the care setting and the team (like making staff members available) are made clear in an initial meeting with the care home manager.

The role of teaching

As explained above, the provision of contextual information is pivotal to the change in staff perspective on the person presenting a challenge. It is often the case that you may

Figure 1: Making the links between the person's understanding of the situation, their emotions, and their behaviour.

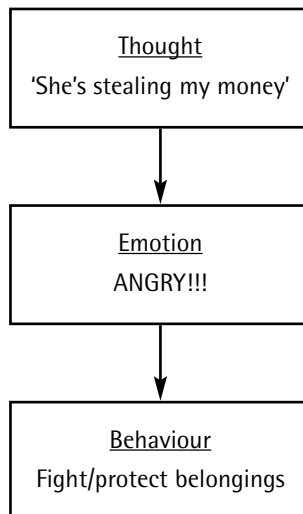
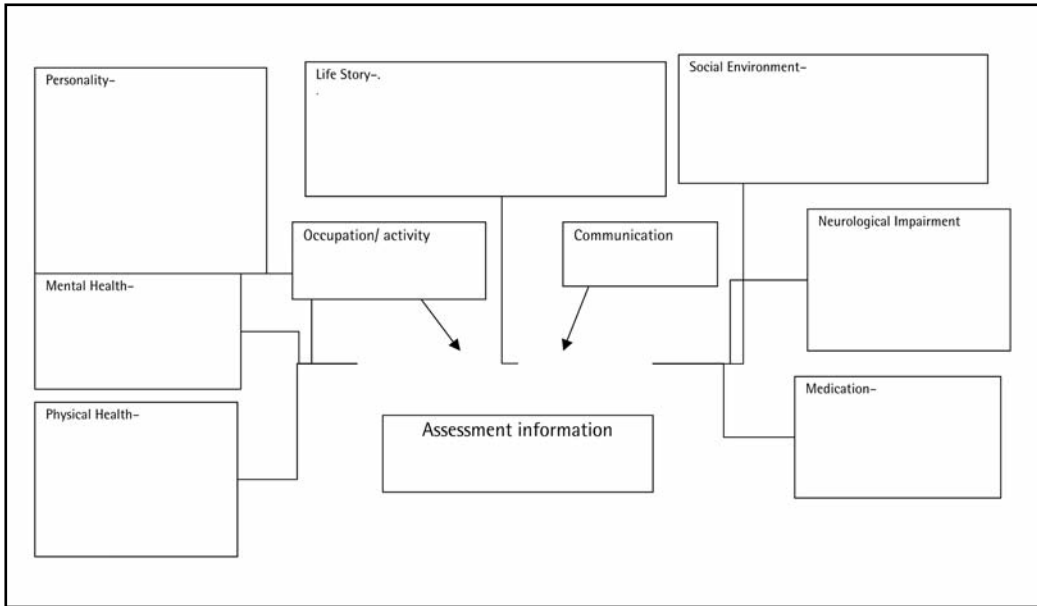


Figure 2: Assessment framework.



be introducing staff to an area about which they have very little knowledge. In this case, we try to give a short teaching session on the relevant topic. Topics range from general information about dementia to very specific sessions about, for example, the psychological impact of being born with cleft lip and palate. This section of the session should take up no more than 10 minutes. The information needs to be clearly explained with examples given where possible, and aimed at the level of the least educated member of the group.

3. Identifying need and planning intervention

Needs identification

Helping the group identify their patient/resident's needs can be the hardest part of the formulation session to facilitate. The first step in this process is to develop a hypothesis about why the challenging behaviour is occurring. This can be done using 'brainstorming' with the group (Stokes, 2000) though we have found it helpful to have a number of ideas in mind before coming to the session. Once the possible reasons for

the behaviour are identified through discussion around the contextual information (e.g. the person feels useless when they see other people working), it is possible to establish what needs are being left unmet in that person's life (e.g. the person needs some meaningful occupation at the times that s/he can see others are busy).

Other methods can be used to help the group identify needs. Groups often find it useful to put themselves in the shoes of the person they are discussing through experiential learning; for example, using specially designed glasses that alter vision so that the person wearing them sees things as if they were suffering from a similar visual impairment to their client. Other methods include playing communication games (e.g. one member of group has to describe how to draw a picture they have in front of them without using non-verbal cues), or using basic, 'bedside' neuropsychological tests like the Key Search from the Behavioural Assessment of the Dysexecutive Syndrome (BADS) to illustrate the deficits that a person may have and how they may be affected by them.

Developing plans

Once the group has identified unmet needs in the resident/patient that have resulted in a challenge to the system, it is possible to work with the group to consider how best to meet those needs. When given the right information in a systematic way, groups are usually extremely adept and creative at thinking of ways in which to meet the needs of the client. Algorithms like Cohen-Mansfield's (2000) are useful to give a guide about ways in which to meet need, but the formulation session is important in providing the time and facilitation to think about interventions that are driven by the personality and history of the identified client as well as the opportunities available for change in the home or on the ward. Change is often constricted by the lay out of the environment, staffing numbers, tasks and roles among the team members. The formulation session should be used to develop bespoke strategies to meet the needs of the client, staff, and others around them.

Strategies developed by the group can become the basis for care plans. The Northumberland service formalises the staff suggestions as care plans making it easier for the team to evaluate the success of their intervention and to work through any problems if the intervention has not been effective.

The care plans should contain three elements:

1. Avoiding the challenge by meeting the need.
2. Noticing that challenge is about to occur.
3. Dealing with risk when an episode has not been diverted.

We have recently described this person-centred care planning method as the Traffic Light Approach (Green signifying a plan to maintain a person's well-being; Amber staff to be alert that there may be an imminent change in behaviour; Red the staff need to activate a risk management plan) (Sells & Shirley, in press) and have incorporated it into the workshops we provide for care homes.

Acting as facilitator for a formulation session

As we feel formulation sessions are integral to the successful implementation of person-centred care planning, we aim to get as many staff as possible to sessions to enable them to hear the information first hand. The group session also provides enhanced assessment information about the group of staff working with the identified client. In these sessions, the facilitator gains first-hand knowledge of the dynamics of the group and what the current understanding of the staff is about the behaviour they have concerns about. During these sessions, natural leaders emerge and potential saboteurs are often exposed.

The group often contribute to the story telling with knowledge they hold of the client that they have not had an opportunity to share before. As the session progresses, and people come up with ideas for how best to meet their client's needs, the group is important in questioning the logic or practicalities of the ideas enhancing or tempering their colleagues' suggestions.

Experience in the Northumberland team suggests that facilitating formulation sessions can be daunting and brings into play a number of skills over and above providing a teaching session. Developing rapport is integral to the success of the process, and facilitators need to be able to think on their feet when staff introduce new information about the client, or dispute your hypotheses. For these reasons, it is important to prepare sessions well.

Organising the sessions

Groups function best when the environment is right. For optimum effect, you need to have space, seating, and staff. You need to decide if you will be inviting family members to the session. There are benefits to having a member of the family present. They have their own anecdotes about their family members. They can clarify the impact the dementia has had on their relative and can agree to support the staff suggestions practi-

cally (e.g. through bringing in photographs). There are also potentially unhelpful aspects to having a family member present: the subject matter is very distressing for relatives and staff can subjugate their own need to talk about their problems to the need of the family member to hear positive things; naturally, some relatives may have had aversive experiences of their family member themselves which, when shared with staff, can give staff further 'evidence' of the hopelessness of trying to change the person rather than encourage them to try new strategies. Similarly, inviting the home's manager can improve the likelihood of suggested strategies succeeding or can discourage care staff from giving their 'warts and all' perspective on how they see the problem. Without knowing this perspective, the facilitator is unable to introduce evidence to countermand the beliefs supporting the current unhelpful care giving practice.

Facilitating the sessions

Our experience has been that it is helpful to present a formulation to a group of colleagues first. This is helpful because it gives the facilitator an opportunity to practice their presentation of the information and be advised by colleagues if the hypothesis they are presenting would make sense to the intended group of recipients. The trick of the formulation session is to present information in the most palatable way possible without losing the complexity of the person or their behaviour.

A number of helpful techniques for presenting a formulation sessions emerged from initial analysis of DVD footage of members of the Northumberland team facilitating formulation sessions. This included nurses, trainees, assistant psychologists and a qualified psychologist. Some examples appear below and are not dissimilar to strategies identified in therapy and supervision in previous studies (e.g. Milne & James, 2000).

Socialising people to the model

The Newcastle approach uses a specific model to help staff form an understanding of somebody's difficulties. The session is introduced with an explanation of the model and its basic assumptions, i.e. if we know enough about a person, it is possible to understand why they act the way they do.

Relationship building

Introduce yourself and find out who you are talking to. Don't be too afraid of self-disclosure (e.g. 'I know when I've been working with somebody with similar problems, I have felt really upset at their reaction to me').

Summarising and checking

Make sure people are following what you are saying. 'Have I got that right?' 'Is that the problem as you would describe it?' 'Have a missed anything?' 'Is there anything else we should discuss?'

Acknowledge the groups' experience

Normalise the group's current response to the challenge without colluding with poor practice. Recognise the expertise of the staff.

'I can see this would be difficult to work with every day.'

'From what you've said, you get to see the worst of this lady's behaviour and don't feel other people appreciate how bad that can be.'

'If I wanted to see things at their worst, what time should I have come in to observe?'

Conclusion

In this paper, I have described the detail of delivering formulations to carers working with older people who challenge. Since the inception of the Northumberland Challenging Behaviour service, these types of sessions have also been used in ward settings and with family and community-based services to facilitate understanding and move people toward appropriate, person-centred care. We have found the format focuses both participants and facilitator to

the needs of the identified client and we have received excellent responses from carers.

‘Let’s do this for everyone!’ (member of staff quoted in Janes & Shirley, 2008).

The simplicity of the format allows new members of the team to learn specific ways of delivering a formulation that gives them confidence in their work and instils confidence in those attending the sessions. The story-telling approach of the facilitator draws people into a new and more positive narrative leading to a focus on formulation-driven intervention.

In developing a specific model of formulation delivery as well as a specific psychological model for understanding the behaviour in the first place, services can be confident in the quality and consistency of their delivery of indirect work.

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A review of clinical supervision in a cold and demanding climate

Holly Gibbons

In a time where proven outcomes and cost effectiveness are paramount within the National Health Service, and where pressures from increasing scrutiny of worker activities continue, the regular and effective practice of clinical supervision may conflict with these target driven agendas. This review looks to recent and relevant literature to consider how the current practice of clinical supervision may be affected and how supervision could, in fact, facilitate efficiency in context with the current cultural and economic climate of health care services.

Cultural and economic context

THE ONCE clearly understood domain of health practice in the UK has been dramatically changed. Health services have been integrated into the community, numbers of patients and clients have increased while staff numbers have reduced, populations are more diverse, and there is a demand for greater accountability and for visible outcomes (Rose & Best, 2005). Workload and pressures in health care have increased exponentially particularly for those providing care to older adults. In approximately the next 10 years, the number of people over 65 in the UK will increase by 15 per cent, and those over 85 by 27 per cent (GAD, 2003). This cohort are predicted to present an enormous challenge to mental health services and some services may find that they are not be robust enough to cope (DOH, 2005).

Whilst public expectations of health care rises, savings of £20bn must be secured over the next four years. Both Health Secretary Andrew Lansley and Nigel Edwards, acting Chief Executive of the NHS Confederation have made statements to the press acknowledging this as an enormous challenge that will require changes in ways of working for all those employed in our health services (Smith, 2010; Lansley, 2010). The radical change in our economic climate demands that we do more for less.

Best practice guidance from the Department of Health states that the provision of a range of evidence-based therapies should be made available as a matter of course to all service users who require them, at any point of contact (DOH, 2004). A survey of psychiatrists working in old age services across the UK revealed that the majority of mental health teams offered clients some form of psychotherapy. However, the requisite staff training and supervision was poorly provided (Evans, 2004). Upon completion of courses in psychological interventions many practitioners have difficulty accessing supervision following their training, which contributes to limited utilisation of these newly-acquired skills (Brooker & Brabban, 2004). It is acknowledged that many professions in mental health services are highly competent in the provision of psychological practices. Clinical psychologists are typically highlighted as experts in this area and have a long standing tradition of providing supervision and training to non-psychologists (Clarke & Wilson, 2008). With the promotion of psychological therapies across mental health disciplines, the numbers of practitioners requiring experienced supervision continues to increase. There are growing concerns over how this need can be met given that clinical psychologists and other qualified therapists are such an under-represented resource, particularly in older adult mental health services (Bedford, 2006).

Furthermore, some health care providers are proposing to dissolve current specialist older adults services. In order to establish a so-called 'ageless' provision, with sufficient resources, supervision and training to work with referrals from all ages. Opinion is divided over the appropriateness of this model and there are claims that the proposal represents a dishonest way of cutting costs to the detriment of older people (Anderson, 2007; British Psychological Society (BPS), 2006). The BPS (2006) acknowledges that work with older adults is not equivalent to working with the general population and recommends that services without age related referral criteria develop strong links with services for older people, to enable appropriate responses to their complex needs. This is another new dimension to the older adult psychologists' role in training and supervision.

The importance of supervision is increasingly recognised even while resources for its provision are not universally protected, resulting in disproportionate practice across health professions (Butterworth et al., 2008). Supervision serves a wide array of functions, that include; ensuring safe and ethical practice is upheld; maintaining and developing competence and effectiveness; increasing awareness of therapeutic relationships; allowing dedicated time for reflection and case conceptualisation; imparting expert knowledge; assessing and supporting the needs of the supervisee; and, providing training and education (Milne, 2007; Holloway, 1997; Kadushin, 1992). Where supervision is seen as another task in the range of health care duties there may be a risk that protected time will be overlooked in favour of meeting target-driven agendas and perceived levels of efficiency. Practitioners and researchers seek to generate evidence about whether clinical supervision is cost effective and benefits patient care, and there is an assumption that to be credible supervision should be evaluated in line with other health care activities (Rose & Best, 2005). Indeed a trend is emerging in recent litera-

ture where development of guidelines and standardised models of supervision are seen as a logical progression in the era of evidenced based practice (e.g. Milne, 2009; Arvidsson et al., 2008; Haggman-Laitila et al., 2007).

Many attempts have been made to define supervision (e.g. Holloway, 1992; Lambert, 1980; Bernard & Goodyear, 1998), each adding further meaning, complexity and variety to our understanding of the supervisory process. Milne (2007) believed there was no clear definition of supervision that could aid future research and practice. A logical analysis and systematic review were employed, resulting in the following empirical definition: 'The formal provision by senior/qualified health practitioners, of intensive, relationship-based education and training that is case-focussed and which supports, directs and guides the work of colleagues (supervisees).' This definition aims to provide clarity, specificity and measurability to the term 'supervision'. However, relying on a single definition may preclude individuals from developing their own meaning and interpretation. Writing your own philosophy of supervision is encouraged as part of the development process early on in health practitioner careers, and coming to an agreed understanding between supervisor and supervisee is not just part of their contractual agreement, but can also help form their relationship (Carroll & Gilbert, 2005).

Greater attention has also been directed towards integrated competency based frameworks for supervision that allow benchmark competencies to be evaluated within the supervisory process (e.g. Falender & Shafranske, 2010; Boswell, Nelson, Nordberg, McAleavey & Castonguay, 2010; Fouad et al., 2009). The knowledge and skills framework (KSF) has placed greater demand on psychologists within the health service to provide evidence of their competencies and professional development. Kleiser and Cox (2008) reviewed literature to look at the appropriateness of the KSF as a structure for

integrated clinical and managerial supervision. They concluded that the roles of appraiser and supervisor should remain separate due to conflicts impacting the effectiveness of supervision. A competency-based approach to supervision may encourage training and development but taking precautions in ensuring precious supervisory time is not dominated by discussions of supervisee competence would be wise.

Group supervision

Supervision in groups is a common format in many professions and can offer a rich combination of learning and development opportunities. Utilisation of the group approach, is accelerating in both training and clinical practice settings, and is seemingly adaptive to different psychotherapeutic orientations (Scaife, 2004).

An almost equal proportion of observed benefits versus limitations of the group approach to supervision can be found in many supervision textbooks (e.g. Carroll & Gilbert, 2005; Scaife, 2004) and others have commented on the complex nature of group supervision. Proctor and Inskipp (2004) believe group supervision can be a restorative opportunity in a pressured, often lonely working life, for both supervisors and supervisees. Whereas, elements that hinder group supervision can include; between-member problems; lack of supervisory experience; problems in working with a co-supervisor; and negative supervisee emotions (Enyedy et al., 2003). In a recent investigation of non-disclosure in supervision groups, a notably high number of psychotherapy students found that groups became more closed as supervision progressed (Sissel et al., 2009). Difficulties in raising areas of perceived inadequacy with supervisory competence were also identified. In contrast, nursing students in Sweden using a pedagogically influenced model of supervision, were noted to demonstrate increased understanding, preparedness and professional strengths (Lindgren & Athlin, 2009).

The advantage of time efficiency offered by this approach may be attractive to supervisors working in the current healthcare climate. Additionally, peer group supervision allows team members to make use of some supervisory functions when issues arise between contracted individual sessions.

BPS guidance (2006) states that the role of clinical psychology in meeting the needs of older people can include the provision of advice and supervision to other multidisciplinary team members using psychological skills and interventions as part of their work as well as providing formal and informal training. Group supervision may go some way towards meeting the need for psychologists within the older adult speciality to share psychological perspectives and ways of working. Perhaps this could allow limited psychological resources to have greater influence, in lieu of increased representation. However, careful planning is recommended for the delivery of group supervision where supervisor training and support is limited (Scaife, 2004).

Supervision and technology

Telehealth is the use of telecommunications technology to deliver health care and information at a distance and may include the use of video-conference equipment, telephone, e-mail, webcams or online chat applications. Its use has largely been implemented in rural areas where the cost, need and efficiency of travel can represent barriers to accessing services, or where there are inadequate numbers of health care professionals to meet local needs. The integration of information technology in health care settings has resulted in less face to face contact with colleagues, and flexible, community based working practices mean that there is more isolation in health worker roles (Rose & Best, 2005). Telecommunications technology may therefore play a role in meeting the needs of health practitioners under increasing pressure to meet targets efficiently whilst also following standards of best practice. A wide variety of clinical tasks including supervision

can be accomplished via a range of telecommunication mediums and, when well-implemented, can reduce costs of care provision (Hueppmeier, Single & Welte, 2010). However, empirical evidence is limited and best practices needed to implement telehealth are still being developed (e.g. the Department of Health's Whole System Demonstrator (WSD) Programme).

In a study that looked at training and supervision using the internet, participants reported a range of benefits including improved competence in their own role and in their ability to support colleagues (Rahman et al., 2006). Hurley and Hadden (2005) highlighted the convenience of record keeping when utilising technology, and suggested digital recordings of supervision sessions may be helpful for evaluating the supervisory process as well as supervisee development. However, this raises issues of ethics and confidentiality, where storage and disposal policies relating to client information would need to be considered. A review by Miller and colleagues (2003) reports further limitations of telehealth supervision such as technological malfunction and potential lack of direct and immediate feedback, thus highlighting the need for telehealth supervision to be viewed as supplementary to face-to-face supervision rather than an adequate replacement (Miller et al., 2003).

Technological applications are developing rapidly as a vehicle for delivering psychological practices and these innovations may provide supervisors facing scheduling and distance constraints an alternative to face-to-face supervision. Video-based supervision in particular offers a viable alternative to face-to-face communication having multi-sensory and real-time qualities. Utilisation of technology to facilitate supervision over distances is potentially a cost-effective method and may encourage a global practice environment.

Self-supervision

The concept of self-supervision has not been a popular strategy for improvement of clinical skills, tending to have significance only in preparing for more conventional forms of supervision. However, there is potential for self-supervision to be a supplementary option when other means of supervision are not present or are insufficient (Lowe, 2000). Self-supervision may be relevant to more senior staff where there can be difficulties in finding supervision in the workplace, resulting in decisions being made without anyone to consult with or supervision being outsourced at considerable expense (Lahad, 2000).

The act of self-supervision has been proposed as a supervisory goal that can be adapted to fit a wide variety of specific practice models, and that encourages skill in deciding when additional supervision is required (Todd, 1997). Lowe (2000) considers this a self-sustaining approach where therapists assume a proactive responsibility for their supervisory needs and professional development. Lahad (2000) describes a method for self-supervision that utilises inner representations of the 'client, the 'therapist' and the 'supervisor'. Individual characteristics are attributed to each representation, and a questioning dialogue is facilitated by a dominant and non-dominant hand technique. Another personal account of self-supervision, promotes writing poetry in response to sessions. Where development and awareness of metaphor and meaning lead to more empathy and responsiveness in clinical work (Philips, 2010). The use of metaphor can allow a complex array of information to be conveyed in a simple way and can foster creative thinking by being somewhat removed from the issue. Clients themselves may introduce metaphors during sessions or they can be created during supervision by identifying the clients frequently used phrases or re-occurring themes (Scaife, 2004).

Self-supervision has obvious limitations, including risk management issues and a lack of challenge to interpretations, when

considered as a sole method of supervision. However, self-supervision may compliment transformational learning, where supervisees critically reflect on their experiences and how they are constructed. The process is said to deepen self-awareness and allow past interpretations to be re-evaluated, a key objective of clinical supervision (Carroll, 2010).

Conclusions

For now the role of clinical supervision seems to hold a relatively secure place within health care practices. Recent literature suggests that supervision is able to adapt to the efficiency and target driven climate and may even be utilised as an 'efficient' tool for enabling psychological perspectives and training to be shared throughout old age services. Where opportunities to engage in traditional approaches to supervision are lacking more unconventional approaches may relieve some of the pressures and constraints that challenge practitioners attempting to follow best practice guidance and develop their professional competence. Whether the evolution of supervisory

practice will be required in order to survive the Governmental push for measurable outcomes is yet to be established. Practitioners delivering psychological therapies in services for older people in particular may benefit from adopting non-traditional approaches to supervision, where there is a growing need for psychological interventions unparalleled by available resources. Unconventional supervision may support those who deliver supervision to many practitioners by providing them with more efficient methods when appropriate, or even by allowing supervisees access to other supervisors. It may also aid those practitioners who have some training but no suitable supervision, as well as facilitating training and education in areas such as acute inpatient wards where time pressures and staffing levels can limit integration of psychological ways of working.

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Supervision of older adult placements in one region: Perspectives of three clinical tutors

Derek Milne, Theresa Marrinan & John Ormrod

To glimpse clinical psychology supervision within older adult placements, we summarise the authors' experience of attending mid-placement meetings with the supervisors in one English region. To clarify these experiences, we used the supervision 'platform' and a key chapter, drawn from experiences in the US (Duffy & Morales, 1997). These provided the basis for an informal, semi-structured interview. This approach mimics the 'aggregate study' method used by Ellis et al. (1996), being a way to characterise a typical supervision paper. In turn, we found the method helpful in trying to characterise the supervision provided over the past year by approximately 10 local supervisors. As a result, we thought that the US profile outlined by Duffy and Morales (1997) fitted closely with our reflections on the local provision of older adult supervision. For example, it appeared to us that a distinctive feature of the older adult placements was the exceptional complexity of the clinical context. This seems to require considerable versatility and commitment of the trainees, with the implication that supervision needs to be particularly effective.

SUPERVISION represents a crossroads between our professional activities, bringing together the supervisor's orientation to their work, their commitment to the profession, their approach to organisational issues, and the demands of their clinical work. Faced with a trainee, these influences can be brought into sharp relief. In order to glimpse the nature of clinical psychology with older adults in one English region, the following account draws on the authors' experience of attending 'three-way' meetings with older adult placement supervisors (i.e. the mid-placement review, involving the supervisor, supervisee and clinical tutor from the local training programme). The material that follows, therefore, represents an impressionistic snapshot of some of the distinctive features of recent older adult placements, as perceived by the authors.

In order to structure this reflection, we used the supervision 'platform' as the basis for a semi-structured interview. The platform has been recommended as a way for supervisors to describe their placements, and for trainees to articulate what they bring to a placement (Milne, 2009). It consists of a list

of factors that might characterise different placements, such as the context within which the supervisor practices (see Figure 1, overleaf). A precedent for this approach is the 'aggregate study' method used by Ellis et al. (1996). They conducted a hugely sophisticated methodological critique of the supervision literature, but helpfully concluded this detailed work with a summary of the weaknesses of this literature, in the form of an aggregate study. This was used as an illustration to 'accentuate both the strengths and limitations of the research in clinical supervision reviewed here ... to clarify and synthesise the data and findings'. This enabled them to profile a typical supervision study in terms of its strengths and weaknesses. To illustrate, their review indicated that the aggregate Introduction rightly recognised the complex nature of supervision, but took an atheoretical stance. Furthermore, it would contain 'vague and general' (p.44) hypotheses, to the point that they made it impossible to falsify predictions.

We thought that this kind of profiling approach held promise for the present attempt to capture something of the nature of supervision, in relation to older adult

placements in the northern region of England. We were unaware of any related prior research. A further aid to our profiling effort was a rare account of supervision within the older adult specialism, the chapter by Duffy and Morales (1997) in *The Handbook of Psychotherapy Supervision* (Watkins, 1997).

Method

In order to develop this aggregate profile we adapted the supervision platform that has been developed for use by individual supervisors and supervisees (Milne, 2009). This is set out in Figure 1.

Within routine clinical supervision, these somewhat overlapping layers of the supervisor’s approach are intended to tease out some ways in which supervisors (and their supervisees) are distinctive, in order to contribute to the important task of conducting an educational needs assess-

ment, leading into the joint construction of a learning contract. In addition to the headings that were in the initial platform, drawn heavily from Watkins (1997, p.9), we drew on the chapter by Duffy and Morales (1997). The parts of Figure 1 that are in inverted commas are drawn directly from Duffy and Morales (1997), and they represent interview prompts. In particular, the first line of the platform, context, was added due to their emphasis on how supervised experience with older adults entailed work into an exceptionally wide ranging and complex health service settings, so necessitating much greater versatility from the trainee. In addition to context, it can be seen that we also picked out a variety of aspects of supervision, including the basic stance or perspective that the supervisor takes towards the supervisee; and consideration of the kinds of roles the supervisor might take in relation to the supervisee.

Figure 1: A platform for profiling supervision.

1. Context
Prompts: PSIGE guidelines/agenda to promote OA experience; range of settings++, requiring 'greater versatility ... complex clinical situations'.
2. Supervision style or 'stance'
Prompts: dominant relationship approach? – for example, 'intensive moulding?'.
3. Supervision methods/techniques
For example, take special care over relevance of trainees' experience and competencies? What use of experiential methods? Which formats?
4. Supervision goals/agenda
Including PSIGE guidelines; addressing attitudes – 'gerophobia'; topics, settings, links to peers, administration.
5. Supervision roles
For example, consultancy/indirect/systems work; team worker; teacher (more challenge?); model competence+?; colleague.
6. Supervision model/orientation
For example, CBT/integrative.
7. Supervision philosophy
Shared core beliefs and values, for example, clinical influences, 'person-centred' model; 'generativity'.

The procedure was that the first author, an ex-clinical tutor, interviewed the two current clinical tutors within the Newcastle Doctorate programme for approximately one hour, using the headings and prompts within the revised platform (see Figure 1). The two current clinical tutors were asked to think about the past year in particular, but during prompting a longer time frame was sometimes used. This allowed the first author to contribute to some general points. The summary that follows is based on what we three authors said, drawn from notes taken during the interview by the first author. In particular, we attempted to restrict the interview to the mid-placement 'three-way meeting' as our sampling frame.

Results

1. Context

In general, the tutors agreed with the Duffy and Morales (1997) account of supervision in the older adult speciality. For example, they thought that there were far more home visits within these placements, and that this came as 'a jolt' to some trainees, being their first experience of the kinds of interruptions and communication problems that can arise whilst attempting to work in someone else's home. On the other hand, the tutors also heard reports of enhanced information-gathering arising from these visits, making it a worthwhile and valid activity overall. They also thought that home visits may have resulted in greater respect for the older adults, perhaps something to do with requiring permission to work within the patients 'territory'.

A second distinguishing feature of the older adults placements sampled was the complexity of the challenge. Specifically, older adult placements necessitate grappling with some of the profound issues associated with ageing. This subsumes mortality, but also includes tasks such as feeding back findings from neuropsychological testing, findings which are often negative (e.g. progressive dementia). Furthermore, there

may be an uncomfortable experience whilst delivering tests and witnessing deteriorating performance. A further characteristic that might well distinguish older adult placements is the involuntary nature of the residential care arrangements for quite a proportion of the patients, making engagement harder (e.g. testing someone in a secure setting). The tutors thought that the care settings might well involve more demoralised and poorly-staffed environments than the ones that trainees would typically come across.

Lastly, the tutors felt that the range of problems presented and the complications that were associated with them were exceptional (e.g. the multiplicity of associated problems: falls, wandering, multiple cognitive and physical deterioration, etc.).

2. Supervision style

The tutors found it harder to identify an aggregate supervision style, in relation to the sampled placements. The 'intensive moulding' described by Duffy and Morales (1997) could be linked to one or two supervisors, and this was seen as an entirely appropriate approach within a particular team and their evidence-based package (e.g. dealing with challenging behaviour). However, it was felt that the dominant relationship style was that of 'travelling', of journeying together through a placement. According to this style, the supervisee is seen as a colleague who will engage equally in a somewhat exploratory approach to dealing with the challenging context of an older adult placement. This would subsume treating the supervisees as adult learners, and regarding the challenges as significant (requiring a particularly thorough, problem-solving approach to supervision). In keeping with this style, supervisors had agreed that placements would only commence in the second year of training, so that the supervisees had the basic competences needed to cope with the exceptional demands of an older adult placement.

3. Supervision methods and techniques

Aside from the comment about 'intensive moulding', the clinical tutors felt that this was an area that was not dissimilar to other kinds of placements. For example, supervisors in the older adult placements were comfortable using the Doctorate programme's competence statement, and feedback from trainees indicated that an appropriate range of didactic and experiential techniques were employed.

4. Supervision goals and the agenda

According to Duffy and Morales (1997), a unique objective within older adult placements is to address 'gerophobia', and the clinical tutors firmly agreed that this was also the case locally, noting that attention was routinely given to supervisees attitudes to ageing. Although this appeared to create anxiety for some trainees, the tutors also noted that ultimately supervisees are often pleasantly surprised by their engagement with older adults, so that it seems that any phobia is suitably desensitised through well-managed exposure to some of the potentially challenging issues. Indeed, it was felt that this effort was so successful it had led to a positive effect on recruitment of these former supervisees to local older adult services.

Other distinctive goals that were noted included attention to confronting a wider range of risk issues (e.g. neglect; assault; and attempted suicide); and the need to set learning objectives about working with carers (including managing the distress of partners who act as carers).

5. Supervision roles

As highlighted within Figure 1, the tutors affirmed that extensive indirect and systems level working was a routine feature of older adult placements. This was similar to placements within the learning disability speciality, but with some interesting aspects to the role. These included playing down expectations of a 'quick fix', whilst also minimising the emphasis on professional

expertise. The impression gained indicated the need to work as a 'non-expert' within teams and systems. This reflects the limited potency of 'off-the-shelf' techniques, meaning that more extensive problem-solving is needed with care staff (e.g. providing formulation sessions, to help them to think creatively about ways of addressing clinical problems within their settings). Also, the non-expert role has the effect of supporting and empowering the carers, staff and others with whom supervisees work indirectly.

6. Supervision model or orientation

Whereas the first author had assumed (perhaps from reading academic material about work with older adults, such as trainees' essays) that a person-centred approach would dominate, the other authors felt that this was not essentially different from the learning disability speciality. And like the supervisors in the LD speciality, they also thought that the older adult supervisors treated supervision particularly seriously, as indicated by the way that they provided one another with continuing professional development (CPD), and by their emphasis on a team ethos, one that very much included the trainees (e.g. trainees would be expected to share equally in the preparation and delivery of CPD presentations on topical issues). In this sense, supervisees are treated as 'adult learners'.

Another feature of the older adult placement is perhaps that, by nature of the clinical presentations, there is a more routine or frequent integration of the biological, psychological and social facets of human functioning. There were also thought to be some particularly clear-cut examples of supervisors who modelled a scientist-practitioner orientation, illustrated too by their contribution to the supervision literature. Finally, in general the supervisors were thought to be more systemic and integrative, again due to the pressures within the speciality.

7. Supervision philosophy

Duffy and Morales (1997) suggested that 'generativity' was a facet of the older adult placement, and our tutors that this also had some basis in their experience. The supervisors concerned certainly appeared to be committed to the development of the next generation, standing out as 'star supervisors' who were also exceptionally committed to their client group.

Discussion

In summary, the profile outlined by Duffy and Morales (1997) appeared to fit closely with our reflections on the local provision of older adult supervision. In particular, we would endorse the following as distinctive features of the older adult placement:

- Complex context, requiring considerable versatility and commitment, with the implication that supervision needs to be particularly effective.
- A supervision stance that emphasises the position of the supervisee as an inexperienced but able and respected colleague.
- An agenda that emphasises a wide variety of indirect work, reflecting the breadth of the service context into which supervisees work.
- Team morale: The older adult supervisors as a group appeared to us to represent an exceptionally cohesive and effective unit, successfully promoting their field of work.

As Duffy and Morales (1997) put it, this group were 'advancing a strong clinical geropsychology' (p.366).

Reflecting on this exercise, we must obviously be extremely cautious about the validity of our observations, as these are

manifestly based on a relatively unstructured and informal approach to data collection. Therefore, we would liken this article to a pilot study, helping to identify some promising areas for systematic investigation. However, we do hope that we have managed to clarify and illustrate some of the variables that may help us to best characterise the older adult placement. With Ellis, et al. (1996), we hope that this 'aggregate study' has helped to accentuate some of the strengths and characteristics of older adult placements within clinical psychology placements in the north of England. We also hope that this serves as a detailed acknowledgment of the commitment and skill of the supervisors and supervisees involved.

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The importance and benefits of sharing the formulation process within an assistant psychologists' supervision

Amy Waugh, Claire Vaughan & Tresa Andrews

THE UK's ageing population (Office for National Statistics – ONS, 2010) has many implications for health and social care, hence for older adult psychology and psychotherapy services. A major implication will be the need to provide health and social care services for an increasing number of older adults with multiple, long standing and complex needs. To meet this need, older adults' services will have to improve and fundamental to this improvement is the development of all professionals' skills and knowledges as recommended by the National Service Framework for Older People (Department of Health, 2001). Supervision could be argued to be an investment and a vital need to develop a skilled future workforce to meet an ageing population's needs. It offers an investment by instilling the key principals, values, skills and knowledge of good practice early in the career pathway. Specifically for assistant psychologists, it can be the starting point of developing skills in formulation, the foundation of clinical psychology. These ideas form the starting point of our paper and the offer to provide an assistant psychologists' perspective on some of the many benefits of sharing detailed biopsychosocial formulations in supervision.

The authors of this paper currently work in the Inner London Borough of Westminster. Westminster has a total population of 236,000 people, of which 26,000 are aged over 65 years (ONS, 2008). It is the 15th most deprived London Borough with an estimated 24 per cent of older people living in deprivation (Westminster City Council, 2010) and 45 per cent with a reported long-

term limiting illness (Mental Health Strategy for Older People in Westminster, 2007–2010). To meet the mental health needs of older adults in Westminster, our Mental Health Foundation Trust provides 10 pathways of care. Our older adult psychology and psychotherapy service radiates out in a spoke like manner into all of these. Two of the authors (assistant psychologists) spoke into two of these different pathways and have benefited from formulations being shared during supervision.

In busy, time-pressured services, the practice of using supervision time to share in detail the formulation process with assistant psychologists may become less of a priority. However, we advocate that this practice should not be overlooked as it can optimise the effective use of assistant psychologists and thus a vital investment in the future of services. To demonstrate the importance and benefits of sharing the formulation process with assistant psychologists we will present two case vignettes. We hope this paper will prompt discussion on the role of assistants' supervision to meet the changing demands upon older adult psychology and psychotherapy services.

People over 65 years of age are more likely to have multiple physical health difficulties (Dalton, Cruickshanks, Klein et al., 2003; Braden, Zhang, Fan et al., 2008; Fox et al., 2007), mental health concerns (Department of Health, 2001) and disabling social factors (e.g. Shifflett & Blieszner 1988). Many have noted that biological, psychological and social factors can lead older people to experience excess disability (e.g. Kitwood, 1997). A biopsychosocial approach

(Engels, 1977) to formulations can help develop, with the service user, a shared understanding of the multi-faceted nature of their difficulties. It can further help plan and co-ordinate with them an integrated, multi-professional, multi-service and multi-agency approach to effective care. What follows is a description of our work with Mrs X and Mrs Y, who were happy for us to talk about our work with them. It is not our intention to provide the reader with detailed formulations of Mrs X and Mrs Y's concerns. Rather, we briefly describe the part we played within Mrs X and Mrs Y's interventions and how this was enabled by experiencing the formulation process in supervision. We will subsequently use these descriptions as a springboard to discuss the importance and benefits of sharing in detail the formulation process with Assistants.

Mrs X is an 81-year-old woman who at the time of meeting the psychologists, self-reported difficulties with 'nerves', 'sadness', 'drinking' and 'getting about'. She described how she had 'recently lost her dear son'. Mrs X was brought to our attention by our mental health colleagues who noted she had been 'admitted to the Acute Hospital Trust nine times in the previous year for alcohol detoxification, resuming alcohol use sometimes only days post-discharge'. Our colleagues were considering a residential care home placement for Mrs X to 'ensure her safety'. Although Mrs X held a different view to the mental health professionals about her risk level, she agreed to liaise with us (the psychologists) and to a voluntary admission to a bed-based unit for further assessment and intervention. Following a comprehensive longitudinal assessment (including a neuropsychological assessment) by two of the authors (qualified psychologist and assistant psychologist), a biopsychosocial formulation was systematically and gradually developed (with visual and written aids) with all concerned in Mrs X's care, including Mrs X herself. The assessment and formulation process was regularly discussed in detail in the assistant psycholo-

gist's supervision as she assisted in the mapping and tracking with Mrs X of her concerns and wishes for the future. The assistant psychologist also assisted in helping Mrs X identify and develop further strategies for managing her concerns and helped in the development of a multi-disciplinary goal setting and recovery resource pack. With time, Mrs X began to narrate how 'the shock of losing her son had led her to want to detach' and to use alcohol as a 'crutch'. However, she also reported in our last meeting how 'she now realised she needed to work with mental health staff'. Mrs X was discharged home seven months ago and has not required an Acute Hospital admission since. She no longer reports difficulties with 'nerves', 'sadness', 'drinking' and 'getting about'.

Mrs Y is an 82-year-old woman who at the time of meeting two of the authors (qualified psychologist and assistant psychologist) self-reported feeling 'annoyed' due to feeling 'physically unwell' and 'not being able to do what she wanted to'. She explained how as a young woman she had been 'as fit as a fiddle'. Her daughters described how she had been an 'independent woman'. However, they also described when recently breaking her wrist she had become 'anxious' and now regularly telephoned them for support. Mrs Y was brought to our attention by our mental health colleagues who had provided her with a diagnosis of mixed-type dementia. They had noted she was 'experiencing cognitive impairment coupled with anxiety, social withdrawal and complex family dynamics'. Although Mrs Y held a different view to her daughters and the care professionals about her main concerns, she agreed to liaise with us and her family about the best ways to support her. Following a detailed assessment (including a neuropsychological assessment) by two of the authors (qualified psychologist and assistant psychologist) a biopsychosocial formulation was systematically and gradually developed (with visual aids) in partnership with Mrs Y and all concerned in her care. The assessment and

formulation was regularly discussed in detail in the assistant psychologist's supervision as she assisted in the mapping and tracking with Mrs Y and her family of their concerns and hopes for the future. With time, Mrs Y and her family began to agree on the changes and losses they were experiencing, acknowledging this was a time of transition and adjustment for all. With an agreed biopsychosocial formulation and a consensus regarding concerns, an agreed contract of care was co-ordinated. Mrs Y agreed to working with a care coordinator, her daughters agreed to meetings with an admiral nurse and the whole family agreed to family therapy.

Mrs X and Mrs Y's experiences are typical of many of our service users and highlight how multi-faceted complex concerns invite a multitude of people into the care network. Our work with Mrs X and Mrs Y hopefully demonstrates the importance of collaboratively generating (with the care network) biopsychosocial formulations as these support the whole network of care (including service users) to develop a better understanding of the complex interplay between biological, psychological and social factors. The collaboratively generated formulations described above helped multi-professional teams to enhance their selection of the most suitable intervention to meet agreed identified needs, which helped ensure good quality integrated care. Importantly, we feel these formulations facilitated Mrs X to enhance old and find new coping strategies enabling her to return home safely. Also, they enabled Mrs Y and her family to enhance their management of their transition and adjustment by fostering a shared understanding of problems and coping strategies.

The notion of jointly formulating an understanding of difficulties is familiar to clinical psychologists and has regularly been advocated as best practice (BPS, 2008). As stated above, sharing the formulation process in an assistant's supervision is sometimes overlooked because of the pressure of

time in busy services. We would like to offer the perspectives of assistant psychologists on some of the many benefits of sharing detailed biopsychosocial formulations in supervision. With regard to an assistant psychologists' professional development, we advocate that experiencing the generation of formulations in a collaborative manner in supervision was a very powerful learning tool. By adhering to the tenet of experiential learning (Kolb, 1984) we began learning how to formulate. Specifically, within supervision we experienced the integration of information gathered through assessment; learned to draw upon psychological theories and evidence base to guide the development of formulations; and the testing and modifying hypotheses in light of new information. Experiencing the formulation process in this manner enhanced our knowledge and skills of this complex and vital psychological practice. It brought to life the process, utility and benefits of formulation that we had frequently read about within academic literature. Particularly, we gained a greater appreciation of how biopsychosocial formulations are crucial to understanding older people's complex and multi-faceted needs; how they assist services to identify the most appropriate person-centred intervention (Kitwood, 1997); enable the most effective integrated care and thereby alleviate difficulties experienced by service users.

Again, from the perspective of an assistant psychologists' professional development, the sharing of formulations within supervision enabled us to work with service users with greater understanding and skill by increasing our empathy and our ability to forge therapeutic alliances. Summer (2006) reported similar benefits when sharing formulations with multi-professional staff. In addition, having biopsychosocial formulations shared with us in supervision also enhanced our appreciation of the context and rationale for our input within overall interventions. This ensured we carried out discreet, meaningful and therapeutic clinical intervention work in an informed, proficient

and safe manner enabling a valuable contribution to a wider integrated piece. It nurtured a greater understanding of the role for different professions, helping us to develop our skills to work in a collaborative manner in partnership with multi-professional colleagues.

From a service perspective, we feel the benefits of sharing detailed biopsychosocial formulations within supervision along with actively involving assistants in the assessment, formulation and intervention process are numerous. We feel it facilitates the skills and knowledges of assistant psychologists and enhances their capacity to be a useful resource when working with older adult's complex needs. This is pertinent as it is recognised that there is an 'insufficient resource available in the NHS to meet the current demand for psychology therapies and services' (BPS, 2007, p.5). Increasing recognition of the benefits of psychological therapies with increasing pressure on psychology to improve the quantity, quality and accessibility of services (Department of Health, 2008) coincides with a time of economic and resource constraints. This is a concern for older adult psychology and psychotherapy services as there will be a growing demand for services coupled with increased pressure for cost effectiveness. *New Ways of Working for Applied Psychologists* (BPS, 2007) explicitly identifies the large pool of psychology graduates and assistant psychologists as one means of increasing access to psychological services. This is particularly apt given the development of Stepped Care Models (Bower & Gilbody, 2005), which invite psychologists into working with greater complexity, at higher levels of the Stepped Care System. Thus, it is important that the value of assistant psychologists as a resource is recognised and embraced by the provision of appropriate supervision. This entails the investment of time to share detailed biopsychosocial formulations and actively involve assistants in the assessment, formulation and intervention process.

In conclusion, health and social care practitioners will in the future be increasingly invited to work with older adults with complex needs. Through descriptions of our work, we hoped to illustrate how supervision can develop a skilled future workforce to meet the needs of an ageing population. We also hoped to illustrate how spending time with assistant psychologists in supervision to discuss detailed biopsychosocial formulations to support their involvement in the assessment, collaborative formulation generation and intervention process of complex cases is a worthwhile investment as this can prove to be a cost-effective means of making the most efficient use of available resources in light of changing service demands and Government policies. We hope this paper encourages more supervisors to share the formulation process in assistants' supervision, even within busy services when time becomes pressured.

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TRAINING DAY
Psychotherapeutic Work with
People with Dementia
led by Rik Cheston

24 November 2010 – 10.30 a.m. to 4.30 p.m.
Venue: South Wales Doctoral Programme in
Clinical Psychology,
Archway House, 77 Ty Glas Avenue, Llanishen,
Cardiff CF14 5DX.

This day will examine issues involved in trying to use psychotherapeutic methods with people with dementia, and in particular group psychotherapy. The day as a whole will concern the need for psychological work to be therapeutic in a general sense as well as the possibilities for doing psychotherapy.

OUTLINE OF TRAINING

Being psychotherapeutic in a general sense: understanding dementia as an existential threat involving threats to life, independence, meaning, relationships and identity; relating this to psychosocial research; and thinking how these broad ways of understanding dementia have implications for the sorts of services we should provide.

Doing psychotherapy: how a generic psychotherapy model of assimilating problematic experiences can be used to understand the therapeutic process, and the implications that this has for work with people with dementia. This includes looking at the importance of ambivalence and the way in which people with dementia may alternately approach and then retreat from thinking about what is happening to them.

BOOKINGS NOW BEING TAKEN

Costs:

PSIGE members – £30; PSIGE Trainees and Assistants – FREE
Non-PSIGE members – £50; Trainees and Assistants – £15
(Free PSIGE membership on the day)

Full details and booking form now available.

Please contact Frances Free (Frances@academictype.co.uk)
for further information.

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as at February 2010

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PSIGE National Committee

as at January, 2010

Don Brechin – *Chair*

Cath Burley – *Vice Chair & CPD Lead*

Polly Kaiser – *Policy & Diversity Lead*

Sarah Dexter-Smith – *Secretary*

Louisa Shirley – *Newsletter Editor*

Mhairi Donaldson – *Membership Liaison and Website*

Cerys MacGillivray – *Conference Liaison*

Liz Baikie – *Scottish Representative and Dementia Lead*

Lyn Sutcliffe – *Dementia Lead*

Julia Boot – *IAPT Lead*

Becci Dow – *Treasurer and Welsh Representative*

Louise Bergin – *IAPT and Newsletter support*



Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: articles, research updates, Letters to the Editor, book reviews. These can be on any aspect of psychological theory or practice with older people.

Articles

Articles form the bulk of contents submitted to the *Newsletter*. As the *Newsletter* aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Articles of any length up to a maximum of 3000 words will be considered. Experimental reports should follow convention in terms of subheadings and sections: Abstract, Introduction, Method, Results, Discussion, References.

References should follow conventional format as in journals such as *Psychological Review*:

- (1) Book reference:
Mischel, W. (1986). *Introduction to personality*. New York: CBS.
- (2) Journal article:
Martin, A. & Fedio, P. (1983). Word production and comprehension in Alzheimer's disease: The breakdown of semantic knowledge. *Brain and Language*, 19, 124–141.
- (3) Paper in a book:
Garrett, M. (1980). Levels of processing in sentence production In B. Butterworth (Ed.), *Language Production (Volume 1) Speech and Talk*. London: Academic Press.

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, for example, ideas for discussion or early stage results, which are not ready for formal publication. Try to keep these submissions below 500 words.

Letters to the Editor

The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

Book reviews

Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed.

Images

The *Newsletter* is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photograph out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure

All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor.

When submitting articles please send the following information:

- Full name;
- Affiliation (title, place of work);
- Contact details (should you be willing to be contacted by the membership);
- Acknowledgements (as appropriate).

Finally, all reports of research should indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

All contributions should be sent to: louisa_shirley@hotmail.com

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