The Cumbria Partnership Journal of Research, Practice and Learning

Instructions for authors

General
The aim of the Cumbria Partnership Journal of Research, Practice and Learning is to share good practice in clinical and professional activity relevant to the services and functions of the Cumbria Partnership NHS Foundation Trust and its partners. We support articles from authors within or outside of the trust that encourage evidence based practice within any part of the trust services and support and educational functions. The Editorial Team will be happy to discuss articles with potential authors and to offer support in developing an idea or working up an existing report for publication in the Journal. If you would like to submit an article or require more information about the journal or the Learning Network you can contact the Editor, Professor Dave Dagnan at dave.dagnan@cumbria.nhs.uk.

Articles may be submitted on a range of topics including:

- Case reports
- Review articles
- Clinical experience
- Key audits
- Research and development
- Health and social care management
- Trust management
- Governance including risk
- Reflective practice
- Adult Learning
- Letters to the Editor
- Events, special training sessions and guest speakers

Articles are encouraged from all partners including:

- Nursing
- Managers
- Finance, Human Resources, Estates, IT and other wider functions of NHS trusts
- Medical
- Psychology
- Allied Healthcare Professionals
- Social Care
- Service users and carers

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Ethical guidelines
Acceptance of papers is based on the understanding that authors have treated research participants with respect and dignity throughout. Papers based on original research must include an ethical statement to confirm either that the research has received formal ethical approval from an appropriate ethics committee or that the research has taken appropriate steps with regard access, informed consent, confidentiality and anonymity.

Copyright and publication in other journals: All refereed journals will have strict rules about the publication of data and text that has appeared elsewhere. This will also apply to the Cumbria Partnership Journal of Research, Practice and Learning.
Editorial

Dave Dagnan

This is the fifth issue of the *Cumbria Partnership Journal of Research, Practice and Learning* and the contents demonstrate how the acts of reflecting, researching, evaluating and auditing our clinical or professional work take place in the Cumbria Partnership NHS Foundation Trust and partner organisations. These articles are significant contributions to the process of service improvement and learning. How we learn as individuals, teams and organisations is complex! The nature of our clinical and professional activity is such that there are multiple opportunities to learn through reflection on our own practice every day. The complexity comes from the challenge of understanding the dynamic inter-relationship of individual, team and organisation learning processes and how we design systems to make this as effective as possible. The contents of this journal represent a contribution to this complex process. The articles are examples of individuals formalising their learning through the process of writing and publication. The act of writing about what we do can be a very powerful form of reflection. Isaac Asimov (the science fiction author of *I Robot* which was made into a film with Will Smith in the lead role) said “Writing to me is simply thinking through my fingers”. I know exactly what he meant by this. Writing a report or a reflective piece of work helps clarify what we think. Putting our thoughts into written (or sometimes even spoken) words can be a daunting process because it commits us to the statements we make; but it is a significant aspect of capturing our learning so that it can be available to others to inform their learning. So, as ever, I would like to thank the colleagues who have put their thoughts into words for the journal, hopefully not a too daunting process, but definitely one that contributes significantly to individual, team and organisational learning.

*Professor Dave Dagnan, Editor, The Cumbria Partnership Journal of Research, Practice and Learning*

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Call for papers – special issue on leadership in the Cumbria Partnership NHS Foundation Trust and wider NHS

Leadership is, today, a highly prominent issue within the UK’s public healthcare system; the work of the NHS leadership academy, and the generation of the NHS leadership framework, stand as direct testament to this. The *Cumbria Partnership Journal of Research, Practice and Learning* will, in line with this national focus, be publishing a special issue in 2014 dedicated to processes, impacts, experiences and innovations surrounding leaders, leadership and leadership development in Cumbria Partnership NHS Foundation Trust (CPFT) and beyond.

As such, the editors of this special issue would like to invite any interested authors to submit manuscripts to be considered for publication. Particularly welcome would be submissions from individuals or groups who have taken part in CPFT’s own leadership training programmes: Foundation in Management and Leadership, Leadership Development and Learning Leaders. Such submissions could include, but are by no means limited to:

- Letters to the editors;
- Reflective pieces on participation in leadership practice and leadership development programmes;
- Critical reviews of pertinent literature;
- Research reports emergent of leadership and leadership development initiatives (such as the change projects embedded in some of CPFT’s own programmes);
- Evaluative reports on leadership practices.

It is anticipated that a range of such contributions will be published alongside practice-oriented reflections from leadership trainers, and research from formal external evaluations of CPFT’s own leadership initiatives. Anyone who wishes to discuss the feasibility of an idea or draft should contact Dr Paul Miller (paul.miller@cumbria.ac.uk) or Dr Tom Grimwood (tom.grimwood@cumbria.ac.uk), who will be happy to advise on development of manuscripts. All papers should be prepared in line with the journal’s house style (see website), around 2000-2500 words in length, and submitted to Paul Miller or Tom Grimwood, by email, by the final deadline of mid June 2014.
LETTERS/NEWS/BOOK REVIEWS/REVIEWS

How to do your case study: A guide for students and researchers

Naomi Pierce

Abstract

Keywords
book review; case study; research

The overarching aim of this book is to demystify the case study and help the reader to conduct their own through a methodical and easy-to-follow process.

Each chapter addresses a particular component of the case study, from defining exactly what one is, to writing up findings. This ensures the reader can easily dip in and out of the book as required, without the need to read multiple chapters in a short space of time. This is further embedded in the structure of the book by ensuring that key reference points can be accessed immediately; the end of each chapter features a brief and informal summary, giving a snapshot of essential information in just a few lines.

As our familiarity with the case study progresses, the theory behind a chosen mode of analysis is introduced, including a brief overview of Gestalt psychology ("things should be seen in their totality" p. 47). For those who learn in a more visual way, each idea and discussion is accompanied by helpful diagrams to illustrate the author’s key points.

Any overreliance on the theoretical aspects of the case study is quickly tempered by the frequent assertion that individual logic and judgement is paramount when conducting one’s own work; a focus on the practical is key.

The ‘Your purpose’ chapter is perhaps the most valuable portion of the book, enabling the reader to thoroughly evaluate their aims and objectives behind the case study and apply these to their analytical framework. The differences between intrinsic and instrumental purpose are clearly demonstrated as being equally valid justifications for a case study – reassurance for those who enjoy learning for learning’s sake!

The write-up stage of any piece of writing is often bemoaned as the most stressful – organising one’s thoughts into something that can be easily read by an audience is not easy but, in keeping with the previous chapters, this aspect of the case study is presented to the reader as easily achievable. The use of a storyboard method – breaking down one’s writing into small parts that can be reordered as the argument develops – will prove invaluable to those who struggle with perfecting the structure of their writing.

The author also takes the time to address the varieties of case studies that exist and how the type employed can affect the final write-up; even those with a prior knowledge of the case study will appreciate this when reviewing the structure of their work.

Rather than overcomplicate the role of the case study in research How to Do Your Case Study provides the reader with a comprehensive guide to the process, backed up by a sound theoretical framework. With a format that allows the reader flexibility in the way that the book is used, this is a valuable guide for those who want to ensure that their case study is a clear and structured showcase of their research abilities.

How to Do Your Case Study cannot write your work up for you, but it can certainly make the process easier and perhaps even enjoyable.

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Prevalence and risk factors of mental health problems in children and adolescents with intellectual disabilities

Dinesh Khanna

Abstract
Learning disabilities (LD), also commonly referred to as intellectual disabilities (ID) is defined as a condition of arrested or incomplete development of the mind as per International Classification of Diseases, version 10 (ICD 10, World Health Organization, 1993). Such a condition is characterised by impairment of skills and functions. Like any other individual, children with LD are prone to a complete range of mental illnesses; in some instances more so than others.

This article aims to look at various studies and research conducted on identifying the prevalence and risk factors of mental illness and behavioural difficulties in children with ID.

Keywords
learning disabilities; intellectual disabilities; review, prevalence; risk factor; mental health

Studies reviewed
Birch et al. (1970) studied 104 children with ID between 8-10 years old and found 30% had clear psychiatric illnesses. Koller, Richardson, Katz and McLaren (1983) studied 192 children with ID and found that 33% showed aggression and conduct disorder, 29% had emotional disturbance, 27% showed antisocial behaviour and 12% had hyperkinesis. Hyperkinesis was more prevalent in children with lower Intelligence Quotients (IQs) and antisocial behaviour was more prevalent in those with higher IQs. In Gillberg et al.’s (1986) study, they found 54.3% of their group were identified with a psychiatric disorder; the prevalence rate for depression was 2.4%, emotional disorder 6.7%, conduct disorder (CD) 7.9%, and for autism was 4.9%.

Linna et al. (1999) measured psychiatric illnesses in about 6000 children in Finland with and without ID using three screening instruments: the Rutter Parent Questionnaire, the Rutter Teacher Questionnaire, and the Children’s Depression Inventory. Using the questionnaires they found higher rates of possible psychiatric disorder (50%) among individuals with ID than those without it (24.0%). Dekker and Koot (2003) studied 474 children in Holland and found 21.9% suffering from anxiety disorder, 4.4% from mood disorder and 25.1% from any disruptive disorder (attention deficit hyperactivity disorder (ADHD) 14.8%, oppositional defiant disorder (ODD) 13.9%). They found the frequency of depression was higher (11.0%) among children with ID compared to without ID (6.6%). However the difference was not statistically significant.

Stromme and Diseth (2000) reported on the prevalence of psychiatric disorder in children with ID in Norway. A total of 178 children with ID were identified from a sample of 30,037. ICD 10 criteria were used to diagnose psychiatric illnesses. They found that 37% of children with ID had a psychiatric diagnosis. The rates of psychiatric disorders were higher (42%) in children with severe ID compared to those with mild ID (33%). The ratio of boys to girls with psychiatric disorders was found to be 1.6. Rates of various disorders found were: hyperkineses 16%, autism spectrum disorder 4.5%, asperger’s syndrome 0.5%, conduct disorder 3%, anxiety/phobias/obsessive compulsive disorder (OCD) 3% and tics 1%.

Emerson and Hatton (2007) report a combined secondary analysis of 1999 and 2004 ONS surveys. They identified 641 children and adolescents with ID. They assessed for presence of psychiatric disorder using the Development and Well-Being Assessment. They found that rates of mental health disorders were statistically higher in children and adolescents with ID (36%) compared to those without ID (8.0%). Point prevalence rates were conduct disorder 20.5%, emotional disorder 12.0%, any anxiety disorder 11.4%, hyperkinesis 8.3%, autism spectrum disorder 8.0%, depressive disorder 1.4%, tic disorder 0.8%, and eating disorder 0.2%.

Dekker and Koot (2003) examined 474 children with borderline to moderate ID between
the ages of 6-18 years in Netherlands. They found that 21.9% children met a diagnosis of anxiety disorder, 4.4% suffered from mood disorder and 25.1% suffered from disruptive disorder (including ADHD) according to the Diagnostic and Statistical Manual version IV (DSM IV, American Psychiatric Association, 2000).

Sleep difficulties have commonly been noted in children with ID. Some need less sleep than others and many have poor sleep patterns since infancy. Such sleep difficulties also have a knock on effect on parents and their relationships (Allington-Smith, 2006). Didden et al. (2002) reported on sleep disturbance in children with mild to profound ID in Netherlands. Out of the 286 children in their study population, 16.1% had a sleep problem. Severity of sleep problem correlated with severity of ID. Such children were also on medication, were younger and had higher frequency of cerebral palsy. Children with sleep problems also showed higher rates of aggression, oppositional behaviour and hyperactivity. Richdale et al. (2000) have also suggested that children with ID have higher frequency of sleep problems (57.7%) compared to their peers without ID (16%).

Reflection
Studies have identified a significant variation in the prevalence of psychiatric illnesses in children with ID. This has ranged from 30% (Birch et al., 1970) to 64% (Gillberg et al., 1986). This variation may be due to various factors such as different sample sizes and populations, researcher or clinician bias, diagnostic criterion, different methods of assessment for psychiatric illnesses and cultural differences.

The sample population in the studies reviewed has ranged from 8 to 18 years; some studies have reported on children from specialist schools and others from the general population. Some studies have used ICD10 criteria (World Health Organization, 1992) and some have used DSM IV or even created their own criteria for a diagnosis. Researchers have also used different methods of assessing psychiatric illnesses ranging from structured assessment tools to questionnaires. However, most studies have identified that boys with ID have higher prevalence of psychiatric illnesses than girls.

It can be hypothesised that children with lower IQ scores also have fewer problem solving skills and hence struggle to manage the day-to-day pressures of life. These can further lead to stress, anxiety and low mood. It can also be conceptualised that other factors such as biological, familial, and social difficulties can mediate or even precipitate the expression of such psychopathology.

Numerous studies have suggested various factors that have a role in development of psychiatric disorders in children with ID. These commonly are poverty or low socioeconomic status (Hatton & Emerson, 2004; Emerson & Hatton, 2007; Koskentausta et al., 2007; Emerson, Einfield & Stancliffe, 2010), parental separation (Hatton & Emerson, 2004), being male (Hatton & Emerson, 2004), having a single parent (Emerson & Hatton, 2007, Koskentausta et al., 2007), poor communication skills (Allington-Smith, 2006; Koskentausta et al., 2007), family dysfunction and maternal/parental distress (Emerson & Hatton, 2007; Wallander, Dekker & Koot, 2006).

Kiddle and Dagnan (2011) also explored the literature to identify developmental risk factors in adolescents with ID and depression. From various studies they identified that female gender, neuroticism, maternal depression, poor attachment formation, life events, peer relationships, and social stigma may play a role in development of depressive illness in adolescents with ID.

Longitudinal data
Chadwick et al. (2005) reported on behavioural difficulties in 111 children aged 4-11 years. Of these, 87 were followed up for 5 years and rates of behavioural difficulties were measured on these two occasions. There were no significant differences between rates of aggression, destructive behaviour, and self injurious behaviour. However rates of overactivity had significantly reduced after 5 years. In their study 25.6% and 32.9% of all cases were diagnosed with a psychiatric disorder at the initial assessment and at the time of follow-up respectively. This difference was not statistically significant. Autism spectrum disorder was the most common (24.4%) followed by ADHD (6.1%) and bipolar (2.4%) and anxiety disorder (2.4%) of all cases. Boys (47.8%) were found to have significantly higher rates of psychiatric illness than girls (13.9%).

The Australian Child to Adult Developmental study findings have been used by many researchers. Einfield et al. (2006) attempted to examine the course of psychopathology in children and adolescents with ID. They conducted an epidemiological study of 578 children and adolescents from the sample and followed them up for 14 years with four waves of data collection. Their results revealed that
levels of behavioural and emotional disturbance decrease only slightly over time. Prevalence rates of psychiatric disorder reduced from 41% to 31% after a span of 14 years. The reduction in psychopathology was more noticeable in boys than girls and also in those with mild ID than those with severe ID. They also found that only 10% participants with psychopathology received interventions. Forster et al. (2011) followed up 107 people with severe ID and 22 people with profound ID for 12 years from this sample and found rates of behavioural and emotional difficulties were found to be lower for people with profound ID compared to those with severe ID; however this may be due to greater passivity noted in young people with profound ID. Moreover, a significant reduction in rates of such difficulties was noted across time span in people with severe ID but not those with profound ID. Other literature reviews have shown conflicting results on associations between psychopathology and degree of ID.

Often psychiatric illnesses in children with ID are chronic in nature and significantly impact functioning of the child and those around. Various disorders commonly seen in children and adolescents with ID are autism spectrum disorder or pervasive developmental disabilities, ADHD, emotional disorders, and behaviour disorder (often presenting as aggression or self-injurious behaviour), sleep and eating difficulties. Assessment of difficulties like schizophrenia and severe affective disorders can be especially difficult due to complexity of presentation and assessment of symptoms (Royal College of Psychiatrists, 2010).

Conclusions

Children with ID often present as a challenge to clinicians. Lack of clarity on prevalence rates, varied symptomatology in this population and limited diagnostic criteria add to the challenge. This article aims to inform clinicians that children with ID can present with full range of psychiatric illnesses and this population is three to four times more likely to suffer from a mental illness. Early assessment and identification is the key to timely intervention in children and adolescents with psychiatric illnesses and ID.

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References


Review of the Helsinki Declaration for research ethics

Yumna Masood

Abstract
The Helsinki Declaration is a statement of clinical research ethical standards and has recently been revised. This paper briefly reviews the history of the Helsinki Declaration and gives an overview of some of its main statements.

Keywords
Declaration of Helsinki; research ethics; review

Introduction
The Declaration of Helsinki is an important document in the history of research ethics as it was the first significant effort of the medical community to regulate research and forms the basis of most subsequent research ethics documents. In the middle of the 20th century, the Nuremberg trials laid bare the abuse of medical knowledge and techniques used in human experimentation. The outcomes of the trials included the Nuremberg Code – a legal document intended to stop such abuse – and the establishment of the World Medical Association (WMA). Both were intended to ensure that doctors never again performed such inhuman experiments.

Over the next two decades, the newly formed WMA began to put together a core set of policies, designed to reflect ethical thinking, to which doctors were expected to conform. The Declaration of Helsinki (first published in June 1964) set out rules and limits for human experimentation based on the findings of the Nuremberg trials and an unshakeable conviction that human experimental subjects have fundamental rights that drive a series of duties for the experimenter. The Declaration was originally adopted in Helsinki, Finland. It has since undergone several revisions and is the basis for good clinical practices used today. The WMA established recommendations guiding medical doctors in biomedical research involving human participants. The Declaration governs


international research ethics and defines rules for research combined with clinical care (WMA, 2013).

**Summary of key points in the Declaration of Helsinki redraft 2013**

The following is a summary of the key issues in the 2013 redraft of the Helsinki Declaration.

**General principles**

- Medical research is subject to ethical standards. It is the duty of the physician/health professionals to promote and safeguard the health, wellbeing and rights of patients, including those who are involved in medical research.
- The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic, and therapeutic interventions. All interventions must be evaluated continually for their safety, effectiveness, efficiency, accessibility, and quality.
- Physicians must consider the ethical, legal, and regulatory norms for research involving human subjects in their own countries as well internationally.
- Underrepresented groups should be provided appropriate access to participation in research.
- Medical research involving human subjects must be conducted by individuals with the appropriate ethics and scientific education/training.

**Risks, burdens, and benefits**

- Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.

**Vulnerable groups and individuals**

- All vulnerable groups and individuals should receive specifically considered protection.
- Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group.

**Scientific requirements and research protocols**

- Medical research involving human subjects must conform to generally accepted scientific principles, and be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation.
- The design and performance of each research study involving human subjects must be clearly described and justified in a research protocol.

**Research ethics committees**

- The research protocol must be approved by the appropriate research ethics committee before the study begins.

**Privacy and confidentiality**

- Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information.

**Informed consent**

- Participation by individuals capable of giving informed consent as subjects in medical research must be voluntary. The potential subject must be informed of the right to withdraw consent to participate at any time without reprisal. They should be given the option of being informed about the outcome of the study.
- In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, storage of data, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions, and any other relevant aspects of the study.
- For a potential research subject who is incapable of giving informed consent or the subjects who are physically or mentally incapable, the physician must seek informed consent from the legally authorised representative.

**Use of placebo**

- The benefits, risks, burdens, and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:
  - where no proven intervention exists, the use of placebo, or no intervention, is acceptable;
  - where no intervention is necessary to determine the efficacy; or
  - where irreversible harm results from not receiving the best proven intervention.

**Post-trial provisions**

- In advance of a clinical trial, sponsors, researchers, and host country governments should make provisions.
Research registration, and publication and dissemination of results

- Every research study involving human subjects must be registered in a publicly accessible database before recruitment of the first subject.
- Researchers, authors, sponsors, editors, and publishers all have ethical obligations with regard to the publication and dissemination of the results of research.

Conclusion

In an effort to update ethical practices for clinical trials, the WMA has revised various principles found in the Helsinki Declaration on medical research (BMJ, 2013). The main principals include recognition that the wellbeing of human subjects should take precedence over the interests of science and society, adding protection for vulnerable patient groups and a more systematic approach to using placebos when no proven intervention exists. The revision introduces the requirement that patients should be provided with compensation and treatment must be ensured if they suffer harm as a result of participating in research.

Although the Declaration is primarily aimed at medical practitioners, the WMA encourages all clinical researchers using human participants to consider the ethical requirements. In the UK, many of these requirements are reflected in the ethical review processes necessary for research studies to be implemented within the NHS. The ethics form from the Integrated Research Application System (IRAS) requires examples of consent protocols, is very protective of vulnerable groups, and requires statements regarding dissemination. Research governance in the NHS ensures that the ethical principles of the Helsinki Declaration are embedded in UK research practice.

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References


RESEARCH REPORTS

A qualitative study of bipolar disorder: The experiences of members of a self-help group

Holly De Luca

Abstract

This qualitative investigation examines members of a self-help group’s experience with regards to aspects of everyday living with a diagnosis of bipolar disorder. Thematic analysis was used as a means to analyse the data produced. From this investigation it would appear that receiving a formal diagnosis of bipolar disorder can have a positive impact in terms of the answers it provides and the support that can be accessed following the formal diagnosis. Relationships were seen as the backbone of maintaining good health, however, ‘caregiver burden’ remained problematic for some, although on a smaller scale than previous literature had suggested.

Keywords

bipolar; self-help groups; patient experience
Introduction
Bipolar disorder is a cyclical mood disorder involving periods of profound disruption to mood and behaviour (McKeon, 2007). Bipolar disorder is characterised by extreme swings of mood from depression, where individuals experience severe lows, to mania where extreme highs are present (Court, 2001). Extremes of behaviour can be interspersed with periods of more or less full recovery; however these periods are often only temporary (Denicoff et al., 2000). Bipolar disorder is a serious, potentially lifelong, condition that is often accompanied by other illnesses meaning initial diagnosis can be a long and difficult process (Cutler, 2004).

Around one in every hundred adults in the UK will be diagnosed with bipolar disorder at some point in their lifetime with both men and women equally affected (Goodwin, 2007). The symptoms of bipolar disorder can occur at any age, however the age of onset usually differs dramatically from the age of diagnosis and it is estimated that it takes an average of five years from the onset of symptoms to reach the correct diagnosis (Evans, 2000). The dual nature of the disorder is a primary reason for the difficulties involved in diagnosing bipolar disorder (Johnson et al., 2000) as well as the number of signs and symptoms associated with other psychiatric illnesses, such as anxiety disorders and schizophrenia, that can mimic the presentation of, or have similar symptoms to bipolar disorder (Wells, 2005).

The purpose of this study is to understand more about the lived experiences of individuals diagnosed with bipolar disorder, with specific attention to their experiences accessing employment (e.g., Bland et al., 2002), the impact on relationships (e.g., Sajatovic, 2005) and the support offered by community based self-help groups (Kalifon, 2004). It is important for medical and mental health professionals to know how this illness impacts on an individual’s relationships and socio-economic status as well as the sources of community support found useful when managing specific symptoms. With this understanding, professionals can better assist individuals and families affected by the diagnosis when they seek help and support.

Method
The main objective for this study is to understand the impact on an individual of receiving a diagnosis of bipolar disorder and how this affects relationships, employment opportunities, and social inclusion. A qualitative method was selected for this study because it is ideal for generating rich descriptions of complex phenomena (Coolican, 2004). This qualitative methodology enabled the capturing of rich descriptions of the emotional impact of receiving a diagnosis, how this affects individual relationships and employment opportunities, and the support offered by self-help groups.

Participants
Participants for this study were recruited through a self-help group set up specifically for individuals who have a diagnosis of bipolar disorder and their carers. To be considered for the study, participants were required to have a formal diagnosis of bipolar disorder and not have experienced any ‘episodes’ within the three months prior to the commencement of the interviews. They also had to be willing to discuss the diagnosis and issues surrounding this. An overview of the study including the inclusion criteria was presented at the end of a self-help meeting and, if potential participants indicated an interest in the study, further information was provided.

A total of six interviews were conducted with four women and two men. Interviewee ages ranged from 25 to 61 years (M = 49 years). Length of diagnosis varied from one year to 23 years. Participant demographic information regarding education, income etc. was not specifically collected. All of the participants in this study consented to be contacted for follow-up questions and for purposes of participant validation.

Interviews
Participants were interviewed at either the day centre where the self-help meetings were held or at their own home depending on their preference. An interview guide with open-ended questions was structured using an initial question and a series of follow-up questions. The follow-up questions were points of reference or guiding markers, not constrictors of conversation. Therefore, true to qualitative research, each interview was unique in its direction, emphasis, and depth, as co-directed by the participant. The initial question asked was “Can you tell me about the impact receiving a diagnosis of bipolar disorder has had on your life?” There were three areas that the sub-questions examined: comparing life before diagnosis with life prior to diagnosis, the impact receiving the diagnosis had on relationships, employment and social inclusion, coping strategies that had been developed, and the impact the self-help group had in adapting to the diagnosis. Interviews ranged from 60–90 mins and were audio recorded for transcription.
Analysis
Thematic analysis was used as a method for identifying, analysing, and reporting patterns or themes within data. It minimally organises and describes your data set in rich detail. However, frequently it goes further than this and interprets various aspects of the research topic (Boyatzis, 1998). Each interview was read several times to gain a general sense of any themes prevalent in the data, bearing in mind the research aims but also keeping an open mind to any themes which had not been considered at the offset. An initial list of recurring patterns within the data was made in order to code the information in a meaningful way and begin to derive themes. Going back and forth between phases of data allowed themes to go beyond surface meanings and tell an accurate story of the meaning of the data.

Results
The data were organised into four themes: (1) impact of the diagnosis; (2) effects of the diagnosis on relationships; (3) consequences for employment; and (4) coping and self-help. Each theme is presented below with an accompanying description and examples from the interviews.

Theme 1: Impact of diagnosis
Every participant discussed at length the impact the diagnosis had on their lives. Most participants emphasised a sense of relief at receiving the diagnosis as an explanation for unanswerable questions and behaviours they had experienced throughout their lives leading up to the point of diagnosis:

> It was just extraordinary because I'd spent so much of my time thinking I'm a crazy person, I'm going to get locked away, I've got multiple personalities, I've got to hide away all these mechanisms for trying to avoid being seen as a mad person and suddenly I was told actually there is a reason.

In contrast, a few of the participants indicated that the diagnosis was a negative experience and saw the diagnosis as taking away their sense of ‘self’:

> Just that I was a victim of mental health that my life had been stolen away and I felt victimised really yeah that’s the right word victimised by mental illness and ill health and I just felt like I wasn’t myself anymore.

Theme 2: Effects of the diagnosis on relationships
Most of the people interviewed indicated that relationships with people were put under strain as a result of the unpredictability of the disorder, particularly during manic phases:

> But he put up with lots of depression when I was working for the bank when I’d just be in bed for ages he put up with the depression because you become harmless and not aggravational but it’s the nuisance of me being high.

The sense of isolation when people do not understand the diagnosis or the symptoms was also discussed by many of the participants, highlighting the difficulties which can result within all relationships for people living with this illness:

> My mother disowned me she didn’t know what was wrong with me I was writing her strange letters from Greece about people being on street corners with guns and knives wanting to kill me and she didn’t seem to think perhaps there’s something wrong here. She just wrote to me and said you’re no longer my daughter.

This highlights the distress which can occur within families prior to understanding the cause and nature of the symptoms of being in a psychotic phase.

Nearly all of the participants interviewed, however, touched on the support offered by family and relationships in terms of ‘staying well’ and how receiving the diagnosis has facilitated understanding within relationships:

> It’s about a relationship with somebody... It’s just being around him and having him around... And that’s been for me an incredible thing about actually addressing the problem of not wanting to move the paralysis that can be there and thinking hang on a minute I love him so much I’m not going to let this happen today and just taking it day by day.

Theme 3: Consequences for employment
Unemployment is known to be harmful to the health of the general population as well as being an element of the social exclusion that those with severe mental illness face (Bland et al., 2002). It was a theme that was prominent in all of the interviews undertaken with many similarities with regards to its effect on health. One participant talked about how she was able to thrive within a working environment and how being in gainful employment with the appropriate support helped her to manage some of her symptoms; however, when the nature of the job changed, she found lack of understanding from her employer and attempting to remain in work precipitated a relapse in her mental health:

> I didn’t have too much trouble for the first few years... I didn’t feel any real stress... then they brought in targets and
I just couldn’t deal with it… I couldn’t push people to buy products, I couldn’t memorise the details of the products and it just turned into a nightmare.

Theme 4: Coping and self-help
The self-help groups and the benefits given from them in terms of coping with certain symptoms of the illness was a unanimous theme from all participants interviewed. Sub-themes were identified which highlighted the varying levels of support taken from the group.

Support
One participant in particular emphasised the great support taken from the group as a vital part of her maintaining her symptoms and staying well. This participant, for the most part of her illness, has not relied on medication, instead choosing alternative therapies and relying on self-help to manage when she recognises symptoms of becoming unwell:

I just find it so important I mean it’s probably more important for me because I don’t have the medication but I think even people with medication find it an anchor in that you can tell people how your months been and it’s an extremely important anchor for you.

Networking
Many of the participants interviewed viewed the self-help group as an opportunity to meet people who shared the same diagnosis, who they could share experiences with and, of particular importance for participants with a relatively recent diagnosis, it was seen as an opportunity to learn from others.

I think it’s good to be able to go to a group where it’s not formal therapy or anything like that it’s just people with the same illness getting together, sharing experiences and supporting one another and hopefully I’ll get some support from it.

Education
The theme of education was one which was particularly important to many of the participants interviewed. It was seen as important to develop an understanding of the disorder and the symptoms of it alongside learning from the various experiences of others and different ways to manage and recognise symptoms. For one participant in particular, the group served as a means to understand himself through learning from others.

It’s just an amazing place to learn and there’s such incredible wisdom in that room and pain and all sorts of things and I come out and I always feel as though I’m walking on air every time.

Discussion
Clinical implications
Some important factors were observed in this study which could serve to inform professional practice and everyday life for individuals with this particular mental illness. Perhaps the most important factor was the benefits that are to be found from accessing self-help groups. It could be extremely beneficial both for the health sector and those accessing it if individuals receiving a diagnosis are made aware of self-help groups and voluntary sector agencies.

Future considerations
There were a number of specific areas which could be considered for future research. The use of thematic analysis served the purpose of allowing the research questions to be addressed in a detailed manner. Despite its usefulness as a research tool in terms of its flexibility, which means that multiple theories can be applied across a variety of epistemologies, there are some limitations to using this particular method. Thematic analysis, although widely used, has no clear agreement about what it is and how you go about doing it (Boyatzis, 1998; Tuckett, 2005). Further to this, thematic analysis is not tied to any theoretical framework which, although in light of this project, was deemed as a positive as it allowed for flexibility; others approaching the same title from a fixed theoretical perspective would see this particular method of analysis as a limitation. With this in mind, future research could approach the data from a slightly different methodological angle.

A second area for consideration pertains to the relationships of individuals receiving a diagnosis of bipolar disorder. The majority of the literature surrounding maintaining relationships with individuals with mental illness has focussed around care-giver burden and negative aspects of this role, however, this study highlighted the numerous benefits to be had from maintaining relationships, particularly in regard to keeping well and managing symptoms.

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References
Anxiety, physical activity, and public performance: An interpretative phenomenological analysis of amateur gymnasts’ competition experiences

Lucy H. Merritt & Paul K. Miller

Abstract
Individuals experiencing elevated levels of anxiety have, for some time, been of significant concern for healthcare researchers and practitioners. Physical activity is, meanwhile, often viewed as constructive for anxiety release. When physical activity and its public performance merge, however, anxiety and anxiety release can come into contradiction. In this paper, an interpretative phenomenological analysis of N = 6 amateur gymnasts’ experiences of anxiety around public performance are explored, with a view to elucidating some psychological issues around practical, everyday performance stress.

Keywords
stress; anxiety; gymnastics; interpretative phenomenological analysis; public performance.

Introduction
Individuals experiencing elevated levels of anxiety have, for some time, been of significant concern for healthcare researchers and practitioners. Not only is this state connected to a range of mood disorders and mental illnesses (Davis-Evans, 2013; Sowislo & Orth, 2013), but is also known to have serious detrimental impacts on somatic health (Egido et al., 2012; Janszky et al., 2010). The role of physical activity in promoting general somatic and psychological wellbeing is, on the other hand, also well documented. Consistent levels of moderate-to-vigorous exercise are demonstrably beneficial for cardio-vascular health (Berlin & Colditz, 1990; Christie et al., 2012). Equally, structured physical activity programmes have been proven efficacious in the treatment of mild-to-moderate depression (Callaghan et al., 2011; Ward & Miller, 2013). The absence of physical activity, meanwhile:

...can have harmful effects on health.
Anxiety, physical activity, and public performance

and well being, increasing the risk for coronary heart disease, diabetes, certain cancers, obesity, hypertension, and all cause mortality. (Ströhle, 2009, p. 777.) Indeed, a wide body of research indicates that physical activity can have productive impacts specifically in terms of reducing anxiety levels themselves (see Ströhle, 2009 for a comprehensive review). A paradox herein – with respect to anxiety – can arise, however, when an individual’s engagement with physical activity advances to a level where ‘public performance’ becomes a feature thereof.

Public performance and performance anxiety

Studies in the sports sciences have, to date, demonstrated that public/competitive performance settings do subject athletes to elevated stress and anxiety levels with mostly detrimental effects (Abrahamsen et al., 2008). Typically, it is observed that:

Considering that athletes in competitive sports need to perform well under pressure, sporting competitions can be considered as potentially threatening evaluative situations… (Englert & Bertrams, 2012, p. 580.)

It is also the case, however, that the bulk of sport psychology in this domain has been geared at examining only the anxieties affecting adult, ‘elite’ athletic performers (Battochio et al., 2009; Kristiansen, Halvari, & Roberts, 2012). By comparison, a much smaller body of investigation has been accorded to the far more commonplace (but no less damaging) performance-related anxieties affecting younger and/or amateur sporting participants who make up the vast majority of the exercising population. From a general healthcare perspective, this is an important shortfall in knowledge. The simple fact that a professional is performing at the highest levels of sport does not necessarily mean that they are immanently subject to proportionately higher levels of anxiety than, say, a teenage gymnast in a school tournament. It may well mean the opposite; anxiety is after all, in most psychological accounts, relative to the individual’s interpretation/understanding of context and experience therein (Orlick, 2000).

As Kreider, Fry and O’Toole (1998, p. 345) note...the quality of a specific stress experience depends not on the demand but on the individual’s perceptual and cognitive processes and behavioural skill or action tendencies.

Anxiety, context and fluidity

From a research point of view, the focus of most sport psychology on elite performance has had the corollary effect of also narrowing the research focus exclusively to anxiety in sporting contexts. Because, for the professional athlete, much of life is centred largely upon sport, this is perhaps understandable. For the amateur, however, sport is likely to be just one of many overlapping life contexts, and to explore the anxieties of these individuals’ experiences as purely ‘sporting’ phenomena is to do scant analytic justice to the manner in which different domains may interconnect for those individuals themselves. Anxieties about sporting performance may well intrude upon other activities and tasks, while pre-existing anxieties are known to often carry over into performance contexts (Bandelow et al., 2004). This narrowing of substantive focus is also reflected in the research tools used in the psychology of sporting anxiety, the overwhelming bulk of which are quantitative in nature, although this is also true of the broader psychology of anxiety. While such forms of analysis have yielded important findings, they inveterately embody the assumptions of the researcher(s) in their design (Miller & Cronin, 2013). As such, they rarely help us understand how individuals organise and interpret their own anxieties, and how these things may be fluid between contexts. Rather, the focus is upon robust measurement of pre-determined constructs in-situ that may not always map onto the experience of the individuals being studied.

This paper, thus, reports findings from a phenomenological study of the experiences of amateur gymnasts surrounding public competition. Without recourse to pre-ordained definitions regarding the character of ‘anxiety’, ‘stress’, or even what actually constitutes ‘performance’, these core concepts are explored in terms of how they are variably assembled, understood, and managed within the participants’ own narratives.

Research design

Design was built around interpretative phenomenological analysis (IPA), which provides a systematic means of qualitatively exploring how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants. (Smith & Osborn, 2008, p. 51.)
Participant selection
With institutional ethical approval, N = 6 active gymnasts (age range 14–23 years) were purposively recruited from amateur clubs in several different regions of England.

Research materials
Data were collected using the semi-structured interviews and open questioning characteristic of IPA. All interviews were digitally recorded and transcribed verbatim. In line with ethical requirements, data were fully anonymised at the point of transcription.

Data analysis
Analysis was conducted in line with the idiographic procedures of IPA. A free textual analysis was subsequently abridged into cross-linked (subordinate) themes, and ultimately into a smaller number of global (superordinate) themes (see Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009).

Results and discussion
Analysis gave rise to three core superordinate themes, outlined below.

Superordinate theme 1: "I worry about my partner(s) and for my partner(s) in competition environments."
Although there is a strong body of research that emphasises the anxiety-allaying force of peer support and interpersonal bonds (Abrahamsen et al., 2008), participants in this study highlighted some ways in which such partnerships can actually increase anxiousness when competition is at stake. Anxiety states were reported to arise from three inferences pertaining to potential public outcomes (what we might conventionally think of as 'stressors'):
1. Concern for a gymnastic partner's success, both (altruistically) in terms of their own wellbeing and (more egotistically) how it reflects upon oneself in coordinative performance, i.e., "What if they fail?" (a largely performance-oriented anxiety).
2. Concern about negative relationships with a peers and partners, i.e., "Will they like me, and can they work with me?" (a predominantly social anxiety).
3. Fear of letting others down, i.e., "What if I fail?" (both performance-oriented and social). For example:

G2: [I]t’s just being stressed about [the regular performance partner] knowing [the routine]. Like, if she forgot it then she’d be upset, so I tend to stress out more about her than me.

G5: You really want to do well for your coach and your partner.
G4: Because you’re working with someone else, you’re conscious…that you’re going to let them down.

Issues 2 (essentially, fear of social isolation) and 3 (fear of failing others) are well documented in extant literature on general anxiety stressors (Bandelow et al., 2004). They also highlight a strong interlacing of general social and domain-specific anxiety stressors at the amateur level that is rather less well documented in psychology oriented towards ‘elite’ sports. Regarding issue 1, however, and while the concern that failure by a third party will reflect badly upon one’s self is also a well-documented cause of anxiety in many domains (Englert & Bertrams, 2012), more novel here is the matter of ‘empathic experience’. This echoes a core theme in Erving Goffman’s (1956) classic text Embarrassment and social organisation, wherein it is observed that, much as people experience embarrassment about things they have themselves done, an equally flesh-crawling sensation can arise from embarrassment for someone else – indeed, a great deal of modern situation comedy depends upon this fact. The matter of anxiety for others is not a strong theme in extant literature on public performance, yet was recurrently articulated as a core problem by the participants in this study. This may well be a function of a general de-emphasising of the importance of social bonds (often framed as ‘distractions’) encouraged among high-level performers (Coakley, 1992) in all fields, and not least sports; a process which is largely absent at grassroots. Thus, far from being an exclusively counter-anxious factor, close social bonds can themselves form bedrock on which a particular form of anxiety is built in performance contexts.

Superordinate theme 2: "I struggle to balance my athletic life and my wider life.”
Closely allied to the final aspect of superordinate theme 1 discussed above was a perception that serious involvement in gymnastics and a wider social life were (a) often mutually obstructive and (b) difficult to balance in such a way that one could draw the maximum benefit from each. These perceptions, in turn, drove two sub-forms of anxiety:
1. Anxieties arose around the participants’ own abilities to meet wider social expectations (idealistic); and
2. Participants also experienced stress around issues of time management, activity prioritisation, and balancing the social...
identities of a ‘gymnast’ and a ‘regular person’ of one’s age and social position (practical).

For example:

**G2:** fitting in homework and stuff, especially because it’s like GCSE year for me and next year, and then there’s now more training sessions than there was before.

**G4:** it tends to be not that I’m physically… worried about the gymnastics but it’s how it’s sort of coinciding with everything else; that I’ll often find that my exams at uni or a big piece of coursework coincides with the same weekend that we’ve got a massive competition….I’ll spend five nights in the gym knowing that I should be at uni or should be at home revising and studying and it tends to be that that makes me anxious as opposed to the actual gymnastics.

**G6:** Probably because we do so much….having to fit other things around gymnastics is very stressful….like homework, meeting up with friends and just life in general.

This experienced tension between the demands of a single high-focus activity and ‘the rest of one’s life’ is commonly described in literature on high-end performance in sports and elsewhere (Coakley, 1992). It is, however, once again crucial to be mindful that level of focus and investment is relative to the person doing the focussing and investing (Orlick, 2000). So, a school-age child who cares deeply about their amateur gymnastics (or, indeed, who feels ‘trapped’ with a particular web of social expectations around it) may be no less psychologically torn between competing identity demands than an ‘objectively’ high-level performer who may have more obvious social/financial barriers to contend with. Thus, when it comes to the practical business of allaying anxiety in more everyday performance contexts, it is not any material measure of importance that necessarily dictates how the matter should be approached, but rather the emotional investment of the performer (Spielberger, 2004).

**Superordinate theme 3:** “Public events make me feel anxious, but also make me feel relaxed.”

Finally, participants strongly allied both public performance, and also the scale of competitive events at which they performed, to their experiences of anxiety. There were, however, some putatively dissonant claims from participants regarding this issue:

- Competition itself was conceptualised as both a source and reliever of stress, and often concurrently.
- Participants did not necessarily conceptualise objectively ‘larger’ events as being automatically more stressful. These matters require some unpacking. Firstly, while the anticipation of public performance was universally viewed as stressful, the act of performing was generally construed as a mood-neutral release-valve leading to a highly relaxed and comfortable state (except in cases where something had gone badly wrong with the performance itself). For example:

**G1:** It’s only about an hour before I compete I get really nervous, the day before I’m fine, on the way there I’m fine and then just before I go on it’s a bit nerve-wracking but then when I’m on the floor or tumbling I just do it.

**G2:** Just after the competition you just chill. Secondly, it was clear that while – as a rule – ‘bigger’ competitions were taken to be more abstractly stressful by participants, in practice there was a range of more experiential factors in play that determined just how much anxiety was actually experienced. So while the totems of ‘formal’ competition could well prove an additional stressor (unfamiliar judges, electronic scoreboards, and suchlike), perceived issues such as ‘supportive home turf’ and the participant’s own chances of success (i.e., ‘nothing to lose’) could almost reverse the valence of stress intensity. Similarly, ‘getting there’ (i.e., to the ‘main event’) was sometimes viewed as more stressful than actually ‘being there’. For example:

**G1:** It’s probably the venue, because like if it’s a bigger venue there’s more people there, so just more people watching, that’s a bit more stressful.

**G5:** Prelims is the one that I get most stressed about because obviously I want to get through with my trio.

**G4:** The ones that are here like in our home gym are not really stressful. You’re in front of people that you know, especially with coaching as well as training. I know a lot of the parents and a lot of the younger gymnasts and they like to see you compete which is really nice, and you go on the floor and there’s a whole the little squad that you coach are all cheering and clapping for you which is really nice.

To reprise a recurrent theme, it is imperative that anxiety within (and about) public performance is viewed as emanating from an experiential field. Even ‘performance’ itself was not viewed by participants as a self-identical ‘event’, but as having distinctively different import immediately before, during,
Anxiety, physical activity, and public performance

and immediately after. Moreover, the situation of performance was also not taken to be self-identical; what constitutes an ‘intimidating’ event in which to perform is highly relative to a range of complex interpretations, investments, and preferences (Spielberger, 2004, p. 444).

Conclusion
Extant research in the sport sciences tend to take into account only anxiety derivative of sport and exercise when encountered in sporting contexts themselves, artificially decoupling the performance domain from individuals’ personal lives. This, it is reasonable to assert, is largely connected to a dominant focus upon high-level performance in elite contexts in which such disconnection is common. It is also noteworthy that the majority of research in this field is quantitative in form when, in fact, “...there is so much diversity in anxiety responses that paper and pencil tests capture an incomplete range of the feelings people experience.” (Wang, Marchant & Morris, 2004, p. 79). For the participants in this study, stress/anxiety in sporting performance and social stress/anxiety were conceptualised as inextricably co-dependent phenomena, with many subtle and sometimes putatively contradictory facets. ‘Social’ and ‘performance’ anxieties need to be understood, thus, as mutually reflexive if research is to reach a fuller understanding of everyday athletes’ own psychological realities in this domain, and thus the mental (and physical) health risks to which they may expose themselves.

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**Mindfulness meditation practice can make concentration feel a little easier**

Robert Ian Hallard

**Abstract**

In order to expand existing thinking about the effects of mindfulness meditation practice on attentional resource efficiency, the present study exposed 16 experienced meditators and 16 non-meditators to a 13-minute sustained attention task and concurrent subjective workload measures. Results did not detect a between group difference in task scores, however a minimising effect of meditation practice on perceived workload was detected. This finding was interpreted to indicate an effect of mindfulness meditation practice on attentional resource efficiency.

**Keywords**

mindfulness meditation; sustained attention; workload; resource efficiency

**Introduction**

Maintaining concentration requires effort to maintain a focus of attention in the face of potential distraction from thought, emotion or environmental event. Because of this persistent demand, we cannot control our attention indefinitely. Resource theory suggests that the voluntary control of attention represents a drain on a limited pool of attentional resources.

When people are subject to a task requiring sustained attention, resource-drain is seen as a deterioration in correct responses over time. This phenomena has been labelled the ‘vigilance decrement’ (for review see, Warm *et al*., 2008a). In a laboratory setting, the onset and magnitude of the decrement has been altered with the manipulation of level and type of attention demand in the task. Incorporating decision-making and memory demands can increase task demand (e.g., Smit *et al*., 2004) and would therefore be expected to increase resource demand and speed resource depletion.

The notion of attentional resource utilisation is also important in research into the effects of some Buddhist meditation techniques. Research from a number of authors has found a link between mindfulness meditation practice and improved attentional resource efficiency. In particular, research has found a reduction in task-induced brain activation in meditating participants with no concurrent drop in performance. This has been observed during a variety of cognitive tasks; some demanding inhibition of automatic responses and conflict resolution (e.g., Moore *et al*., 2012) and others demanding focused attention on one point (e.g., Lutz *et al*., 2009). Although not yet investigated using subjective measures, brain
imaging findings might suggest a reduction in required mental effort (e.g., Kozasa et al., 2012), possibly a result of mindfulness training-related attentional skill acquisition (Slagter et al., 2011).

Considering these findings in relation to a resource theory of vigilance performance, it could be expected that greater efficiency in resource allocation could delay resource depletion and reduce the performance decrement in sustained attention. The aim of the present study was to investigate this possibility.

The research reviewed in this article is concerned with a particular form of Buddhist meditation known as mindfulness meditation. This practice encourages non-judgemental and deliberate awareness of subjective experience in the present moment. The reported short-term effect of mindfulness meditation is a gradual settling of the mind (Gunaratana, 2002). The long-term goal is to cultivate an attitude of non-reactivity to any conscious phenomena; to simply be aware without attachment (Suzuki & Chadwick, 2010). It is widely reported that continually returning one’s attention to the present moment can feel effortful for a beginner, but is more easily sustained with practice, as the mind’s habitual tendencies reduce (Brefczynski-Lewis et al., 2007). Advanced practitioners are reported to be able to sustain their attention for long periods with little effort (Wallace, 2006). The meditative practices mentioned above are expected to train the core cognitive skills required to remain focussed in the face of distraction (Slagter et al., 2011).

The vigilance task used in this study was a novel task designed to exercise sustained executive attention by incorporating a persistent decision-making factor. As such, the task required the active maintenance and updating of short-term memory, a process expected to rely upon an executive attentional control (Engle, 2002). Comprehensive behavioural data allowing for the interpretation of effort/workload was provided by the NASA Task Load Index (NASA-TLX: Hart & Staveland, 1988). This tool is used routinely in cognitive and vigilance research (Warm et al., 2008). Two novel factors were added to the tool to measure the extent to which each participant noticed themselves feeling bored during the tasks, and to what extent they noticed their minds wandering.

The present study had two hypotheses. Firstly, it was expected that as a result of attentional skill acquisition and the subsequent efficiency in resource allocation, meditators would be better able to meet the attentional demands of the response selection task. This was expected to be observed as an overall difference in performance scores (main effect of group), or as a greater consistency in performance during each task (group x time interaction effect), or as a positive relationship between meditation experience and performance scores.

Secondly, it was expected that for the same reasons, experienced meditators would perceive the tasks to be less demanding than non-meditating controls.

Method

Participants
Sixteen meditators (11 female, 5 male) were recruited from Buddhist meditation groups and one monastery in the North of England. All meditators reported practising meditation regularly for at least two years. Ages ranged from 29 to 69 (M = 51.4, SD = 10.6) and meditation experience from 624 to 31,200 approximate hours (M = 6, 209, SD = 7960). None of the meditating participants reported practising meditation in isolation from any other task within two hours of the beginning of the study.

Sixteen non-meditators (9 women, 7 men) were recruited from the North West of England by word of mouth. Age ranged from 32 to 75 (M = 51.8, SD = 16.0) in the non-meditating group. All participants reported normal or corrected-to-normal vision and no diagnoses of cognitive impairment. All participants were asked to abstain from caffeine for at least 4 hours prior to the study.

Materials

Response selection task
Participants were instructed to monitor the repetitive presentation of 12mm x 12mm light grey capital letters (O, D and backwards D) appearing in the centre of a plain white computer display. Participants were instructed to alternate responses to the letter O between hitting and not hitting the space bar (hit one, miss one, hit one, miss one...). They were instructed to ignore the other two letters. Incorporating this decision-making factor into the response selection task (RST) instructions was expected to increase executive attentional demand. A response was considered erroneous if it followed a similar response, i.e., two consecutive ‘hits’ in response to two

Mindfulness meditation practice can make concentration feel a little easier
consecutive Os. Each letter was exposed for 100ms followed by a gap of 1,200ms. As such, the event rate was calculated at 46.15 events/min.

**Subjective workload measures**

Workload measures were provided by the NASA-TLX (Hart & Staveland, 1988) and subjective boredom and perceived mind-wandering items. The NASA-TLX provides six measures pertaining to workload, mental demand, physical demand, perceived performance, effort exerted, and frustration. Subjective boredom and mind-wandering measures required a response from 0 to 100 on a visual analogue scale relative to how bored the participant felt while completing each task and how much they noticed their mind wandering.

**Procedure**

Following study briefing, each participant completed the RST which lasted for 13 mins. Upon completion of the RST, participants were asked to complete the NASA-TLX to demonstrate their perceptions of the task. Meditating participants were not instructed to adopt meditative strategies during the task.

**Results**

**Response selection task**

Mean percentages of correct responses to critical signals for both groups are given in Figure 1, in 3 x 200-letter (4 mins and 20secs) blocks.

**Figure 1: Mean percentages of correct responses to critical signals for both groups (note that the y-axis does not begin at 0; error bars reflect standard error)**

A 2(group) x 3(time-block) analysis of variants (ANOVA) was conducted on an arcsine transformation of the dependent variable, response accuracy. The analysis did not detect a significant main effect of time-block, $F(2,60) = 0.31, p = .74$, therefore a vigilance decrement was not detected for either group. Contrary to study hypotheses, the interaction effect, time-block x group, was not significant, $F(2,60) = 0.28, p = .76$ and no main effect was detected for the between-subject variable group, $F(1,30) = 0.63, p = .43$. A linear regression analysis was also conducted on an arcsine transformation of the overall mean response accuracy scores. The analysis did not detect a relationship between the dependent variable and total meditation experience, $\beta = -.21, F(1,14) = 0.62, p = .60$.

**RST workload data**

Mean scores and standard errors for the NASA-TLX workload factors and perceived boredom and mind-wandering measures for the RST are displayed in Figure 2.

**Figure 2: Means for RST workload factors and perceived boredom and mind-wandering measures for both groups (MD = Mental demand; TD = Temporal demand; E = Effort exerted; P = Performance; F = Frustration; B = Boredom; MW = Mind-wandering; error bars reflect standard error)**

A multivariate ANOVA detected a significant between-subjects effect of group for the dependent variables – frustration, $F(1,30) = 9.07, p = .005$ and boredom, $F(1,30) = 8.31, p = .007$, indicating that the meditating group reported the RST to be less frustrating ($M = 25.3, SD = 18.5$) than non-meditating controls ($M = 47.8, SD = 23.3$) and less boring ($M = 23.0, SD = 20.4$) than non-meditating controls ($M = 49.4, SD = 30.5$). No significant effect of group was detected for the other variables: mental demand, $F(1,30) = 0.14, p = .71$; temporal demand, $F(1,30) = 1.52, p = .23$; effort, $F(1,30) = 1.01, p = .32$; performance, $F(1,30) = 2.65, p = .11$; or mind-wandering, $F(1,30) = 3.90, p = .058$.

In contrast to the above between-group analysis, linear regression analysis revealed that total meditation hours significantly predicted all of the contributing workload factors: mental demand, $F(1,14) = 5.05, p = .041$; temporal demand, $F(1,14) = 5.05, p = .041$; effort, $F(1,14) = 7.01, p = .01$; performance, $F(1,14) = 7.01, p = .01$; and mind-wandering, $F(1,14) = 7.01, p = .01$.

Mindfulness meditation practice can make concentration feel a little easier
Mindfulness meditation practice can make concentration feel a little easier

In support of part of the second hypothesis (that experienced meditators would perceive the tasks to be less demanding than meditation-naive controls), study data showed a relationship between meditation experience and perceived task demand for the RST. This indicated that as meditation experience increased, perceived cognitive workload decreased. This was reflected in all four demand-related contributing workload factors: perceived mental demand, temporal demand, effort exerted, and frustration. These findings were accompanied by between-group differences in frustration showing that the meditating group reported being less frustrated than the non-meditating group during the RST. A resource theory of vigilance would suggest that a reduction in task-irrelevant processing facilitated more effective task-relevant processing, perceived workload might be expected to decrease as a function of reduced mind-wandering.

This study clearly identifies that frustration during the RST was reduced by meditation experience. This manifested as both a between-group difference and as a function of increasing meditation experience. This might indicate that the meditating group did not judge the RST as demanding.

In contrast, between group differences were not detected for the mental demand, temporal demand and effort measures. This might be a product of insufficient sample size. None the less it can be concluded that regular mindfulness meditation practice can reduce the perceived demand of an executive sustained attention task, but only after a great deal of meditation practice might one expect these effects to be observable against the normal variation expected in any population.

Interestingly the observed effect of meditation experience on the perceived temporal demand of the RST indicates that experienced meditators tended to find the pace of the RST to be more manageable than non- or inexperienced meditators. This could perhaps suggest an effect of meditation practice on processing speed and should be explored in future research. Alternatively, this finding might reflect a benefit of a reduction in task-irrelevant processing (mind-wandering) which might normally compete for limited resources (see Figure 1). If a reduction in mind-wandering facilitated more effective task-relevant processing, perceived workload might be expected to decrease as a function of reduced mind-wandering.

Discussion

The present study had two hypotheses. Firstly, it was proposed that sustained attention performance as demonstrated by the RST would be improved as a result of expertise in mindfulness meditation practice. If valid, this would be expected to manifest in overall performance scores (main effect of group), as a greater consistency in performance during each task (group x time interaction effect), or as a positive relationship between meditation experience and performance scores. Secondly, it was proposed that experienced meditators would perceive the task to be less demanding than meditation-naive controls. Study data provided some support for the second of these hypotheses, but was not able to provide support for the first. Findings will be considered in detail below.

In relation to the first study hypothesis, no between-group differences were apparent in the response accuracy measure of the RST. In addition, data did not show a significant vigilance decrement for either group and, as such, differences in performance consistency were not detectable. The executive component of the RST was expected to increase attentional demand and therefore exaggerate the effects of resource depletion. However, this was not observed and a gradual improvement in response accuracy was suggested. This finding resembles cognitive vigilance research data (vigilance tasks which require cognitive discrimination of critical and non-critical signals). Deaton and Parasuraman (1993) suggested that a gradual performance improvement shown during cognitive vigilance might reflect a learning effect occurring during the task, or a benefit of practice. Nevertheless, the RST produced a workload profile which suggested that the task demanded significant resource utilisation. It is unclear whether an extended version of the RST would induce resource depletion. On this occasion, the RST did not provide adequate data to compare resource depletion between groups.

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In relation to the first study hypothesis, no between-group differences were apparent in the response accuracy measure of the RST. In addition, data did not show a significant vigilance decrement for either group and, as such, differences in performance consistency were not detectable. The executive component of the RST was expected to increase attentional demand and therefore exaggerate the effects of resource depletion. However, this was not observed and a gradual improvement in response accuracy was suggested. This finding resembles cognitive vigilance research data (vigilance tasks which require cognitive discrimination of critical and non-critical signals). Deaton and Parasuraman (1993) suggested that a gradual performance improvement shown during cognitive vigilance might reflect a learning effect occurring during the task, or a benefit of practice. Nevertheless, the RST produced a workload profile which suggested that the task demanded significant resource utilisation. It is unclear whether an extended version of the RST would induce resource depletion. On this occasion, the RST did not provide adequate data to compare resource depletion between groups.
Mindfulness meditation practice can make concentration feel a little easier. Alternatively, this finding might reflect group differences in emotion regulation. This would suggest that meditators were better able to regulate their affective state even when occupied with another task. Although improvements in emotion regulation have previously been linked with meditation practice (Baer, 2006), this finding is novel in that effects have been demonstrated in the presence of a concurrent, attentionally demanding task. This finding might suggest that meditators are better able to notice and disengage from the thoughts and feelings associated with frustration, even while devoting significant resources to another task. This alludes again to notable group differences in the way that attentional resources were distributed during the RST. Over a longer duration, increasing levels of frustration might be expected to provide a significant distracter and might influence task performance. Meditation practice probably allowed meditating participants to allocate fewer attentional resources to the cognitive and affective markers of frustration.

A similar explanation might be considered for group differences in reported boredom. The meditating group may have been more proficient at noticing judgmental appraisals of the task and disengaging from them, again at the same time as devoting a large quantity of attentional resources to the tasks. It is conceivable that, in the event that fewer resources are devoted to self-concern and cognitive appraisal of the present situation, an experience of absorption in the present task might occur. This kind of interpretation finds some cohesion with traditional meditation literature suggesting that absorption states can occur as a result of extensive meditation practice and an environment free from distraction (Gunaratana, 2009).

It is also possible that group differences in self-report boredom could reflect individual differences in boredom proneness which may have existed even before meditation practice. To further this line of thinking, it is plausible that those who are less prone to boredom are more likely to stick to a regular meditation practice.

A particular strength of the present study was its inclusion of comprehensive behavioural measures allowing for the investigation of both the inner and outer effects of meditation practice during sustained executive and orienting attention. These behavioural data demonstrated that the act of sustaining concentration on one task may feel a little easier following a history of mindfulness meditation practice. In addition, other negative emotional responses to the act of sustaining concentration such as frustration and boredom can be reduced.
Targeted Mental Health in Schools: Confidence-building among school staff as a latent systemic impact of the Cumbrian initiative

Paul K. Miller, Nicki Wilson, Alyson Dickson & Joanne C. Gaffney

Abstract
This paper reports findings from a qualitative evaluation of the Targeted Mental Health in Schools (henceforth TaMHS) programme in Cumbria. Utilising a grounded theory methodology, and thematically drawing on the social theory of Robert K. Merton, specifically addressed is a key 'latent' and highly positive impact of the initiative, which is the building of individual and collective confidence among school staff around the understanding, discussion, and handling of mental health issues in their student cohorts.

Keywords
confidence; intervention; learning; mental health; teaching; schools; youth

Introduction
As described in greater depth by Miller et al. (2013), the national TaMHS programme was initiated in 2008 "to transform the way that mental health support is delivered to children aged 5 to 13, to improve their mental wellbeing and tackle problems more quickly." (DCFS, 2008, p. ii). The programme, which was specifically tasked with enabling schools to deliver a more holistic approach to the promotion of children's mental wellbeing, was implemented in three phases. The Cumbrian initiative itself was part of Phase 3, beginning in 2010 and receiving funding from the Department of Children, Families and Schools for one year. A total of 18 Cumbrian schools, in three clusters, were involved, with each cluster including one secondary school and partner primary schools.

Central to the operation of the initiative was the secondment of mental health specialists to support each cluster of schools. These specialists were drawn from tier three Child and Adolescent Mental Health Services (CAMHS), and from the Local Authority, Children's Services, Educational Psychology and the Behaviour Support Team, and were tasked with training school staff, supporting parents, implicating group interventions, and working directly with young people. Miller et al. (2013, p. 42) summarise the day-to-day provision thusly:

Through the TaMHS project, all involved schools accessed cluster meetings, support from a Primary Mental Health Worker, Specialist HLTAs supporting schools in providing small group Social and Emotional Aspects of Learning (SEAL) and Family SEAL, mental health training and a mental health toolkit, including a mental health and emotional wellbeing policy and information on mental health and emotional wellbeing for students. Additionally, some schools accessed parenting workshops, counselling for staff, outdoor activities for young people, 'Stardom' projects or after school craft activities, and/or a whole school health day.

Manifest and latent impacts
In terms of desired impacts, the Cumbrian TaMHS set very specific goals in terms of 'system outcomes'. These are summarised from the proposal document (Cumbria County Council, 2010, p. 8) below:

1. The establishment of improved systems and processes for early intervention and prevention in schools and their communities including, better interagency collaboration, joint workforce development and improved ability to measure outcomes for children and young people.
2. The increase in capacity and capability of schools and their support services
3. A contribution to the ongoing work across the partnership to develop more integrated
The Cumbria Partnership Journal of Research Practice and Learning 4(1)

pathways, specifications and performance frameworks.

It is helpful, at this stage, to draw upon Merton’s (1949) distinction between ‘manifest’ and ‘latent’ systemic functions. Merton argues that, within any social system, actions and interventions are usually designed with intended manifest (i.e., intended) functions (i.e., impacts) in mind. The system itself can also benefit, however, from latent impacts that were not intended and/or foreseen, and/or can go unrecognised without careful analysis. Merton himself famously provides the anthropological example of a tribal rain dance which is manifestly designed to induce rain, but latently reinforces the group identity and promotes social integration by providing a regular activity around which the group meets. This is not to draw any direct equivalence between the TaMHS initiative and a rain dance, of course, given that rain dances are not hugely likely to actually produce rain, while all collected evidence indicates that TaMHS in Cumbria was highly successful in achieving its manifest systemic goals (Cumbria County Council, 2012). The salient point is, herein, that the intervention also produced distinctive and highly positive latent impacts that may not have been specified within the original aims, but were revealed by rigorous post-hoc qualitative research. This paper addresses one such latency, which is the impact on individual and group confidence.

Research design
With ethical approval and informed consent, qualitative data were collected via semi-structured interviews, which were conducted via telephone over a period of two weeks in 2011, immediately following the conclusion of the TaMHS initiative itself.

Participation selection
Participants (N = 30) were purposively selected from the three categories of professional involved in TaMHS implication in order to provide the most multifaceted overview possible: (a) school TaMHS leads (N = 13), (b) staff members at participating schools (N = 11) and (c) dedicated TaMHS workers (N = 6) (though evidence from the latter category is not addressed in the main analysis, given the focus on how the initiative was experienced by recipients of the programme).

Research materials
Three interview schedules were developed (available from the corresponding author) one pertinent to each category of respondent. Interviews were organised around broad and open questions, with subsidiary topical ‘prompts’, permitting participants to voice both a range and depth of opinions (Fielding & Thomas, 2008). Moreover, this research strategy explicitly permits for the emergence of participant-driven novelities – or latencies – that may not have been predicted by the researcher, and therefore are unlikely to have been coded, a priori, into a quantitative instrument such as a questionnaire (Silverman, 2006). Interviews averaged approximately 20 mins in length.

Data analysis
Transcribed data were examined for patterns and themes in line with the core principles of Straussian Grounded Theory (Strauss & Corbin, 1998), a process conducted using Scientific Software’s ATLAS.Ti 6.1 qualitative analysis package, which is highly apposite to this methodology (Lewins & Silver, 2007).

Results and discussion
The Cumbrian TaMHS project was manifestly focused on raising awareness of mental health issues among school staff and developing the skills to recognise when students are experiencing emotional distress, and to intervene and support when appropriate. A major crosscutting theme within the findings, however, relates to the rather less tangible issue of confidence-building. While there was a near-universally positive assessment of impacts on knowledge and skills, impressions of impact level varied, largely on account of many members of staff at participating schools asserting that knowledge and skill levels were high already. Respondents from both of the categories of participant addressed in this paper, however, recurrently reported an enhanced confidence among school staff in the use of knowledge and skills as a critical output of TaMHS involvement. This phenomenon manifested in six particular domains which are discussed below, with sample evidence provided to illustrate the key themes.
**Impacts on staff confidence**

**Theme 1:** Some participants explicitly highlighted that the function of TaMHS as a ‘confirmer’ of good knowledge was a major confidence boost.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>School TaMHS Lead #9</td>
<td>“What it does is it reinforces your...instinct... which I think is really important because it gives people confidence.”</td>
</tr>
<tr>
<td>School Staff Member #13</td>
<td>“[TaMHS has] confirmed what [we’re] already doing and made [us] more confident, I think when, when working with young people.”</td>
</tr>
</tbody>
</table>

**Theme 2:** As evident in the second quotation above, this confidence manifested in greater optimism regarding current and prospective participant dealings not only with students, but also with the students’ families. For example:

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>School TaMHS Lead #2</td>
<td>“[A] lot of parents perhaps, you know, having to go through that formal process of a referral, are put off by...especially when they see sort of ‘mental health’... and that’s a really big issue...but to have the professionals there that we could sort of tap into on the phone without having to have a referral and make a file on the child...was really beneficial to, to us all.”</td>
</tr>
<tr>
<td>School TaMHS Lead #5</td>
<td>“[Getting] that confidence to talk to that young person. Or the confidence to pass it on, to signpost it, you know.”</td>
</tr>
</tbody>
</table>

**Theme 3:** School staff members also identified an enhanced self-assurance when discussing mental health issues openly with colleagues. This, in particular, was reported to engender a stronger shared sense of priorities.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
</tr>
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<tbody>
<tr>
<td>School TaMHS Lead #1</td>
<td>“I think staff have maybe discussed more pupils with me than previously. I mean we are a very open staff so we do discuss...issues going on within our own classrooms...nobody is afraid to say ‘oh this has happened, or that’s happened’......but I think because of that heightened awareness they sort of brought it to me with a mental health eye on it.”</td>
</tr>
<tr>
<td>School TaMHS Lead #2</td>
<td>“[Staff] come to me and say ‘Look...I’ve got a problem this child is maintaining this, you know, level of heightened distress, if you like, about something or they keep saying this, or they’re obviously bothered about that’ for us to then intervene either with the parents or with a referral.”</td>
</tr>
<tr>
<td>School Staff Member #10</td>
<td>“[O]ther staff, that I have spoken to, informally can, can [now] talk about this in a way that I probably wouldn’t have expected them to talk about it... staff that I have spoken to are, are certainly talking about it more than they were.”</td>
</tr>
</tbody>
</table>
**Theme 4:** Working directly with TaMHS staff in practical sessions was reported to have direct impacts on staff confidence in their work with students.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
</tr>
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<tbody>
<tr>
<td>School Staff Member #9</td>
<td>“[T]he site manager...didn’t think he had the skills to do it. But we all thought that he did have the skills to do it; and [the dedicated TaMHS worker] was fantastic with him, she gave him the confidence...to carry on and do the whole group project...with the children.”</td>
</tr>
</tbody>
</table>

**Theme 5:** An improved confidence to apply knowledge to the issues of problem-recognition was a major theme raised by respondents, as illustrated below:

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>School TaMHS Lead #1</td>
<td>“I think it'll greatly help the staff in that...we can sort of see early indications...you hear mental health and you have all sorts of images in your mind but actually having these ideas pointed out to you, well, you know, we could be looking at emotional disorders, or it could be eating or...self-harming then...to have that set out of us was very good, because then we've got a baseline to be looking at, to be working from.”</td>
</tr>
<tr>
<td>School TaMHS Lead #11</td>
<td>“I think it's improved [the staff's] awareness. I think it's given them the confidence to be able to look more closely and being to think what factors maybe underlying...if a child presents in a negative way at school sometimes it's often easy just to see the behaviour rather than looking underneath and think well 'why is it they're doing that, what might be the underlying triggers?' So I think that's been a real strength. And it's also given them a confidence...to know [that]...it's not necessarily a negative reflection on the parents or on the adults working with them, it's just how a child's choosing express their need. And I think that's been quite helpful for some staff.”</td>
</tr>
<tr>
<td>School Staff Member #10</td>
<td>“I think probably there are some very obvious signs of, of mental health issues emerging in young people which staff are probably, as being teachers and caring people and usually quite empathic probably...can pick up on quite quickly but I think there are some more...subtle signs which a TaMHS project may well have helped staff to pick up on.”</td>
</tr>
<tr>
<td>School Staff Member #11</td>
<td>“[B]ecause we've done all of this training, we're all [now] watching for little things that may be a problem.”</td>
</tr>
</tbody>
</table>
Theme 6: Theme 5, regarding enhanced confidence to recognise problems, was itself seen as having corollary effects. Participants recurrently reported an increased readiness to (a) trust their own opinion when they suspect that something is wrong and, moreover, to (b) trust their own ability to do the right thing when taking action.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sample Evidence</th>
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</thead>
<tbody>
<tr>
<td>School TaMHS Lead #4</td>
<td>“I think [TaMHS has] alerted staff to the fact that things that we’ve dealt with in school should be flagged up to other agencies.”</td>
</tr>
<tr>
<td>School TaMHS Lead #8</td>
<td>I think it’s having the confidence...to know [the] child’s got a problem and it’s, it’s the confidence of the staff to say ‘right who do I need to go to?’, you know ‘do I need to get in touch with TaMHS?’</td>
</tr>
<tr>
<td>School TaMHS Lead #9</td>
<td>“[T]It’s helped. [T]here’s been some new training, so new awareness...but also it will give [the] staff confidence, it will reassure them, they know there are materials there that they can get to support [the students].”</td>
</tr>
<tr>
<td>School Staff Member #3</td>
<td>“I think that the knowledge and understanding that the TaMHS project has brought in...I definitely think that it has helped to work better and more clearly with the children.”</td>
</tr>
<tr>
<td>School Staff Member #13</td>
<td>“[I]t’s made [us] more confident I think when, when working with young people.”</td>
</tr>
</tbody>
</table>

Thematic integration
It is highly noteworthy that a majority of participants themselves made very explicit connections between the confidence-related themes identified above, often linking them to other strengths of the TaMHS initiative.

Figure 1: Network analysis of confidence impacts

Figure 1, below, schematises the full range of ways in which these themes were linked by participants themselves. One should be mindful that this schematisation is one of the relationships between issues that were raised, not quantification thereof.
When viewed in terms of the national picture, the results from the Cumbrian TaMHS indicate a particularly strong qualitative impact upon school staff confidence. Jeyasingham (2011, p. 3), for example, foregrounds some incidences where participants in Trafford have actively gained in this respect, but concludes more circumspectly regarding the overall impact of TaMHS consultations and contacts.

[They] have ensured good communication about children receiving support from TaMHS although there is less evidence that they have enabled school staff to develop confidence and skills in enabling children's emotional wellbeing more widely.

In the Middlesbrough evaluation, meanwhile, Larkin (2011) finds extensive and compelling evidence regarding the positive impact of the local TaMHS initiative on the confidence of students in the participating schools, but data pertaining to such impacts on staff are far from pervasive within the report. The findings in Cumbria are, in this respect, more in line with those reported from North Somerset (Pye, Kleve & Hooper, 2011), wherein quantitative and qualitative findings register school staff as having gained enhanced "confidence in improving child behaviour, child social skills as well as in identification and monitoring" (p. 47).

Conclusion
The central issues raised by the findings generated in this paper are two-fold: one substantive and one methodological. Regarding the former, it is plainly evident that the Cumbrian TaMHS initiative had a very substantial positive impact on the confidence of school staff in the business of identifying, and working with, mental health matters pertinent to their charges. There was, however, a further group of mutually reflexive and more nuanced impacts in the confidence domain. Participants reported that TaMHS was a strong 'confirmer' of good knowledge already held; that it generated optimism regarding current and prospective participant dealings with students and parents; that it enhanced self-assurance when discussing mental health issues openly with colleagues; that it helped school staff overcome trepidation regarding their own skill sets. These are all demonstrable successes, if not necessarily predictable ones. It is, however, very difficult to foreground such latencies of an intervention unless they are systematically identified in the first place. This leads to the second issue to address.

For all of the huge value of quantitative designs in robustly measuring the manifest impacts of a healthcare initiative, their efficacy in identifying the 'unexpected' – the latent – is rather weak (Silverman, 1997). As Aaron V. Cicourel (1964) notes in his seminal work on social scientific method, pre-categorised quantitative instruments are only as good as the imagination of the researcher; in short, statistical results can – by and large – only reflect socio-structural arrangements assumed within the tools of measurement.

Methodologically speaking, the use of a priori analytic categories mandates that nuanced features of the participants' own complex experiences of an intervention such as TaMHS are often reduced to ticking a box (Silverman, 1994; 1997). This deflects attention from the complex ways in which the phenomenon of interest might be meaningful to the persons actually involved in it. Systematic interpretative work, on the other hand, facilitates participant voice and illuminates potentially unforeseen successes to celebrate, and problems to learn from. Moreover, it provides a means by which our future manifest aims might be adjusted using something rather more robust than assumption. In these terms, the analysis above reminds us dually of the effectiveness of the Cumbrian TaMHS initiative, and also the importance of sustaining engagement with strong qualitative components in evaluations of future initiatives, in order to comprehensively elucidate the full range of their real-world impacts.

Acknowledgement
The research reported herein was commissioned and funded by Cumbria Children’s Trust, Cumbria Partnership NHS Foundation Trust and Cumbria County Council Children’s Services.

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References
To what extent do parental attitudes affect adolescents’ self-esteem, body image and eating attitudes

Chloe Hole

Abstract
This paper describes a quantitative study that explored the effect of parental attitude on male and female adolescents (aged 11–14) body image, self-esteem and eating attitudes. The study tests the hypotheses derived from previous literature that fathers would have greater effect on males for the chosen variables and mothers would have greater effect on females. Furthermore females would have lower self-esteem, a more negative body image and an unhealthier eating attitude than boys. The results of the study are discussed.

Keywords
self-esteem; body image; eating attitudes; parenting

Introduction
Factors that have been identified as important in the development and maintenance of eating disorders include self-esteem, body image, eating attitudes, and parental attitudes. This paper explores the link between these factors. Previous research and some of the inter-relationships between factors for each area is briefly discussed below.

Adolescence is a time where there is a noticeable dip in self-esteem and problems with self-worth become more significant in this developmental stage when identity and sense of...
To what extent do parental attitudes affect adolescents’ self-esteem

self is established (Robins et al. 2002). Furnham et al. (2002) found that girls’ self-esteem was correlated with weight control and boys’ self-esteem was significantly correlated to distorted eating attitudes. Furthermore, Furnham found that there was a greater discrepancy between ideal and actual body shape in girls in comparison to boys, and that girls were more dissatisfied with their weight and exhibited higher rates of abnormal eating attitudes and behaviours.

McCabe and Ricciardelli (2001) found that 50% of his male participants between the ages of 11 and 14 were not happy with their body image and, the older the participants, the less satisfied with their body shape they became.

Furthermore, current literature demonstrates a difference in body image concerns for boys and girls; for example, Cash et al. (2004) found that women are more concerned with their thighs and hips and men are more concerned with their abdomen. Body satisfaction is the extent to which an individual is satisfied with their body image. Polivy and Herman (2002) describes how body dissatisfaction is a key factor in predicting distorted eating in adolescent girls, indicating the importance of measuring self-esteem, body image, and eating attitudes together.

Eating attitude is a clear component of the eating disorder. The Dual pathway model (Stice, 2000) concludes that ‘dietary restraint’ is a mediator between body dissatisfaction and binge eating in both male and female adolescents, demonstrating the importance of researching eating attitudes when researching body image in adolescents. In a study of 1739 12 to 18-year-old females, Jones et al. (2001) found distorted eating attitudes were present in over 27% of the sample and 23% of the participants were currently dieting to lose weight. Furthermore 13% of 12–14-year-olds displayed distorted eating patterns.

Family functioning has been found to be a strong predictor of self-esteem in both male and female adolescents (Mandora & Murray, 2000). Family relational factors were found to be more important to girls, whereas structural and growth factors, such as family income, were more important to boys. Similarly, Ricciardelli et al. (2000) interviewed 40 adolescent boys, with a particular focus on body image. The findings showed that for a third of boys, parents were perceived to have an influence over their views about their own body and how they went about changing it. Mothers were perceived to have a positive impact on body image, whereas fathers were seen to have a more important role on influencing how the boys transformed their bodies through either diet or exercise.

Rationale
Self-esteem, body image, and eating attitudes are all important aspects of adolescents’ feelings of their own self-worth as they progress into adulthood, which will have consequences on their future wellbeing. There are gaps in the existing research literature on the inter-relationships between these variables, particularly for male adolescents.

This study reports on the effect of mothers’ and fathers’ perceived attitudes to appearance on participants’ body image, self-esteem, and eating attitudes for male and female adolescents (aged 11–14). The hypotheses are as follows: males will be more affected by the perceived parental attitudes of fathers for all variables and the same will be true for females with perceived parental attitudes of mothers. Additionally, self-esteem, body image, and eating attitudes will be affected regardless of gender. However, females will be more affected by these variables than males; having lower self-esteem, a more negative body image, and unhealthier eating attitudes then males.

Method

Participants
Some 93 participants, 46 males and 47 females, were verbally recruited from their own home in the County Durham area of England after their parents had signed a consent form. All participants were aged between 11 and 14, with the male mean age was 12.87 and the female mean age was 13.02. The male mean body mass index (BMI) was 23.03 (SD = 5.74) and the female mean BMI was 21.31 (SD = 4.85); 2.79% of the sample had been treated for an eating disorder in the past. All participants gave consent to provide data for the study and were given no financial or other gain for completing the questionnaire.

Procedure
The participants were asked to complete the following questionnaires in any order over any length of time and omit questions they felt they were unable to answer. The Family Focus Questionnaire (Rosenberg, 1965) was used to
To what extent do parental attitudes affect adolescents’ self-esteem

measure adolescents’ self-esteem. The Eating Attitudes Test-26 (EAT-26) (Garner & Garfinkel, 1979) was used to measure adolescents’ eating attitudes. Body image was measured in two categories: body image difference (Stunkard et al., 1983) and body satisfaction, using the Body Image State Scale (Cash et al., 2002). Extra questions added to the questionnaire included age, gender, current weight, current height, highest weight ever, when was the highest weight, lowest weight at current height, desired weight, and whether the participant has been treated for an eating disorder.

Results

To explore the effect of fathers’ and mothers’ attitudes on variables and whether their effects differ by gender, a 2 x 2 ANOVA was conducted. Participants were split into two groups in terms of their fathers’ perceived attitudes (Table 1) and mothers’ perceived attitudes (Table 2) using median split. The high category indicates strong perceived attitudes to social and physical appearance.

Table 1: Mean scores for male and female participants based upon a median split of father’s perceived attitudes to social and physical appearance

<table>
<thead>
<tr>
<th>Eating attitudes</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low in father</td>
<td>5.03 (.65)</td>
<td>5.09 (.52)</td>
<td>4.97 (.78)</td>
</tr>
<tr>
<td>High in father</td>
<td>4.88 (.61)</td>
<td>4.97 (.56)</td>
<td>4.81 (.66)</td>
</tr>
<tr>
<td>Total</td>
<td>4.96 (.63)</td>
<td>5.04 (.53)</td>
<td>4.89 (.71)</td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in father</td>
<td>3.19 (.50)</td>
<td>3.33 (.47)</td>
<td>3.02 (.50)</td>
</tr>
<tr>
<td>High in father</td>
<td>2.99 (.47)</td>
<td>3.05 (.44)</td>
<td>2.93 (.51)</td>
</tr>
<tr>
<td>Total</td>
<td>3.09 (.50)</td>
<td>3.20 (.47)*</td>
<td>2.98 (.50)*</td>
</tr>
<tr>
<td>Body image</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in father</td>
<td>-.48 (.90)</td>
<td>-.17 (.83)</td>
<td>-.81 (.88)</td>
</tr>
<tr>
<td>High in father</td>
<td>-.63 (.84)</td>
<td>-.52 (.81)</td>
<td>-.73 (.87)</td>
</tr>
<tr>
<td>Total</td>
<td>-.56 (.88)</td>
<td>-.34 (.83*)</td>
<td>-.77 (.87)</td>
</tr>
<tr>
<td>Body satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in father</td>
<td>5.46 (1.01)</td>
<td>5.76 (.84)</td>
<td>5.12 (1.28)</td>
</tr>
<tr>
<td>High in father</td>
<td>5.23 (1.04)</td>
<td>5.50 (1.13)</td>
<td>4.99 (.91)</td>
</tr>
<tr>
<td>Total</td>
<td>5.35 (1.07)</td>
<td>5.64 (.98)*</td>
<td>5.05 (1.09)*</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

Table 2: Mean scores for male and female participants based upon a median split of mothers’ perceived attitudes to social and physical appearance

<table>
<thead>
<tr>
<th>Eating attitudes</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low in mother</td>
<td>5.02 (.64)</td>
<td>5.06 (.58)</td>
<td>4.99 (.70)</td>
</tr>
<tr>
<td>High in mother</td>
<td>4.91 (.61)</td>
<td>5.03 (.51)</td>
<td>4.74 (.70)</td>
</tr>
<tr>
<td>Total</td>
<td>4.97 (.63)</td>
<td>5.05 (.54)</td>
<td>4.89 (.70)</td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in mother</td>
<td>3.14 (.49)</td>
<td>3.26 (.50)</td>
<td>3.05 (.47)</td>
</tr>
<tr>
<td>High in mother</td>
<td>3.951)</td>
<td>3.15 (.44)</td>
<td>2.81 (.53)</td>
</tr>
<tr>
<td>Total</td>
<td>3.08 (.50)</td>
<td>3.20 (.47)*</td>
<td>2.95 (.50)*</td>
</tr>
<tr>
<td>Body image</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in mother</td>
<td>-.50 (.87)</td>
<td>-.29 (.78)</td>
<td>-.66 (.90)</td>
</tr>
<tr>
<td>High in mother</td>
<td>-.58 (.90)</td>
<td>-.38 (.88)</td>
<td>-.84 (.88)*</td>
</tr>
<tr>
<td>Total</td>
<td>-.54 (.88)</td>
<td>-.33 (.83*)</td>
<td>-.84 (.88)*</td>
</tr>
<tr>
<td>Body satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low in mother</td>
<td>5.6 (1.10)</td>
<td>6.06 (.90)</td>
<td>5.23 (1.11)</td>
</tr>
<tr>
<td>High in mother</td>
<td>5.09 (.99)</td>
<td>5.28 (.91)</td>
<td>4.85 (1.06)</td>
</tr>
<tr>
<td>Total</td>
<td>5.36 (1.07)**</td>
<td>5.66 (.98)**</td>
<td>5.08 (1.09)**</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001
As demonstrated in Tables 1 and 2, the main findings of the research were that both mothers (F (1, 93) = 2.95, p = 0.09) and fathers’ (F (1, 86) = 4.86, p = 0.07) attitudes had a marginally significant effect on their child’s self-esteem, regardless of the child’s gender. Also, as verified in Table 2, mothers had a significant influence on their child’s body satisfaction (F (1, 93) = 7.65, p = .007), again regardless of the child’s gender.

In addition, the 2 x 2 ANOVA also revealed that compared to males, females were seen to have significantly lower self-esteem (F (1, 88) = 5.40, p = 0.02), body image (F (1, 88) = 5.40, p = 0.02), and wanted a body shape significantly smaller than their own (F (1, 89) = 6.66, p = 0.01).

A correlation test was computed to see the full extent of how each variable correlated to one another (Table 3 shows male scores, Table 4 shows female scores).

### Table 3: Correlation of males’ self-esteem, eating attitudes, body image, body satisfaction, mothers’ and fathers’ attitudes to social and physical appearance

<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>0.62***</td>
<td>0.35*</td>
<td>0.56***</td>
<td>-0.33*</td>
<td>-0.47**</td>
</tr>
<tr>
<td>2. Eating attitudes</td>
<td></td>
<td>0.36*</td>
<td>0.21</td>
<td>-0.18</td>
<td>-0.27</td>
</tr>
<tr>
<td>3. Body image</td>
<td></td>
<td></td>
<td>0.35*</td>
<td>0.12</td>
<td>-0.23</td>
</tr>
<tr>
<td>4. Body satisfaction</td>
<td></td>
<td></td>
<td></td>
<td>-0.34*</td>
<td>-0.29*</td>
</tr>
<tr>
<td>5. Mother’s attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.71***</td>
</tr>
<tr>
<td>6. Father’s attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

### Table 4: Correlation of females’ self-esteem, eating attitudes, body image, body satisfaction, mothers’ and fathers’ attitudes to social and physical appearance

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.49***</td>
<td>0.57***</td>
<td>0.52***</td>
<td>-0.27</td>
<td>-0.26</td>
</tr>
<tr>
<td>2. Eating attitudes</td>
<td></td>
<td>0.67***</td>
<td>0.48**</td>
<td>-0.26</td>
<td>-0.27</td>
</tr>
<tr>
<td>3. Body image</td>
<td></td>
<td></td>
<td>0.55***</td>
<td>-0.10</td>
<td>-0.10</td>
</tr>
<tr>
<td>4. Body satisfaction</td>
<td></td>
<td></td>
<td></td>
<td>-0.07</td>
<td>-0.07</td>
</tr>
<tr>
<td>5. Mother’s attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.91***</td>
</tr>
<tr>
<td>6. Father’s attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

As demonstrated in Tables 3 and 4, for both genders self-esteem was significantly correlated with eating attitudes and body image. In addition, body image was correlated with body satisfaction and eating attitudes. However, Table 1 demonstrates self-esteem was only significantly correlated to mother and father attitudes in male participants and only male participants’ body image was significantly correlated to mothers’ attitudes. Similarly, Table 2 demonstrates eating attitudes were only significantly correlated to body satisfaction in female participants. Neither fathers nor mothers attitudes were found to be significantly correlated to eating attitudes; however, mothers and fathers were found to be significantly correlated to each other.

### Discussion

This study has demonstrated limited links between mothers’ and fathers’ attitudes to social and physical appearance, and male and female participants’ self-esteem and eating attitudes, body image, and body satisfaction. The correlations of the key variables show a number of interesting associations which are discussed below.

The correlations for self-esteem extend results in the current literature. That self-esteem was correlated to eating attitudes in males and females supported the results from Furnham et al. (2002), who found that boys’ self-esteem significantly correlated to distorted eating attitudes. However, Furnham’s research found that...
To what extent do parental attitudes affect adolescents’ self-esteem

Girls’ self-esteem was more highly correlated to exercise, rather than eating attitudes. Attitudes to exercise were not measured in this study. Self-esteem was also correlated to mothers’ and fathers’ attitudes in males, but not females. However, the ANOVA did reveal that both mothers and fathers had a marginally significant effect on both males’ and females’ self-esteem, showing the stricter the parent’s perceived attitudes, the lower the child’s self-esteem. If the sample had been larger, then the correlations would possibly have reached a significant level. As predicted, girls were found to have significantly lower self-esteem than boys. This could be attributed to Paxton et al.’s (2005) explanation that females are more likely to internalise cultural beliefs about beauty, which in turn affects their self-esteem.

Body image was significantly correlated for both males and females with body satisfaction. It is unsurprising that the amount an individual wants to change their body shape is correlated to the amount they are satisfied with it. Body image was also significantly correlated for both males and females with eating attitudes, extending results of current literature (McCabe & Ricciardelli, 2001; Polivy & Herman, 2002). A male’s body image was significantly correlated to their mother’s attitude. This does not support the hypothesis that only fathers would affect males’ body image. As predicted, females were found to have a significantly worse body image than males. Similarly the ANOVA revealed mothers significantly affected adolescent’s body satisfaction, regardless of gender. This could be attributed to modelling of mothers’ behaviours for girls, having a greater than expected effect on boys.

As previously discussed, eating attitudes were significantly correlated with both males’ and females’ body image. Eating attitudes were also correlated with body satisfaction in female participants, which supports Polivy et al. (2002) who found that dieting was linked to body dissatisfaction in girls, aged 13–16. Neither mothers’ nor fathers’ perceived attitudes were significantly correlated to male or female adolescents’ eating attitudes, which is a different finding from previous research (e.g., Ricciardelli et al., 2000).

The aim of the current research was to examine the effects of mothers’ and fathers’ attitudes on adolescents’ body image, self-esteem, and eating attitudes. The key finding was that regardless of the child’s gender, mothers and fathers had a significant effect on adolescents’ self-esteem, and mothers had a significant effect on adolescents’ body satisfaction. Mothers and fathers had no significant effect on eating attitudes. This may be due to adolescents’ eating attitudes being influenced by other socio-cultural factors, such as the media (Durkin & Paxton, 2002) or their peers (Lieberman et al., 2001).

The organisation Beat found that only 1% of children felt that they would be able to talk to their parents about any eating-related concerns they were having. More resources need to be circulated across the country for both parents and adolescents, such as the workshop created by O’Dea and Abraham (2000). This workshop educated young people about the dangers of eating disorders, increased their self-esteem and body image satisfaction, and created healthier eating attitudes.

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References


PLANNED RESEARCH

Does therapeutic writing help people with long-term conditions? Systematic review, realist synthesis, and economic modelling

Catherine Meads

Abstract

This article, which was first published in the *Lapidus Journal*, introduces a research project commissioned by the National Institute for Health Research. Two approaches will be used: (i) a systematic review focusing mainly on outcomes and quantitative data, and (ii) a realist review which will enable evaluation of the contexts where therapeutic writing is more likely to be beneficial and the mechanisms that might be operating. The team will also evaluate whether therapeutic writing would be good value for money if implemented more widely in the NHS.

Keywords
evidence synthesis; systematic review; therapeutic writing; long-term conditions; economic modelling; realist review

The National Institute for Health Research (NIHR) is a main funding body for medical research in the UK. They have recently commissioned a major piece of research on the evaluation of therapeutic writing in people with long-term physical or mental health conditions.

This is an 18-month project which started at the beginning of 2013 and the team conducting the project are listed towards the end of this article.

There are a number of reasons why this project may have been initiated recently, but one is possibly the large amount of research...
that has been carried out on an intervention known as 'emotional disclosure' or 'expressive writing', where participants are invited to write for a short amount of time, such as 60 mins in total, about their illness, other things that are troubling them, or traumatic events in their past lives. Studies known as 'randomised controlled trials' have been undertaken comparing expressive writing to writing about everyday topics, or where people have not been asked to write at all. Participants are then followed up for three months or more and both groups evaluated for a variety of health-related outcomes, so a comparison can be made in order to estimate the effectiveness of the writing on health.

Some of the results have suggested that this structured intervention may help participants cope better with illness and maintain better overall health, but other studies have not had such optimistic results. Whilst the benefits of expressive writing in some conditions appear to be well established (albeit relatively modest in magnitude), there are several things we don’t yet know about this intervention. There are also many other forms of therapeutic writing that are being used in a variety of health settings such as psychiatric wards and outpatient clinics. Many of these have not been subject to evaluation through a randomised controlled trial but nevertheless may well be beneficial for patients. The questions we are addressing are as follows:

1. What different kinds of intervention might be offered under the umbrella term ‘therapeutic writing’, and (overall) how effective is each of these in different conditions?
2. In what conditions, and what subgroups of patients, is each type of therapeutic writing most effective; and conversely, are there situations, settings, or patient groups (for which this intervention is likely to be) less helpful or even harmful?
3. What are the mechanism(s) by which therapeutic writing achieves benefit to patients, and what aspects of context, setting, or patient characteristics might make these mechanisms more or less effective?
4. In situations where therapeutic writing is effective, what does it cost and is it good value for money?

In order to answer these questions, we will search widely in the published and unpublished literature for studies on therapeutic writing. To give an overall unbiased summary of the health effects of therapeutic writing, we are using two different approaches: (i) a systematic review where all relevant evidence of therapeutic writing – compared to no writing or standard writing in people with long-term conditions – is collated and summarised, and which focuses mainly on outcomes and quantitative data; and (ii) a realist review which will enable us to evaluate the contexts where therapeutic writing is more likely to be beneficial and the mechanisms that might be operating. These will then be combined to provide a meaningful description of the literature. We will also be evaluating whether therapeutic writing would be good value for money if implemented more widely in the NHS.

Since this is secondary research, where no new studies are undertaken but existing research evaluated, there are no direct ethical issues related to the execution of this project. However, we believe that consumers with chronic conditions have the right to evidence-based information about the effectiveness of any treatments that might be recommended to help them manage their condition. The majority of research has been published in the mainstream medical literature and we will be able to find these articles relatively easily. However, there may well be other comparative studies that have not been published, maybe because they were performed as part of a master’s degree dissertation or as an audit of service delivery. We would be very keen to hear from anyone who has a comparative study of any type of therapeutic writing in any group of people with any long-term or chronic conditions, who would be willing to share their results with us.

Our team is well placed to carry out the research because we have expertise and multi-professional connections in all relevant clinical areas regarding the treatment of chronic conditions. We possess a track record of successfully delivering systematic reviews on a variety of subjects and other work for the NIHR-HTA (Health Technology Assessment) Programme on time and within budget. Special expertise is required to carry out realist reviews and health economic assessments. Our group has published numerous systematic reviews, realist reviews, and health economic assessments and produced educational publications in this highly specialised area. We also have three therapeutic writing experts who are already using some writing techniques with people with long-term conditions. The team are as follows:

- Professor Stephanie Taylor, Professor of Public Health and Primary Care, expert in chronic medical conditions
- Professor Trisha Greenhalgh,
EDUCATION AND LEARNING

Evaluation of dementia, depression, and delirium (3Ds) training

Holly De Luca & Rebecca Parkinson

Abstract
This paper describes the evaluation of training to support staff working with older people to screen for dementia, depression, and delirium. We describe the approach to training. The evaluation shows a significant increase in confidence in screening in these areas and qualitative feedback offers data to support the development of the training delivery and curriculum.

Keywords
dementia; delirium; depression; training; evaluation

Introduction
The National Dementia Strategy (Department of Health, 2009) highlights the importance of early recognition, diagnosis, advice, and support for all people living with dementia. The strategy also focuses on more integrated working between mental health services, GPs, and primary care services. The Cumbria Dementia Strategy has aimed to meet some of the national objectives by introducing training aimed to improve recognition of common needs for those living with dementia. The training aimed to raise awareness of dementia, depression, and delirium (the 3Ds) while also introducing a screening tool to differentiate between the three conditions. It also highlighted the appropriate action to take following completion of the tool including referral information and advice and support from memory services where this was of benefit.

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The results of the project will be published in a monograph that will be freely available in the NIHR Journals Library, which can be found on the following website: http://www.journalslibrary.nihr.ac.uk/. This project is funded by the National Institute for Health Research Health Technology Assessment (NIHR HTA) Programme (project number 11/70/01) and will be published in full in Health Technology Assessment. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HTA programme, NIHR, NHS, or the Department of Health.

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The 3Ds screening tool is comprised of three sections, a screen for dementia using the General Practitioner Assessment of Cognition (GPCOG), a screen for depression using the Patient Health Questionnaire for Depression and Anxiety (PHQ-4), and a delirium screen. The GPCOG is a reliable, valid, and efficient instrument to screen for dementia specifically in a primary care setting (Brodaty et al., 2002). Recent reviews of dementia-screening tools for primary care settings recommend the use of the GPCOG and indicate that it performs at least as well as the standard screening tool, the Mini-Mental State Examination (MMSE) (Brodaty et al., 2004). The PHQ-4 was developed to create an ultra-brief screener for depression and anxiety for use in primary care settings. The PHQ-4 combines two validated two-item screening questions. A recent study found that increasing PHQ-4 scores were strongly associated with functional impairment and that anxiety had a substantial effect on functional status that was independent of depression (Kroenke, et al., 2009). The delirium screen is a brief version of the confusion assessment method (CAM). The CAM is a standardised, evidence-based tool that enables clinicians to identify and recognise delirium quickly and accurately in clinical settings (Inouye et al., 2001). The CAM has demonstrated sensitivity of 94–100%, specificity of 89–95%, and high inter-rater reliability (Pompei et al., 1995).

An evaluation tool was developed to assess whether trainee confidence in recognising the early signs of dementia had been increased following training, along with confidence in knowing where and how to make an appropriate referral. The three hypotheses to be tested are:

1. Confidence in recognising dementia will significantly increase from pre-training to post-training (Question 1 in Table 1 below).
2. Confidence in knowing where/who to contact for advice if concerned about a patient’s memory will significantly increase from pre-training to post-training (Question 2).
3. Confidence in knowing where to make a referral if concerned about a patient’s memory will significantly increase from pre-training to post-training (Question 3).

**Method**

Training was delivered in four waves, targeting community hospitals in the first, GP practice nurses in the second, and district nurses in the third. The fourth wave consisted of central training sessions being held in each locality with a view to catch those who had been unable to attend the session at their place of work, but also for those interested in learning more about the three conditions. Within this wave, training sessions were also delivered to services that had got in touch with the Memory Matters service requesting the training, e.g., Hospital at Home, the Community Rehabilitation Service, and the Respiratory Service. Organising training within the community hospitals involved contacting ward managers, discussing their training needs, and arranging appropriate times to deliver the training in order to capture varying shift patterns. GP practice managers were contacted via opt-in letter, offering training to practice nurses tailored to their training needs. District nurse managers were also contacted and offered the training.

Training sessions were delivered into community hospitals across the county where training around dementia, depression and delirium was offered alongside specific training on the 3Ds tool and referral information. GP practices requested the training for their practice nurses. Due to the opt-in letter, it was presumed practices that did not contact us as detailed in the letter did not require training at this time. Sessions were delivered to district nurses in the east and west localities with a future plan to deliver training to district nurses in the south of the county.

Each person attending a training session was asked to complete a pre- and post-training evaluation form. The evaluation forms were devised to collect both qualitative and quantitative data to consider if the training had impacted on clinicians’ confidence in recognising dementia, where to seek advice when concerned about a patient’s memory, and making a referral to the appropriate service. Quantitative data were gathered using a Likert scale using the format below:

1 not much 2 a bit 3 a lot

**Results**

Descriptive results from the data obtained are shown in Table 1.

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre Mean</th>
<th>Pre SD</th>
<th>Post Mean</th>
<th>Post SD</th>
</tr>
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<tbody>
<tr>
<td>Question 1</td>
<td>3.35</td>
<td>.82</td>
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<td>Question 2</td>
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<td>.74</td>
</tr>
<tr>
<td>Question 3</td>
<td>3.14</td>
<td>1.15</td>
<td>4.48</td>
<td>.78</td>
</tr>
</tbody>
</table>

Does therapeutic writing help people with long-term conditions?
Evaluation of dementia, depression, and delirium (3Ds) training

The data collected were ordinal and a repeated measures design was used so the difference between two conditions (pre-training and post-training) was tested using a non-parametric Wilcoxon statistical test. There was a significant increase from pre-training to post-training in trainee confidence in recognising dementia ($Z = -7.611, p < .001$), confidence of knowing where to contact for advice if concerned about a patient’s memory ($Z = -7.761, p < .001$) and in confidence of knowing where to make a referral if concerned about a patient’s memory ($Z = -7.831, p < .001$).

Qualitative data were also collected from two questions; "What was the best thing about the training? Can you say why it was the best?" and "What could have been improved about the training?" Feedback was used to inform future training.

Discussion

The descriptive statistics from the data set show the mean level of confidence in recognising dementia went from 3.35 to 4.29 pre- to post-training, confidence in knowing where to contact for advice and knowing where to make a referral if concerned about a patient's memory went from 3.21 and 3.14 to 4.48 and 4.48, respectively. From further in-depth statistical analysis it can be seen that all three of these results were significant at $p < .001$, meaning the three hypotheses outlined above are supported.

This therefore means the 3Ds training sessions which have taken place across the county have been successful and effective in meeting some of the objectives set out in the National and Cumbria Dementia Strategy. Specifically, objectives aimed at improving early recognition and closer working relationships between mental health services and primary care have been met as staff begin to use the screening tool as part of their everyday practice and liaise with memory services. Staff comments have included:

- Very communicative staff with understanding of the workplace. Underpins work/community role.
- Like the scenarios which help give you an idea of some situations you'll be experiencing. Going through the assessment tools. Helpful and appropriate hand-outs. Learning about the new tool for screening and implementing into my practice.

Issues to consider when looking at the results of the evaluation are that the training session was the same regardless of the skill set and level of knowledge of those attending. Responses from the question asking what could be improved about the training included:

- Just a little more in depth.
- Went too fast.
- A lot to take in in an hour.
- No improvements needed. Straight to the point.

While statements from the question asking about the best part of the training included:

- Information about delirium with a refresher for dementia and depression.
- Being able to ask questions throughout the presentation. Well-presented and clear slides. Easy to understand. Knowledgeable trainers. Good delivery and length of session.

These highlight the differences of opinion in terms of the length, delivery speed, and depth of information discussed. This means for some the course will have been a refresher while for others new information will have been learned. To address this issue in future it may be worthwhile having different training sessions designed to cover differing skill sets and levels of knowledge surrounding dementia, so that more time can be taken in explaining some of the course content when needed.

In future, if this or similar training were to take place again, what may be a more effective use of time and resources would be if more central sessions where held within each locality, each targeting a different service or skill set and knowledge base. The training could be designed in such a way that people booked onto the training session they believed best suited their needs through the learning network. Organising the training this way would ensure there would be an adequate number of people at each session to maximise the trainers’ time as well as saving on resources through the reduced travel time and cost incurred. However, a disadvantage of using this method for the training would be that it isn’t as easy for certain staff members to attend, e.g., those working within community hospitals where certain minimum staffing levels must be maintained at all times. Therefore, the training design used for this evaluation was appropriate for the audience which needed to be targeted.

- Our fault, not enough attendees at one session but good for staff attending – personal support.

Due to the evaluation forms being developed and implemented after training sessions had already been commenced in community hospitals, in Eden it means the results reported are only from sessions which took place after
that. In light of these positive results for the training sessions being effective, training is still ongoing and so it may be worthwhile re-analysing these results when all training sessions have taken place and a complete data set has been obtained. Nevertheless, this analysis provides support for the importance, need, and effectiveness of the training and so demonstrates the reason why training should continue.

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References


Cognitive behavioural training for physical health staff

Lucy Eastlake, Brenda Connolly, Catherine Cooper & Elspeth Desert

Abstract
The psychological needs of people with long-term conditions (LTCs) cannot be met through conventional psychological services, as for many patients this would not be appropriate or financially sustainable. Physical health and rehabilitation psychologists (PHRP) are running cognitive behavioural therapy (CBT) tasters for staff working with LTCs. The aim is to pilot CBT training, give an awareness of CBT, and encourage trainees to progress onto a further CBT course. Evaluations have indicated that participants find training beneficial.

Keywords
cognitive behavioural therapy; training evaluation; physical health

Introduction
Background
An LTC persists for over three months and can be controlled but not cured (Fellow-Smith et al., 2006). Individuals suffering from an LTC are more likely to have a mental-health problem than the general population (Fellow-Smith et al., 2006). Mental-health difficulties can have a detrimental effect on physical health, with a reduction in the ability to manage the condition and quality of life (QoL) (Naylor et al., 2012).

CBT is recommended to alleviate the effects of psychological difficulties (NICE, 2009). The NHS Confederation (2012) recommends further investment to meet the needs of this group. PHRP offers psychological therapies for level 4/5 complexities (Figure 1). That is, patients whose psychological difficulties interfere with their ability to care for themselves, interfere with their QoL and require specialist interventions.

However, a significant proportion of patients with LTCs have levels of distress in level 2/3. Some patients may be effectively treated in other
services, e.g., IAPT; however, because of co-morbid issues, such services cannot offer all patients appropriate support. Thus we are faced with the question of how these needs can be met most effectively in a rural population with higher levels of LTCs and unhelpful health-related behaviours than average.

Mannix et al. (2006) identified the need for healthcare professionals to be competent in delivering psychological support to patients with LTCs. CBT has been shown to be effective for patients suffering from the most common psychological issues in this group. Mannix et al. (2006) trained professionals working in palliative care, finding a mixture of training and supervision increased CBT skills. Anderson, Watson and Davidson (2008) measured the effect of CBT delivered by a healthcare professional on patient outcomes. They found that patients showed improved levels of depression and anxiety after intervention. In addition, Moorey et al. (2009) found when nurses working in palliative care were trained according to the model by Mannix et al. (2006), levels of anxiety significantly reduced. These studies support the provision of CBT skills training for professionals working with LTCs.

The Mannix et al. (2006) programme is being rolled out across Cumbria initially funded by Macmillan Cancer Support. It is intended to be Cumbria-wide for professionals working with LTCs. The intention is not to produce new therapists but to enhance the psychological skills of professionals, enabling them to meet some of the needs of patients with LTCs. These are known as ‘CBT First Aiders’, who are able to deliver care in a CBT style to patients with level 1, 2, or 3 complexity (Figure 1).

![Figure 1: The pyramid of psychological need (taken from Fellow-Smith et al., 2012)](image)

The training programme comes in two parts. The core is a six-day course taking place over six months, including three two-day teaching sessions six to eight weeks apart, interspersed with five group supervision sessions. Before completing the six-day course, trainees are required to have prior awareness of CBT. To facilitate this, we offer a CBT taster. This article concerns the evaluation of that day.

**Overview of training**

Trainers were experienced in delivering interventions at levels 4 and 5. The taster day is structured as follows:

1. **Introduction** – Brief overview and use of techniques and applications of CBT in physical health.
2. **Thoughts, moods, behaviours links** – Hot cross bun and links. Emphasise thoughts underlying observable behaviours and brief discussion of unhelpful thinking styles and behaviours.
3. **CBT style and key skills** – Style of collaboration, curiosity, and investigation. Skills of discovery via experiments and questions. Trainers use personal example to demonstrate the style.
4. **Skills practice 1 and feedback** – Trainees use questions to help a colleague to resolve a low-key personal dilemma.
5. **Demonstration from trainers of a hot cross bun formulation of a patient**

6. **Skills practice 2 (role play)** – Trainees use a case example to take a history, use questions and summaries to elicit a hot cross bun, invite the ‘patient’ to look for links and use strong emotion to look for hot thoughts.

7. **Demonstration from trainers of looking for evidence** – Testing beliefs, challenging thoughts, changing behaviours, and setting goals if appropriate.

**Objectives of evaluation/study**
- To pilot CBT skills training for physical health staff in Cumbria;
- To equip healthcare professionals working in LTC with CBT skills;
- To evaluate the taster by assessing trainees’ perception of training;
- To encourage trainees to progress onto the six-day training course.

**Delivery**
The training was run in both North and South Cumbria. Trainees were recruited by advertising through the Cumbria Partnership NHS Foundation Trust (CPFT) Learning Network. No experience was required. All trainees were required to have the support of managers in attending the course. A total of 168 trainees completed a taster day. Table 1 shows the profession of trainees.

**Table 1: Profession of trainees**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>68</td>
</tr>
<tr>
<td>Doctors</td>
<td>4</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>30</td>
</tr>
<tr>
<td>Social workers</td>
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</tr>
<tr>
<td>Assistant Psychologist</td>
<td>1</td>
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<tr>
<td>Complementary therapists</td>
<td>3</td>
</tr>
<tr>
<td>Health visitor</td>
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<tr>
<td>Management</td>
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<tr>
<td>Rehabilitation/Health Care Assistant</td>
<td>11</td>
</tr>
<tr>
<td>Assistant Practitioner</td>
<td>5</td>
</tr>
<tr>
<td>Medical staff</td>
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</tr>
<tr>
<td>Dietician</td>
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</tr>
<tr>
<td>Unknown</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
</tr>
</tbody>
</table>

*9 speech & language therapists, 11 physiotherapists, and 10 occupational therapists

**Outcomes**
For the taster, trainees were asked to evaluate the day by indicating their level of agreement with each of nine statements (below) on a scale of one to five, where 1 = ‘Totally Agree’ and 5 = ‘Totally Disagree’. A total of 117 evaluations were returned. Figure 2 shows average ratings.

**Statements**
1. Overall this teaching met the stated objectives and aims;
2. This teaching was relevant to my clinical practice;
3. I have learnt new skills from this teaching;
4. The material was all new to me;
5. The teaching has encouraged me to consider further training in CBT;
6. Discussion of issues was encouraged;
7. As a result of this teaching I feel more prepared for my role;
8. My confidence will be increased in coping with clinical situations as a result of this teaching;
9. I would recommend this day to colleagues.

Participants were also asked to provide comments about the taster. Some 44 of 168 trainees left qualitative feedback. The feedback which was received has been grouped into themes, and the number of responses in each theme and examples are displayed in Table 2.

**Figure 2: Taster day ratings**

Participants also made several suggestions which could be considered for future training, these include:

*Example of real life patient interaction. The exercises given – if they could be enacted by trainers.*

*As discussed scenarios relevant to sexual health would be useful.*

*Extend variety of situations for role playing or encourage triads to use a situation from their own clinical experience to encourage (better!) questioning.*
Table 2: Themes arising from the qualitative feedback

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to practice skills</td>
<td>1</td>
<td>&quot;It has made me realise I need to do further practice and training to embed this into my practice.&quot;</td>
</tr>
<tr>
<td>Enjoyable, good, great, etc</td>
<td>18</td>
<td>&quot;Enjoyed immensely.&quot;</td>
</tr>
<tr>
<td>Venue</td>
<td>6</td>
<td>&quot;Venue cold in the morning.&quot;</td>
</tr>
<tr>
<td>Helpful/beneficial to their practice</td>
<td>7</td>
<td>&quot;Very beneficial day, look forward to learning more!&quot;</td>
</tr>
<tr>
<td>Desire to progress to six-day course</td>
<td>3</td>
<td>&quot;I am hopeful I shall continue to be able, with the six-day course, to enhance my skills.&quot;</td>
</tr>
<tr>
<td>Informative</td>
<td>2</td>
<td>&quot;An informative session, would encourage other team members to attend.&quot;</td>
</tr>
</tbody>
</table>

I would have liked to have longer to read and absorb the case (patient role) than was available, otherwise fine.
More on finishing techniques – difficult in time schedule. Thank you.
Maybe having different scenarios in the group would have been more interesting.

Discussion
This paper has described an evaluation of a CBT taster day for healthcare staff across Cumbria. Evaluations of the taster day were generally positive with trainees agreeing or totally agreeing with the majority of items on the questionnaire. In particular participants agreed that the training was relevant to their clinical practice and that it had encouraged them to consider further training in CBT. In fact, three trainees specifically stated in their qualitative feedback their desire to progress onto the six-day course.
Trainees also agreed that they had learnt new skills, which indicates that the training met another of its aims. The only item that trainees did not agree with was ‘The material was all new to me’. This is understandable as some trainees may have already had some prior awareness of CBT or have been using CBT skills in their clinical practice without realising.

Limitations and future plans
Of the suggested improvements to the course, all but one concerned the scenarios given to trainees in order to practise their skills. This mainly addressed the lack of relevance of the scenarios to some professionals (e.g., cancer scenarios not relevant for sexual health nurses). We have now started offering taster days on a profession-specific basis. We have already delivered one to staff working with diabetes and are planning to deliver one to physiotherapists working with LTCs which are neurological in origin.

Although several trainees indicated in their qualitative feedback that they would like to progress onto the six-day course, we do not have quantitative data for trainees on whether they would like to do this. The majority of trainees indicated that they would consider further training in CBT, but participants were not specifically asked if they would want to progress onto the six-day course offered in Cumbria. A further improvement to our evaluation questionnaire could therefore be to specifically ask trainees about their intention to progress onto the six-day course rather than just their general intention to consider further training in CBT, as is currently the case. In addition, the item ‘the material was all new to me’ could be removed from the questionnaire as it does not fit in with all the other items. We would expect people to not have prior awareness of CBT and to therefore disagree with this item, whereas the aim of the training is to increase agreement with the other items.

A further limitation was that recruitment of trainees sometimes proved difficult. This could be due to several reasons including a lack of awareness over the impact of CBT ‘first aid’ on clinical practice and patient outcomes leading potential trainees to be wary. There was also, on occasion, a lack of management support, as managers are not aware of the benefits of training in terms of efficiency of the use of resources and patient wellbeing. Some trainees even commented in their feedback that they felt further training would not be supported by their manager. Therefore we plan a further assessment of the impact of training on patient outcomes.
Conclusions
Our evaluation has demonstrated that CBT training for health care staff working with LTCs is feasible in Cumbria. Participants find training in CBT techniques helpful and offering a taster day of these techniques encourages participants to progress onto further training. Furthermore, the training was deemed acceptable by trainees, indicating that the course met its aims and trainees felt they would use their new skills to the benefit of their practice.

This has implications for the provision of psychological support in a physical health care setting. If training can be further rolled out amongst healthcare professionals, this will greatly reduce the strain on psychological services and ultimately benefit the patient care journey.

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References

Team training triumph
Lindsay King

Abstract
Enrolling on the Learning Leader project in 2012, the author describes her experience of Action Learning Sets and how she applied this reflective methodology to her team. The learning outcome exceeded all expectations in terms of team health, unification, knowledge, and resilience.

Keywords
training; reflection; team development

The story begins...
In April 2012, the Trust was in the throws of staff and strategic re-organisation with many key employees facing significant changes to their roles. It was during this turbulent period that I came across a leaflet boldly entitled Become a learning leader promoted by the Learning Network. I enrolled on the Learning Leader programme, but initially found myself confused and unable to grasp the expectations of the course tutors or the Trust.

The programme introduced me to the continuous process of learning and reflection known as ‘Action Learning’, a term coined by Reg Revans (1907–2003). Revans (2011, p. 1) stated "those organisations unable to adapt are soon in trouble”. He asserts:

Adaptation is achieved only by learning, namely, being able to do tomorrow that which might have been unnecessary today, or
to be able to do today what was unnecessary last week.

Revans’s original idea involves learning taking place in a ‘set’ which is a group of people working together for a concentrated period of time. On the programme we were randomly assigned our set, but at this early stage on the course I failed to see how this was particularly significant or groundbreaking.

We were encouraged to keep a journal to chart the progress of the programme. On the evening of day one, (after reading the handouts and an extremely helpful booklet DIY Handbook for Action Learners produced by Mersey Care NHS Trust, 2010) I found a quote from Edgar Schein: “You can’t impose anything on anyone and expect them to be committed to it.”

It dawned on me that the learning culture of the Trust had been one of ‘imposition’. For example:
1. Imposition of targets and not outcomes;
2. Imposition of compulsory audits with little space for individual and team areas of interest; and
3. Significant imposition of mandatory learning with little scope for team-led learning.

Within my team, the Cumbria Community Acquired Brain Injury Rehabilitation Team (CCABIRT), such a culture seemed to have a dampening effect on enthusiasm and quest for knowledge to enhance our skills. There seemed to be little value placed in engaging, sharing, and communicating the wisdom held within an inter-disciplinary team such as ours. We seemed to be experiencing learning stagnation, which was at odds with my personal experience of the team psychologist, I devised a Learning Needs Assessment (Milne & Noone, 1996) to enable us to discover our own learning needs. I also wondered if the team might be interested in discovering theirs and others’ learning styles so I acquired Kolb’s 1984 shortened version of the Learning Style Questionnaire (Milne & Noone, 1996). To baseline the team’s view of the Trust’s current learning culture, I used Marcia Conner’s Learning Culture Audit (Connor, 2004).

References to ‘culture’ led me to reflect on the team culture that had insidiously developed over the four years of my employment within CCABIRT. Not only had this had a detrimental impact on the team’s learning, as I have outlined above, but also, in my view, operationally in terms of the team’s performance. Hinshelwood and Skogstad (2005) vividly describe ‘defensive techniques’ adopted by groups of healthcare workers which are then maintained by and locked into the group’s social system of becoming the ‘cultural norm’ in that setting. For example, the cultural norm in CCABIRT became a rising competitive anxiety between the North and the South teams which resulted in a defensive corrosive attitude of distrust, not only between the teams, but also between disciplines within each team. Thus, my personal outcome from the project was “to understand more about organisational cultures and how it develops in the...
workplace and influences team functioning and behaviour”.

Our first meeting of the sub-group (which I shall refer to from now on as the CCABIRT set) took place on 3 October 2012 at a neutral venue mid-way between the two teams. In spite of enthusiastically encouraging team members to attend, I received only three apologies for non-attendance and just three CCABIRT members accompanied by their two students came. I felt disheartened by the lack of members. I wrote in my journal “I had expected greater interest and support. It takes such a lot to instigate change and I arrogantly thought I could!”

We administered the Learning Needs Assessment which resulted in the CCABIRT set wanting to pursue learning through: (i) debate; (ii) contemporary newspaper articles; and (iii) radio/TV news coverage. The CCABIRT set was not interested in examining their learning style so this was abandoned. Instead we formulated our ground rules and decided that we would identify presenters for a debate at the next meeting on 7 November 2012. The topic for the meeting would be gleaned from the Jeremy Vine Show on BBC Radio 2, which we all planned to listen to en route. It seemed important to the CCABIRT set that preparation time be kept to a minimum as everyone felt that their current workload precluded any further demands on time.

On 7 November 2012, five members of CCABIRT and two students attended. We held one informal and one formal debate. For the formal debate, one member of the team volunteered to take one side of the argument and one volunteered to take the opposing view (irrespective of their personal beliefs). It became a lively, entertaining, and informative debate. One member noted at the close that “It had really helped her to talk on her feet” as it was all unprepared and unscripted. The CCABIRT set decided that the rapport and ambience was sufficiently robust to debate a work-related issue at our next meeting on 19 December 2012. Therefore we agreed to identify an issue from the following business meeting on 5 December 2012.

Though the CCABIRT set had now met on just three occasions, it felt as if we were taking enormous strides. The trust and commitment between members had grown and we felt that we had a safe and friendly environment in which to explore and learn. However, at this time I became consciously aware of the exclusivity of the set and the time prioritised by the CCABIRT set to attend provoked some derogatory remarks from the wider team.

I reflected on this within my Learning Leader Set (LLset). I seemed to have inadvertently perpetuated the team divisions. The LLset asked me some very probing, insightful questions which led me to see another way forwards in which I could include the whole CCABIRT team. By planning a training morning, utilising the skills of the programme tutors, I could give my whole team the experience of action learning and not just the CCABIRT set.

Therefore I decided to spend my project budget on the entire CCABIRT team by hosting a morning of Action Learning Sets on 6 March 2013 at a suitable hotel. I was thrilled to have found a way to satisfy the demands of the whole team and fulfil the expectations of the Learning Leader project.

Listening closely throughout the next business meeting for a topic we could bring to the CCABIRT set, I was overwhelmed when a CCABIRT member remarked that she “missed doing CPD together”. Consequently, at the following CCABIRT set meeting this was the pressing issue that we chose to debate. The CCABIRT set considered CCABIRT’s expectations of continuing professional development (CPD) in terms of:

1. Mandatory CPD;
2. CPD for role within CCABIRT;
3. CPD to maintain registration; and
4. CPD needs identified by CCABIRT.

Points (a), (b), and (c) were largely acknowledged to be the responsibility of individual clinicians. However, the identification of ‘needs’ could emerge from acknowledging ‘trends’ that the team face. For example, the team had recently received four referrals for clients suffering an acquired brain injury following encephalitis. The team felt in need of revision of ‘needs’ could emerge from acknowledging ‘trends’ that the team face. For example, the team had recently received four referrals for clients suffering an acquired brain injury following encephalitis. The team felt in need of revision and updating of knowledge about encephalitis, which would increase their confidence and competence in dealing with these clients. Thus, three positive actions emerged from the CCABIRT set:

1. To invite the Encephalitis Society to give a presentation;
2. To briefly research the current encephalitis pathway within the team; and
3. To feed back to the wider team.

The whole day on 6 March was dedicated to learning. Initially, through the CCABIRT set and then as a whole team, we have been able innovatively to address our team’s learning needs productively, surpassing my original ambition of simply re-introducing case study presentations. The secondary aim of my project to “understand more about organisational cultures and how it develops in the workplace and influences team functioning and behaviour” has been a personal voyage of discovery.

Though a moderate cultural change was required to bring our team in line with the Trust’s renewed vision of learning, it was not as catastrophically incongruous as I had initially
thought it to be. We simply required a safe space and forum in which to confidently share our knowledge, insights, and reflections to enable us to grow and learn together.

The team training day on 6 March dawned. I was feeling anxious as we had not spent a full day as a team since a troubling one 20 months earlier when our relationships and style of working had been measured by Judi Egerton in her capacity as a Psychotherapist.

The business meeting commenced and the Project Manager gave a brief explanation of his six-week role in assessing the viability of the Gill Rise unit in Ulverston as a base for the developing Neuroscience Service in which CCABIRT sits. Following a brief introduction to the origins and aims of one method of reflective learning, the team divided into two sets and Gill Rise became the “live issue” presented for Action Learning. One set was led by the Project Manager and the other set led by a combination of the Team Leader and myself. We asked the team to consider:

1. What are the key issues to CCABIRT when delivering their service to clients?
2. What is the potential viability of Gill Rise in Ulverston as a base for CCABIRT?

After approximately one hour the team regrouped and fed back their views and thoughts in to “Pro and Con” columns regarding Gill Rise. The Project Manager remarked on the “enthusiastic reception and helpful comments” provided by the team.

Now that the team was gelling and working well, I presented the two groups with a couple of reflective questions for them to discuss and give feedback on later in the day. This degree of openness would not have been conceivable six months earlier.

When the Chief Executive Officer of the Encephalitis Society, Ava Easton, arrived, CCABIRT gave an overview of our issues of working with encephalitis clients within the community to which Ava listened and, as planned, was able to address during her highly inspiring and informative presentation. Her talk was well received by the team who asked many questions and gave her extremely positive feedback. She, in turn, commented on the “fabulous atmosphere” within the team and how she had found this “most invigorating”.

We were joined in the afternoon by a CPFT Governor. He summed up all that he had heard, seen, and learnt during his visit concluding boldly: “there’s no fear of innovation...[within CCABIRT] that’s often prevalent in other parts of the Trust.”

My reflections
Summarised in July 2012, the aim of my project was to “draw the team together to focus on learning opportunities we can develop for ourselves.” From a personal perspective I wanted to firstly “develop myself and my role, in relation to the team, as a positive influence and facilitator of the team’s growth”. Secondly, I wanted to “understand more about organisational cultures and climates, how each is present, impacts on the workplace and influences team functioning and behaviour” (King, 2012). As part of the organisation context at the start of this period (April to June 2012) the team had relatively high sickness levels (e.g., in April 2013 the team lost over 20 days in sickness). Over the summer months our referral rate slowly increased as did face-to-face contacts. Simultaneously, over the same period, the sickness rate fell to just three days lost for the whole team in August. Though there was another peak in sickness in November (15 days lost), it quickly fell again to just four days in December and January 2013. We saw a surge in referrals by October 2012 to 20 new referrals in one month (double the referral rate of just 9 in April 2012). However, the referral rate has remained steady at 21 in January 2013, sick leave fell to four days lost and, incredibly, the face-to-face contacts for the team has surged by almost 100% to 258 in January 2013 from just 132 in April 2012.

I consider that these figures show a general trend towards a healthier team, receiving increasing numbers of referrals and making double the number of face-to-face contacts with clients. Consequently, some of the conjectured social, economic, and environmental impacts of my project (dated 8 July 2013) have indeed come to fruition. For example, I speculated that the social impact would result in a “greater sense of team vision/purpose/focus with improved levels of trust” coupled with a “more constructive and healthy team culture”.

I predicted that the environmental impact would be “more productivity overall” and that the economic impact would result from “less staff sick leave”.

It is clear that the team benefitted from the time spent together on the team day. Constructive comments following the day suggested a need for more time to debate, discuss, and talk together, and the team felt that the impact of the day was that it was easier “to do our job”. The reasons for this outcome range from “feeling more valued” to there being greater team “blending”.

The Cumbria Partnership Journal of Research Practice and Learning 4(1)
Conclusions
Experiencing Action Learning Sets first hand within the Learning Leader project followed by the Action Learning Set within CCABIRT, led me to believe that attitudes towards our own learning and culture could be changed. Importantly, the CCABIRT Action Learning Set gave a forum in which the team could safely communicate and reflect as a team on our own learning needs, which we had never experienced before. This resulted in us identifying current trends in recently referred clients with encephalitis which added to new management interest and support, we were able to capitalise on and utilise this information, creating our own solution in the form of a team training day.

Learning and reflection are considered essential to support successful adaptation of an organisation. (Revans, 2011). CCABIRT seems to be embracing a positive cultural adaptation, becoming more open to cross-team collaboration and cooperation which has the potential to further improve team durability, resilience, and flexibility. Our unique composition as an interdisciplinary team is now a healthy asset to the Trust at the time of writing.

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References


QUALITY/ORGANISATIONAL CHANGE
Effectiveness of the One Step Further exercise programme for clients with neurological disability

Tracy Johnson & Stephen Atkinson

Abstract
The ‘One Step Further’ exercise class provides an opportunity for clients with neurological impairment to participate in aerobic and strength training, preparing them for long-term participation in exercise in community settings. The class is accessed by over 20% of the team’s caseload and provides an increase in service capacity of over 12%. Clients, on average, display a 22% increase in walking speed, are able to participate in aerobic exercise on average 16 mins longer than at the start of the programme, and, subjectively, describe the class as being hugely beneficial in the rehabilitation and management of their individual conditions.

Keywords
neurological disability; exercise programme; rehabilitation; walking speed; accessibility; self-efficacy

Introduction
Exercise is recommended as a long-term treatment strategy for clients with neurological disability in a range of national guidance (e.g., NICE, 2013; 2003; 2007) as well as the National service framework for long term conditions (Department of Health, 2005). More specifically, across the guidelines, exercise is further defined into sub-categories such as endurance training, cardiovascular training, strength training, balance training, and task-specific training. A review of the relevant guidance breaks down the recommendations into three broad themes: accessibility of exercise programmes;
improvement of cardiovascular fitness, gait speed, and target muscle strength through exercise programmes; and social participation and self-efficacy.

This audit will aim to examine accessibility, improvements in terms of gait speed, and self-efficacy through the use of a patient experience questionnaire.

Service context
Clients in the west of a large rural county, with neurological impairment, are able to access rehabilitation via the neurological physiotherapy teams based at the physiotherapy departments of two local hospitals. Sessions are predominantly clinic based, and last approximately one hour. Domiciliary interventions are offered to those unable to access the clinics. Clients access the service via referral from health, social, and voluntary sectors. The service receives up to 170 referrals each year across both localities and will provide over 3000 treatment sessions each year. Many clients are treated in blocks of intense treatment, whilst some are seen on a less frequent but ongoing basis, depending on the nature of their condition. We believe that a 'one size fits all' service model is not appropriate and we tailor our service delivery to the needs of our clients.

The opportunity to provide an extended service for those clients able to participate in exercise classes further allows us to shape our service to the needs of the client and allows us to increase the extent to which we are able to comply with relevant national guidance.

Service model
The classes are run by a specialist neurological physiotherapist, an advanced practitioner and a physiotherapy assistant. Following an induction appointment clients start the 10-week exercise class. At the induction appointment, goals are set and outcome measures recorded.

The first part of the session includes feedback from the clients of any problems encountered following their last session and changes in medical condition. The blood pressure (BP) of all clients is monitored. If persistent problems with BP are identified or their medical condition changes, patients are referred back to their GP for advice or back to their referring therapist.

The class is divided into three sections: warm-up, individual exercise programme tailored to individual goals, and warm-down. The warm-up is undertaken as a group and can be done in a seated position; exercises are adapted to the individual needs.

The exercise programme consists of endurance training using gym equipment including treadmill trainers, cross trainers, stepper, and static bike. Assistance and supervision are provided for clients to get onto equipment. Clients are encouraged over the 10 weeks to become independent in using the equipment. This part of the programme also includes strength training, using resistance bands and weights, and balance challenges. The session is rounded off with relaxation consisting of Tai chi, hold-contract, or visualisation. All clients’ activity is logged on a weekly basis. All components of the exercise class are evidenced based for neurological clients.

Accessibility
We are able to offer six classes each year, running two at a time over 10 weeks. Each class has up to six participants, allowing us to offer places to 36 clients each year. This represents approximately 21% of our yearly referrals. Bearing in mind the severity of disability of many of our clients, we are able to offer places to a large proportion of clients who are capable of participating.

Service capacity
The exercise class runs for 10 weeks, with two 1 hour classes running each week. Clients attend one of the two classes each week. Each class has approximately six clients in each group. On average, we are able to run three classes every year. This then equates to 60 clinical hours every year. Working on a one-to-one basis, we would only be able to offer 60 treatment sessions in that period. The exercise class allows us to offer 360 sessions in the same period, giving a six-fold increase in capacity for those sessions. Looking at the overall capacity for neurological physiotherapy in Copeland, the exercise class adds 300 additional sessions to our capacity, adding approximately 12% to our overall yearly capacity.

Clients
The class is open to all clients with neurological conditions. All patients must have been assessed by a member of the neurological specialist team and the class usually follows a period of one-to-one therapy. Before clients enter the group, an initial assessment is undertaken which includes identification of clients’ goals, recording of outcome measures, and general discussion of the benefits and training effect of exercise.

Outcomes
All clients have a pre-class assessment, to ensure suitability for the class, and to allow outcome measures to be recorded. For the purposes of measuring gait speed, the 10m walk test is used (Wade et al., 1987). We also measure length of time being able to take part in aerobic exercise. For the purposes of self-efficacy, a questionnaire is given to the client at the end of the class. This allows us to gain qualitative data on self-efficacy, satisfaction, and patient experience.
Following the completion of the 10-week programme, clients are invited back for a discharge interview where outcome measures are repeated, goals revisited, and discussion takes place to identify how clients can continue to exercise in the community.

Outcomes for the first 10 clients in the programme are presented here. The time in weekly participation in cardiovascular exercise pre- and post-treatment was measured. The group shows an average improvement in time in exercise of 16.6 mins which was an average increase of 350% (Figure 1) The walking speed for clients pre- and post-treatment over the 10-min walking test showed an average improvement of 22% in walking speed between pre- and post-treatment measures (Figure 2).

**Client feedback**
The following quotations from the satisfaction survey were recorded.

The weekly sessions provided me with an excellent background from which to begin exercising at home and the gym. I feel confident that I will continue my development, I feel much more positive about my future.

On completion of the course of physiotherapy at WCH I was introduced to the gym and swimming pool facilities at Moorclose Sports centre by the neuro therapist which is very

---

**Figure 1**

```
<table>
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**Figure 2**

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good follow from WCH
Thank you very much for the hard work
which has taken me another significant step
closer to full independence. The genuine
enthusiasm which accompanies your
treatment is invaluable and I think you have
a huge impact on the lives of people such as
myself, a very positive and uplifting one.
One Step Further, in my case a lot, lot
further. Resources should be made available
for this to enable other stroke patients to
benefit from this excellent programme.
I found the group very beneficial. My regret is
that it does not last long enough. My walking
has vastly improved.

Discussion
The results from the audit show increases in
clients’ participation in exercise and an increase
in walking speed at the end of the 10-week
programme. Whilst it is easy to measure these
beneficial effects, increased physical activity
is now recognised as a management strategy
to prevent secondary complications associated
with a more sedentary lifestyle. Clients with
longstanding neurological conditions are often
forced to accept a more sedentary lifestyle
due to poor mobility, poor accessibility to
community-based exercise opportunities, and
social isolation. An aerobic-based exercise
programme can enhance glucose regulation
and promote decreases in body weight, blood
pressure, and levels of total blood cholesterol.
With this in mind, it is recommended that
clients’ blood pressures will now be recorded at
the beginning of each exercise class, in order
that potential blood pressure problems can be
identified and reported to clients’ GPs to reduce
the risks associated with uncontrolled blood
pressure. It is also the intention to involve the
Dietetics Department to assist clients in weight-
reduction programmes in association with the
exercise programme. This will add a further
dimension to the programme and help promote
lifestyle changes proved to be beneficial in
the management of secondary complications
associated with cardiovascular disease and
physical inactivity.

Summary
The ‘One Step Further’ exercise class provides
an opportunity for clients with neurological
impairment to participate in aerobic and
strength training, preparing them for long term
participation in exercise in community settings.
The class is accessed by over 20% of our
caseload, and provides an increase in service
capacity of over 12%. Clients, on average,
display a 22% increase in walking speed,
are able to participate in aerobic exercise on
average 16 mins longer that at the start of the
programme and, subjectively, describe the class
as being hugely beneficial in the rehabilitation
and management of their individual conditions.

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Extracorporeal shockwave therapy: An audit report on initial outcomes and annotated bibliography

Steven Wright

Abstract
In an extracorporeal shockwave therapy (ESWT) trial undertaken within a hospital physiotherapy department, 70.8% of patients who received ESWT as part of their treatment package recorded a significant positive outcome when comparing their pre- and post-patient-specific functional scale (PSFS) measures.

Keywords
extracorporeal shockwave therapy; clinical audit; outcomes; bibliography

Introduction
ESWT is treatment that delivers high-energy shockwaves to areas of chronic inflammation and pain using a portable hand piece which stimulates the growth of new blood vessels and healing. Radial shockwave treatment utilises a ballistic technique. A projectile accelerated by compressed air and propelled at high kinetic energy, hits an applicator placed on the skin. By using a coupling medium such as ultrasound gel, this impulse is delivered to the tissue in the form of a shockwave. From this point, the shockwave continues to spread inside the body in the form of a spherical ‘radial’ wave with the applicator surface being the geometric point with the highest pressure and the highest energy density.

The treatment initiates an inflammation-like response in the tissue that is being treated. The body responds by increasing the blood circulation and metabolism in the impact area, which in turn accelerates the body’s own healing processes. The shockwaves break down injured tissue and calcifications.

The uses of ESWT have been reviewed by National Institute for Health and Care Excellence (NICE). The four areas that have been reviewed are:

- shockwave for Achilles (NICE, 2009a);
- shockwave for plantar fasciitis (NICE, 2009b);
- shockwave for tennis elbow (NICE, 2009c);
- shockwave for calcific tendonitis shoulder (NICE, 2003).

A 2009 guidance statement found that the current evidence on the efficacy of ESWT is inconsistent and should only be used with special arrangements for clinical governance, consent, and audit or research. The annotated bibliography at the end of this article shows that the research data has mixed results for the use of ESWT; although many areas require further good quality studies, there is evidence that does suggest ESWT has positive effects. More evidence is emerging to support the use of ESWT particularly in the treatment of Achilles tendonopathy, plantar fasciitis, and lateral epicondylgia.

Aim
The purpose of the audit was to assess the effectiveness of ESWT on patient treatment outcomes when used within the musculoskeletal outpatient physiotherapy team at West Cumberland Hospital. ESWT was used on conditions identified on clinical assessment as being appropriate for ESWT with reference to the manufactures guidelines. The outcome of the intervention was recorded with pre- and post-validated outcome measures (the Patient Specific Functional Scale (PSFS); Stratford et al., 1995).

Method
Two ESWT machines were loaned on a six-week basis (total loan time 12 weeks – August to October 2012). The machines used were the Shockmaster 500 supplied by Phoenix Healthcare Products Ltd and BTL-6000SWT supplied by BTL Industries Ltd. The machines were demonstrated within the Physiotherapy Department and each physiotherapist was allocated time to familiarise themselves with the machines’ operational procedures and the parameters of use.

The ESWT machines were kept and used within the Physiotherapy Musculoskeletal (MSK) Outpatient Department at West Cumberland Hospital. All patients assessed were reviewed for suitability for the application of ESWT. ESWT, if indicated, was used in accordance to the operational parameters and as part of the...
patient’s treatment package. All patients were scored using the PSFS (Stratford et al., 1995) prior to and at the end of the course of ESWT. It was not a randomised control trial or blinded study.

Response
Twenty four patients completed pre- and post-PSFS scales during the trial period. The pain sites of the patients seen were: Achilles (9), knee (2), lateral epicondylia (3), plantar fasciitis (6), infra patella (1), shoulder (3).

Seventeen of the 24 patients recorded a significant positive improvement in the PSFS measure. Therefore, 70.8% of patients had a significant positive change following the application of the ESWT. Seven of the nine Achilles patients treated with ESWT had a significant positive shift in their recorded PSFS outcome measure. Therefore, 78% of Achilles pain patients were improved with the use of ESWT.

The average PSFS score at pre-treatment was 3.5 and at post-treatment was 7.4; thus there was, on average, a 3.9 point shift in the PSFS recorded across the patients in this trial.

Clinical feedback
The feedback from physiotherapists using the ESWT machines throughout the trial was positive. The machine was used initially on some patients who had failed to improve with previous physiotherapy treatment, yet who went on to record improvements on the PSFS following treatment with ESWT. The physiotherapists also started to have a ‘feel’ for when they thought it would be appropriate for use. As a result, a shift began to occur in the success rate of its use. It was used less but with greater effect.

There were some patients who were not able to tolerate its use due to treatment discomfort, so for some patients who it was thought the shockwave would be an appropriate treatment choice, the treating physiotherapist was unable to use it due to patient’s compliance.

Conclusion
The ESWT trial undertaken within the Physiotherapy Department, West Cumberland Hospital demonstrated that 70.8% of patients who received ESWT as part of their treatment package recorded a significant positive outcome when comparing their pre- and post-PSFS measures. The recorded improvements may be even higher in particular sub-groups, although for most groups the numbers were too small to interpret meaningfully. However, in our trial, 78% of Achilles patients who used ESWT had a significant improvement recorded on the PSFS outcome measure.

This audit was only designed to review patients in the window period who had loan of the ESWT machines. As a result, our review has a number of limitations. These include a small sample size, no use of controls, an exclusion from the study of patients with incomplete data, varying number of treatments, variation in treatment parameters between patients even with similar conditions, and use of two different ESWT machines within the trial period. However, enough treatments were given in all cases to ensure that the treatment had time to take effect.

A larger and more robust trial is indicated to validate the results of this trial; however, the results are similar to those reflected in some of the published studies.

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Annotated bibliography
Eighty-eight percent of the ESWT group were pain free or had good results compared to 0% of the placebo group who were pain-free and 33% had good results. The results of this study corroborate the value of ESWT for recalcitrant plantar fasciitis as a non-invasive technique with low side effects; it can complement the conservative treatments.

Al-Abbad, H. & Simon, J.V. (2013). The effectiveness of extracorporeal shock wave therapy on chronic achilles tendinopathy: a systematic review. Foot and Ankle International, 34, 33–41 – Overall, review showed satisfactory evidence for the effectiveness of low-energy ESWT in the treatment of chronic insertional and noninsertional Achilles tendinopathies at a minimum 3 months’ follow-up before considering surgery if other conservative management fails. However, combining ESWT with eccentric loading appears to show superior results.


Kearney, R. & Costa, M.L. (2010). Insertional achilles tendinopathy management: A systematic review. Foot and Ankle International, 31, 689–694 – There is a consensus that conservative methods should be used before operative interventions. Current evidence for conservative treatment favours eccentric loading and shockwave therapy, although there is limited evidence by which to judge their effectiveness. Evaluation of operative interventions has been mostly retrospective and remains inconclusive.

Lee, S.Y., Cheng B. & Grimmer-Somers, K. (2011). The midterm effectiveness of extracorporeal shockwave therapy in the management of chronic calcific shoulder tendinitis. Journal of Shoulder and Elbow Surgery, 20, 845–854 – Due to variable treatment parameters (e.g. dosage), this review was unable to provide clear guidance of the dose-effect of the midterm effectiveness of ESWT. Studies of better methodological design using standardized treatment protocols and studies with longer follow-up are required.

Rompe, J.D., Furia, J. & Maffulli, N.J. (2008). Eccentric loading compared with shock wave treatment for chronic insertional achilles tendinopathy. A randomized, controlled trial. Journal of Bone and Joint Surgery, American Volume, 90, 52–61 – Eccentric loading as applied in the present study showed inferior results to low-energy shockwave therapy as applied in patients with chronic calcific tendonopathy of the insertion of the Achilles tendon at four months of follow-up. Further research is warranted to better define the indications for this treatment modality.


Rompe. J. D., Segal, N. A., Cacchio, A., Furia, J. P., Morral, A. & Maffulli, N. (2009). Home training, local corticosteroid injection, or radial shock wave therapy for greater trochanter pain syndrome. American Journal of Sports Medicine, 37, 1981–1990 – The role of corticosteroid injection for greater trochanter pain syndrome needs to be reconsidered. Subjects should be properly informed about the advantages and disadvantages of the treatment options, including the economic burden. The significant short-term superiority of a single corticosteroid injection over home training and shockwave therapy declined after 1 month. Both corticosteroid injection and home training were significantly less successful than was shockwave therapy at 4-month follow-up. Corticosteroid injection was significantly less successful than was home training or shockwave therapy at 15-month follow-up.
not attend’ (DNA) rate of more than 50%. The service was offered in three pathways representing increasing levels of severity and complexity. The majority of patients in all pathways improved and were satisfied with the service.

**Keywords**
low back pain; musculoskeletal physiotherapy; service development

**Introduction**
Approximately 30% of patients referred to the Cumbria Partnership NHS Foundation Trust Musculoskeletal (MSK) Physiotherapy Service, in one area of Cumbria, are referred because of LBP. The MSK physiotherapy team for this area undertook a four-month pilot, from January to May to redesign the service for patients with LBP. The team used the STarT Back predictor tool (Beneciuk et al., 2013) to stratify patients into one of three pathways. The aim of the pilot was to provide cost-effective treatment whilst simultaneously improving the quality of care, using current best practice.

Evidence shows that 94% of patients with LBP have a diagnosis that is mechanical in origin and 90% of these patients will improve with the correct advice and medication within six weeks. Five percent of patients will have unilateral nerve root involvement, with 50% of these patients improving within six weeks. The remaining 1% of patients will have ‘red flag’ symptoms that require urgent attention. Our objective for the redesign of the service was to target the patients most at risk of developing long-term LBP, who potentially wouldn’t improve without intervention. To reach this objective we provided an appointment within two weeks. The patients were assessed by an experienced member of the team, to provide the right amount of treatment at the right time.

Until recently, there has not been a validated tool to assess the risk of a poor clinical outcome around LBP, especially around the risk of developing long-term (chronic) pain and disability. The National Institute for Health and Care Excellence (NICE; 2009) points to the importance of not only assessing the mechanical reasons for LBP, but also assessing a broad range of other risk factors including fears and anxieties about pain, mood, and motivation, and also the patient’s work situation.

**Methodology**
The total number of referrals to the physiotherapy service received each year was calculated from the previous three years’ data; this indicated that 30% of patients were referred for LBP. Following an initial two-month audit, we predicted the percentage of patients who would be stratified into each of the three pathways (low risk, medium risk, and high risk). Using this information, we created assessment clinics to accommodate patients referred with LBP and increased the assessment clinic capacity by 10–15% to allow for an initial potential increase in the referral rate to the new service. We allocated experienced team members to assess the patients on their initial appointment. Assessment clinics consisted of five or six 30-minute assessment slots across four clinical sites in the same areas. A broad spread of days and times were offered to meet patient needs, including some early evening appointments. We ensured there were sufficient resources within the team to accommodate the predicted number of patients that needed further appointments following the initial assessment.

**Improving services during the redesign**
• Additional ‘back classes’ and acupuncture clinics for patients in pathways 2 and 3 were created to comply with NICE (2009).
• Links were made with Carlisle Leisure Limited (CLL) to look at the feasibility/cost implications of running classes within the CLL facilities.
• Prior to the redesign, a member of the team was trained in psychologically informed physiotherapy (PIP), and during the pilot all staff had additional training on the management of chronic LBP and long-term conditions.

**Measures**
• The STarT Back screening tool is a brief prognostic tool to assist clinicians to develop appropriate initial treatment pathways. The tool has been tested for psychometric properties, including reliability and validity in different settings internationally (Hill, 2011).
• The patient-specific functional scale (PSFS) outcome measure would measure the effectiveness of the treatment/advice given. The PSFS has been shown to be valid and responsive to change in musculoskeletal conditions such as neck pain, cervical radiculopathy, knee pain, and low back pain (e.g., Chatman et al., 1997; Pengel et al., 2004). The outcome is patient centred with the patient specifying problems/goals of treatment.
The STarT Back screening tool and the PSFS outcome measures were completed before the first assessment and once again upon discharge. Patients stratified to pathway 1 were contacted by phone/letter to complete the outcome tools, approximately six weeks after the initial assessment.

**Patients taking part in the pilot**

We were able to compare activity within the pilot compared to the four-month period of the previous year. In 2012, there were 300 people referred; in 2013, during the pilot there were 405 people referred. This is an increase of over 30% in assessment appointments. In 2012, there was a DNA rate of 22%; in 2013, during the pilot there was a DNA rate of 10%. In 2012, the waiting time was over six weeks; in 2013, during the pilot the waiting time was less than two weeks.

A total of 380 patients were included in the pilot, 38 (10%) did not attend, 87 (23%) were in pathway 1, 153 (40%) were in pathway 2, and 102 (27%) were in pathway 3.

**Outcomes**

**The STarT Back tool** provides a consistent measure of the broad impact of the back problem for an individual. A lower score would indicate a lower risk of developing long-term chronic LBP (Hill, 2011). For pathway 1, the pre-treatment average score was 2.25 and at discharge it was 0.8. A total of 77% of the group improved in this period, 12% stayed the same, 11% of the group were worse at discharge. For pathway 2, the pre-treatment average score was 4.0 and at discharge it was 1.1. A total of 85% of the group improved in this period, 15% stayed the same, and none of the group was worse at discharge. For pathway 3, the pre-treatment average score was 6.3 and at discharge it was 2.6. A total of 92% of the group improved in this period, 8% stayed the same, and none of the group was worse at discharge.

The average overall improvement for all patients across the three pathways was good. Most patients have lowered their risk of developing chronic LBP. Unfortunately, a small proportion in pathway 1 had a score which became worse; these patients were picked up through the six-week ‘SOS’ system where patients are encouraged by the Physiotherapists to contact the department if they are not improving.

**PSFS** is used at pre-assessment and on discharge. A minimal detectable change is set at 2 points: 90% confidence interval (Stratford, 1995). The higher the PSFS score, the better the outcome for the patient. For pathway 1, the pre-treatment average score was 5.3 and the discharge average score was 7.4. A total 80% of the group improved in this period, 9% stayed the same, 11% of the group were worse at discharge. For pathway 2, the pre-treatment average score was 3.6 and at discharge the average was 6.7. Some 91% of the group improved in this period, 6% stayed the same, and 3% of the group were worse at discharge. For pathway 3, the average pre-treatment score was 3.3 and at discharge the average score was 6.3. A total 94% of the group improved in this period, 6% stayed the same, and none of the group was worse at discharge.

The average PSFS outcomes have increased in all pathways. Most pathway 1 patients improve with only a minimal package of care; a small proportion in pathway 1 had a score which became worse; these patients were picked up through the six-week SOS system.

**Patient experience**

Questionnaires were posted out to 50 patients from pathways 1, 2 and 3: these questionnaires included a self-addressed envelope for the Patient Experience team at the Carleton clinic.

For pathway 1, there were 22 responses (44% of the total); 58% reported they were very satisfied with the service, 27% were satisfied, 5% were uncertain, 5% were dissatisfied, and 5% were very dissatisfied. Positive comments related to the effectiveness of the treatments and positive views on the clinicians involved. Areas that could be improved were the time offered in the appointment, the environment of the appointment, and there were two comments on the difficulty of using the booking system.

For pathway 2, there were 23 responses (46% of the total responses); 65% reported they were very satisfied with the service, 13% were satisfied, 9% were uncertain, 9% were dissatisfied, and 4% were very dissatisfied. Positive comments related to the effectiveness of the treatments, positive views on the clinicians, and overall service involved. Areas that could be improved were discussion of possible side effects of treatment (soreness), and the gap between initial assessment and follow-up treatment.

For pathway 3, there were 15 responses (30% of the total responses); 80% reported they were very satisfied with the service, 13% were satisfied, 7% were uncertain, none...
were dissatisfied or very dissatisfied. Positive comments related to the effectiveness of the treatments, positive views on the clinicians, and overall service involved. One respondent felt there was nothing that could be done to help them.

**GP experience of new service**

There have been no complaints from the GPs in the local area. However, despite sending questionnaires to all GP practices and emails to all practice managers, there has been no response from any of the GPs. The Commissioning Officer for the Carlisle Locality also discussed the questionnaire with the Carlisle Practice Managers at their July 2013 meeting. We therefore presume that GPs in the Carlisle Locality are not unhappy with the redesigned service.

**Staff experience**

There was generally positive experience reported by the staff involved. Comments included:

- **Good to see patients in less than 2 weeks from referral** – reduced DNA rate and less frustrated patients due to the reduced wait. We have learnt how to be more streamlined with assessments.

- **We have gained confidence that patients from Pathway 1 do not need a review appointment in the majority of cases.**

- **Great to identify P3 patients** – so I can give them increased input to improve their outcome to treatment.

Some concerns were expressed, these included:

- **Feel it is not equitable to see patients with LBP in less than 2 weeks** – yet there is a larger waiting list for conditions that are not LBP.

- **Feel 30 mins is not long enough to assess/ and give advice to patients on P1** – feel rushed with some patients.

- **A clinic of 5-6 LBP patients is exhausting and don’t look forward to the clinics.**

- **Some clinicians do not feel adequately trained in PIP for P3 patients.**

These concerns are being addressed by increasing the assessment slots to 45 mins to improve patient and staff satisfaction with the service: this would mean 40 mins for assessment and advice with 5 mins for paperwork after each assessment. An additional one day PIP training, focusing on low back pain, was completed in December 2013 for those staff who identified this as a personal development need, and a service development day in October 2013 looked at a possible service redesign for the remaining 70% of the service.

**Conclusion**

The aim of this pilot was to redesign the MSK physiotherapy service for patients with LBP in one area of Cumbria. Patients were stratified into one of three pathways using the STarT Back predictor tool (Hill, 2011) and appropriate treatment plans were developed, alongside best practice. We aimed to see all patients in less than two weeks, with patients being assessed by an experienced member of staff. Between January 2013 and May 2013 there was an increased referral rate into the LBP service by 30%, with a simultaneous reduction in the DNA rate of more than 50%. We aimed to improve patient, carer, staff and gp experience of the MSK physiotherapy service. Overall the team have achieved these objectives. The team were able to provide cost-effective treatment whilst simultaneously improving/maintaining the quality of care.

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REFLECTIVE PRACTICE/CASE STUDIES

Care and confinement: A reflective overview of mental health service development in Lancaster and the UK

Edward Fearnley

Abstract
This article examines the development of mental services in the UK, with a particular focus on Lancaster. The changing treatment of and perspectives on mental health and their relationship to changes in society, wider medicine, and the legal system are reflected on; as are the reasons for the institutional models that occurred in previous centuries.

Keywords
mental health; Lancaster; psychiatry; asylum; reflection

Introduction
Health services are undergoing a major transition. The NHS is facing significant financial pressure and The Health and Social Care Act (Department of Health, 2012) is driving a reorganisation of services. In Lancaster, the city is venue to a historic county asylum, and in 2009 the local mental health trust announced that the acute adult inpatient service would move to a community setting. It is therefore opportune to examine, compare, and reflect on previous development of mental health policy, delivery, national trends, and the impact of broader social change.

Before the asylum era
Care of those with mental illness was predominantly laissez faire prior to the 18th century. Modern psychiatry was non-existent and formal organisation of mental health services had not been considered. Writing on madness had survived from Ancient Greece and in 1621 Robert Burton wrote *An Anatomy of Melancholy*; one of the first modern textbooks on the subject. However, the aetiological basis of madness remained both divine in origin and focused on the ‘four humours’ (Porter, 2002). Porter identifies that the majority of inpatient care was provided in small-scale private madhouses, often managed by a solitary medical attendant. A notable exception is Bethlam hospital in London (originally opened in 1247 and the etymological origin of ‘bedlam’).

Changing minds – the case of James Hadfield
The crescendo of the Enlightenment encouraged a re-evaluation of madness. The archetype of this ‘age of reason’ was the Quaker-run York Retreat (established in 1772), which promoted a humane and moral treatment of mental illness (Digby, 1985). Public perception of madness was also affected after James Hadfield attempted to assassinate the reigning monarch, King George III. It was possible to ‘plead insanity’ but this demanded that the defendant was "lost to all sense ... incapable of forming a judgement upon the consequences of the act which he is about to do" (Moriarty, 2001). In this case, Hadfield had planned his actions, meaning that he was considered legally sane. However, it was clear that he was suffering from delusions, and Thomas Erskine (the defending barrister) challenged the law, arguing that as Hadfield did not fully appreciate his actions, he did not commit treason. The Judge, Lord Kenyon, also described the verdict as "clearly an acquittal" but "the prisoner, for his own sake, and for the sake of society at large, must not be discharged" (Moriarty, 2001). An Act of Parliament was necessary to change the law, and now a ‘not guilty’ verdict was possible on the grounds of (latterly known as) ‘diminished responsibility’. This was a dramatic and sympathetic change of legal and public perception of mental illness. The high profile of the case confirmed that it was rapidly becoming an important medical, social, and legal issue.

Lancaster County Asylum (1816–1840)
The 1808 County Asylums Act enabled local magistrates to commission rate-supported asylums and 1816 marked the opening of the County Lunatic Asylum for the County Palatine for Lancaster. This was the fourth asylum in the country built after the Act and, by 1836, patient capacity had increased to 406 (Williamson, 2002).
When the asylum was first opened the profile of patients also differed significantly from the profile that would be found today. For example, mothers of illegitimate children, vagrants, and other marginalised members of society were frequent attendees at the asylum. This demonstrates the dearth of alternative social support and reflects wider religious and moral values of the time. Mental illness associated with older age was less prevalent, as the percentage of people over 65 in 1881 Lancaster was 4%, compared to 17.8% in 2001 (University of Portsmouth, 2014). Additionally, tertiary syphilis accounted for approximately 20% of psychiatric admissions prior to the advent of penicillin (Friedrich & Geusau, 2009). Hypoxic brain injuries from complicated, prolonged labour were also more prevalent. This vividly illustrates the impact that antibiotics and obstetric techniques have played in transforming the nature of psychiatric morbidity.

**Conditions and treatments (1841–1857)**

In 1841, a local physician and surgeon, Dr Edward de Vitre and Dr Samuel Gaskell, co-authored a report of the Lancaster County Asylum (Williamson, 2002) describing the conditions and treatments they encountered. The asylum now housed over 530 patients and it appears that gastro-enteric infections were prevalent "of which many of the patients died within a few weeks". They also described an "extensive use of mechanical restraint". This was partially consequential of overcrowding and restraints used on "idiotic and violent patients, and those of filthy habits" included handcuffs, leg locks, and straight waistcoats.

However, the first Superintendent and resident surgeon, Paul Slade Knight, demonstrates a degree of compassion by demanding "good, moral and religious characters" as staff (Williamson, 2002). Whilst it is unwise to categorically deny that incidences of abuse occurred, the evidence in Lancaster is antithetical to the cruel asylum superintendent caricature. It is also unsurprising that Victorian asylums were custodial in nature. With no effective drug therapies available for the treatment of psychotic symptoms or effective sedation, confinement was often a practical compromise. Nevertheless, the tenure of Dr de Vitre (of which De Vitre House in Lancaster is eponymous), coincided with the abolition of mechanical restraint at the asylum, as an atmosphere of persuasion over coercion appears to have been adopted. Patients were increasingly free to move around the asylum, the gardens were landscaped and occupational therapy was introduced. Visitors included Charles Dickens and, in 1846, commissioners reported patients to be "clean, tranquil and in a contented state with few exceptions" noting the development of a therapeutic community (Williamson, 2002).

**Continued expansion and change (1858–1916)**

During this period, the state became increasingly interested in social control and welfare. The metropolitan police force was established in 1828 and, in 1870, the Elementary Education Act introduced the beginning of universal education. The public health reforms of Edwin Chadwick had been progressing since the 1840s and the 1834 Poor Law meant that many previously reliant on community support now migrated into the workhouses. Reflecting this, the 1881 census reveals that 99 resided in Lancaster’s Union workhouse and by 1883, the asylum (now with an annex extension) had 825 beds (Higginbotham, 2011). The Royal Albert Hospital opened for the care of children with intellectual disabilities in 1870 and was later opened to adults in 1913.

The 1890 Lunacy Act recognised that those "of unsound mind" were to receive inpatient care. Now administered by Lancashire Asylums board, Lancaster witnessed a further expansion in patient numbers (Roberts, 2005). The reasons for this mass confinement are complex and multifactorial. Pertinently, the industrial revolution catalysed unprecedented urbanisation in Lancashire. Arguably, this massive societal change was accompanied by increased vulnerability, recognition, and decreasing tolerance of mental illness. Whilst inpatient care was necessary (asylum is Greek for ‘refuge’) the removal of patients from society fostered stigma of the ‘unknown’, institutionalisation, and deskilled long-stay patients. The place of refuge often became a place of lifelong confinement.

In 1916 the "Ladies’ and Gentlemen’s villas" (eventually Ridge Lea Hospital and Campbell House) were constructed and, in 1929, the asylum was renamed the Lancashire County Mental Hospital. Williamson (2002) cites the motivation for the villa as due to the families of wealthier patients objecting to the class diversity present at the asylum. This provides an interesting commentary of how openly class divided British society was a century ago.
Lancaster Moor Hospital, the National Health Service and beyond (1948–)

In 2000, Lancaster Moor Hospital closed for the last time, following a sequence of events over half a century. The NHS was founded in 1948 and was an antecedent to the Mental Health Act in 1959 (Parliament, 2007). Patients were now entitled to attend hospital voluntarily, rather than being committed for a prolonged time. ‘The Moor’ was converted into a ‘comprehensive hospital’ with the addition of elective surgery and physiotherapy. Yet whilst the hospital’s population peaked over 3000 in 1940 (Williamson, 2002) the age of the Victorian asylum was already over.

The psychopharmacological revolution of the mid-20th century had meant that active treatment was quickly replacing long-term confinement. The Griffiths Report (1988) recommended flexible care packages and more patients were now receiving community care. By 1999, all but 22 of Britain’s 130 asylums had closed. Edward Shorter (1998) recognised that asylums had been chronically underfunded over this time of unprecedented demand, leading to a decline in quality. This pressure was compounded by the antipsychiatry movement, who challenged conventional wisdom surrounding long-term confinement (Paulson, 2012). Whilst closures ensured that patients no longer orbited the asylum and provided patients with independence, adequate support did not consistently follow.

Conclusions

The history of Lancaster’s mental health services, in context of wider development, is extremely relevant. It describes the evolution of British psychiatry and also broader societal changes. Mass confinement coincided with urbanisation, state intervention, mass movement of people, and the scientific enlightenment. Medical advances created an optimism for cure, if not always care, and whilst mechanical restraint must not be excused, it does, however, reflect the compromise involved with underfunded services and, more positively, how medication has subsequently transformed management.

Despite the spectre of mass confinement, it is important to ensure that hospitals remain available for the very ill. In context of bed reductions, it is vital to reiterate that all areas of medicine are migrating to the community, as demand shifts towards chronic conditions such as diabetes, cancer, and dementia. This is likely to continue as GPs receive further commissioning responsibilities. The history of mental health must be retained, as not only does it contextualise present services and attitudes, but also advises on how to approach future challenges.

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References


Improving practice in pressure ulcer grading and the prevention of pressure ulcers

Janet Lancaster

Abstract
The study reflects upon introducing and managing change in order to improve the skills and knowledge around pressure ulcer grading and the prevention of pressure ulcers on a 20 bedded step up/step down (SUSD) unit based within an acute hospital. The report is based on a Masters dissertation submitted as part of the MSc in Advanced Practice in Health and Social Care, NMLB 7071.

Keywords
pressure ulcer; practice development; grading; prevention

Introduction
The full report on this piece of work (available from the author) overviews significant literature pertaining to pressure ulcer grading and prevention, offers a critical discussion of change management theories, and discusses time spent observing practice to identify where the problems lay and gain insight into the ability of nurses to accurately grade pressure ulcers. This brief report is a reflective article that considers the change processes that were important in engaging the systems and effecting positive outcomes. The report first identifies the change activities from the project, and then reflects on the change and evaluation processes that were important in the project.

The change activities
1. The first activity involved observing current practice and carrying out a pressure ulcer grading test in which nurses’ accuracy in grading pressure ulcers was established. Feedback on this was provided in the form of a report for managers and in clinical meetings with staff. Feedback provided an opportunity to report areas of good practice but also identify resisting and driving forces in order to facilitate moving forward (Lewin, 1951). By identifying and highlighting problem areas I hoped to empower people to take action that would improve practice (Patton, 1994).
2. The ward introduced the ‘safety cross’ which provides a monthly snapshot of pressure-ulcer-free days and pressure ulcers transferred or developed on the unit (Healthcare Improvement Scotland, 2011; Whitlock et al., 2011), the nursing staff took ownership of completing it daily.
3. I adapted the colour EPUAP (European Pressure Ulcer Advisory Panel) tool incorporating moisture lesions as well as pressure ulcers and this was trialled by a small focus group to identify any problems in the design that might need to be modified (Polit & Hungler, 1997). Inter-rater reliability was checked and, although only a small sample was assessed, the accuracy in grading was good compared with previous assessment of inter-rater reliability using the black and white EPUAP tool.
4. I condensed the National Institute for Health and Care Excellence (NICE; 2005b) guidance for patients on pressure ulcers so that it was easier for patients to understand, thus making it more user friendly, as involving individuals in their own care is said to achieve a higher degree of concordance (James, 2010). The information was made into a booklet for staff across the Trust to give to patients/carers.
5. I conducted an audit of the SSKIN bundle tool looking specifically at the quality of the information on the tool. This provided objective evidence and supported the need for further training and education. Acknowledging that in the area of clinical audit I was a novice (Benner, 2001), I enrolled the support of the clinical audit team and attended a study day looking at all aspects of the clinical audit process. I put forward an audit proposal based on SMART (specific, measurable, achievable, realistic, and timely) objectives which was accepted by the clinical audit team. I devised an audit tool which aimed to assess the quality of the information documented on the SSKIN bundle. The audit was completed on all patients on the SUSD unit on a given day; the results corroborated my findings from
observation that the SSKIN bundles lack documented evidence to support the fact that effective strategies are in place to prevent avoidable pressure ulcers from occurring (Welford, 2006). The audit was identified as a priority audit within the locality, therefore, following analysis of the findings, recommendations/actions were made in conjunction with senior management, thus ensuring high-level support in making change happen.

The change process
In this section I reflect upon the processes involved in implementing change. In this I used ‘force field analysis’ (Lewin, 1951) which identifies forces that drive change and those that resist change, with the intention of working on both factors in developing the project.

A consideration of driving forces suggested that, while internal stakeholders such as the SUSD unit staff had considerable influence on the proposed change, external stakeholders were equally as important (Hayes, 2010). Through the report on observations of practice on the SUSD unit I was able to gain high-level support in driving change forward. National targets and processes such as Commission for Quality and Innovation (CQUIN) were also driving forces supporting this project, (NPSA, 2010). Another driving force was my desire to improve practice on the unit; as internal stakeholders, the unit staff also needed to share this desire as they were influential in the success or failure of the proposed change.

The initial feedback gave the staff an understanding of why practice needed to improve, however, there were still resisting forces that had to be overcome in order to push people in the desired direction (NHS Institute for Innovation and Improvement, 2005). Lewin (1951) advocates spending more time on driving forces as opposed to expending energy on the resisting forces, however, it was important from the outset to recognise areas of resistance in order to identify strategies to overcome them. Motivating the staff at a time when they felt vulnerable due to other organisational changes was a challenge (Bridges, 2009). Many of the staff had been working together within the same area for many years; the way things are done within teams are heavily influenced by shared unwritten rules which can be one of the most powerful parts of culture (NHS Modernisation Agency, 2005).

Discussions with staff members highlighted issues around roles and clarification of my place within the hierarchy. It was important not to be seen as a threat: my role was not that of a manager but of a clinical leader aiming to facilitate the development of best practice. Anderson and Ackerman Anderson (2001) argue that change agents sometimes need to look beyond external barriers to change and look internally at themselves. Self-awareness and advanced interpersonal skills were essential in helping me to recognise when I needed to modify my approach in order not to alienate individuals. On the other hand, working on the unit enabled day-to-day communication and embedding of my values and beliefs through my actions, reflecting the qualities of congruent leadership and being a role model for staff (Stanley, 2008).

Congruent leadership occurs where clinical leaders translate their values and beliefs about care and nursing into actions (Stanley, 2008); nursing clinical leadership involves working closely with other nurses, sharing their values and living them out in action. Cain (2005) maintains that leaders need to earn the right to lead, by being a visible presence, directly involved in not only providing quality clinical care but also inspiring others to improve their practice which brings respect and credibility and encourages others to follow. Congruent leadership is said to fill the gap for those nurses with leadership skills who want to stay by the bedside or in strong clinical posts as opposed to moving into traditional leadership that is affiliated with a leadership or management function (Stanley, 2008).

I saw my role as having a visible presence and was keen to share my values and beliefs but recognised that as a clinical leader it was important to empower and develop others. Rogers’ (2003) theory of diffusion describes how innovations diffuse through social systems; ideas are initially adopted by innovators before diffusing down to early adopters who then spread the idea to the early majority, then late majority, and finally to the laggards (Giddens & Walsh, 2010). I considered myself to be the innovator but required early adopters to help diffuse the idea through the rest of the team. One of the registered nurses, who took on the role of Tissue Viability Link Nurse, represented an early adopter (Rogers, 2003), and she was encouraged to attend the Tissue Viability Link Nurse Meeting which is an educational forum whereby link nurses can increase their knowledge then cascade to other members of their team. Supporting the link nurse by ensuring she was given the time out from the ward to attend the meeting was an important
Evaluation

Ovretveit (1998) argues that evaluation can be viewed from one of four perspectives (Experimental, Developmental, Managerial, and Economic). Developmental evaluation tends to take a more flexible and inclusive approach to change, allowing those affected by the change to reflect on problems encountered and formulate actions to overcome them (Lazenbatt, 2002). It was felt to be the most appropriate type of evaluation to utilise within this project where my role as a clinical leader has been to motivate and innovate staff to learn and develop, exploring potential solutions with the team.

Evaluating improvement in practice is an ongoing process (Redfern & Christian, 2003). Ongoing evaluation was an important part of the change management strategy used within this study, as it provided a cyclical process of collecting information through observation, providing feedback, and making actions based on the latter. Formative feedback/evaluation was delivered through focus groups and clinical meetings. Bridges (2009) suggests that constant feedback and communication helps people through the transition and forms part of the ongoing cycle of evaluation. The feedback session provided impetus for the team to identify strategies for improvement.

Outcome evaluation was used to assess whether the interventions introduced within this project achieved the aims and objectives with regards to the ability of nursing staff on the SUSD unit to accurately grade pressure ulcers and determine whether current practice in respect of prevention and management of pressure ulcers reflect the recommendations of NICE (2005a). As identified through the SSKIN bundle audit, there was 100% compliance in the use of the tool, however, staff often failed to provide evidence of prevention and management strategies for those who had a pressure ulcer and those at risk of developing one. Lazenbatt (2002) suggests that as well as measuring the extent to which the intervention has achieved its objectives, other outcomes such as Effectiveness (does it work in everyday practice?), Efficiency (how well resources are used), Equity (the extent to which everyone, ideally, has a fair opportunity to attain full health potential), and Economy (costs such as staff, materials, facilities and the benefits of the intervention such as changes in attitudes and knowledge) are important; economy is threaded throughout the indicators so is not considered in isolation.

In order to monitor effectiveness of intervention, the safety cross was introduced. As well as supporting data collection, the safety cross acted as a visual tool to monitor monthly performance. It was also useful as...
Improving practice in pressure ulcer grading

a learning tool to discuss good/poor practice within teams and identify learning needs, as it generated discussion around whether an ulcer could be defined as avoidable or unavoidable, which is undoubtedly an important factor with regards to CQUIN targets (Black et al., 2011). Completing incident forms with the staff enabled us to look in more detail at why the pressure ulcer had developed and whether prevention strategies had been put in place in a timely manner. Recognising skin changes and accuracy of grading was highlighted to be extremely important; for example, if skin changes were documented stating ‘reddened area’, but not followed up as to whether it was ‘blanching or non-blanching’, indicating a grade 1 pressure ulcer, then skin integrity could deteriorate further (EPUAP/National Pressure Ulcer Advisory Panel (NPUAP), 2009). Initial feedback regarding the use of the adapted pressure ulcer grading tool is positive and inclusion of moisture lesions in the tool was said to be beneficial, as it increased awareness of the difference between moisture lesions and pressure ulcers (Bianchi, 2012). Local data show an increase in reported pressure ulcers from the unit, but, as highlighted in other studies, increasing awareness often leads to increased reporting (Phillips & Buttery, 2009).

Organisations tend to use data-gathering measures to evaluate and improve care, but also to identify compliance or variation from policies and procedures (Ovretveit, 1998). Locally, the Trust use the NCSIs to evaluate compliance with local and national guidelines (NICE, 2005). Conducting an audit of the quality of the information on the SSKIN bundle was a means of determining its efficiency. By completing the audit myself, extra resources were not required and it was, therefore, economical in terms of cost (Lazenbatt, 2002). A re-audit of the SSKIN bundles is planned for six months’ time, thus forming part of the ongoing evaluation process that is needed in order to achieve long-term sustainability of change (Lewin, 1951).

Equity is concerned with everyone having a fair opportunity to achieve the best care possible and receive evidence-based care with the aim of reducing risk of harm (Lazenbatt, 2002). Monitoring standards on the unit over time with regards to incidence of avoidable pressure ulcers will help determine whether change management strategies introduced within this project improve practice in terms of detection and prevention of avoidable pressure ulcers. Senior management support has influenced Trust-wide adoption of the adapted EPUAP tool, safety cross, and adapted NICE (2005b) guidance for patients booklet, thus sharing good practice across the wider locality.

Conclusions

Although progress to improve practice has been much slower than anticipated, I feel that my participation and input in facilitating change within the SUSD unit has been a success. Through the work I have been doing during the course of this project, there has been a substantial advancement in knowledge and understanding of non-qualified and qualified staff around the subject of pressure ulcer grading and prevention of pressure ulcers. Evaluation of the project so far has highlighted the benefits of using an action research approach as a means of identifying problems, and working closely with staff to find solutions and develop action plans to improve practice. Working on the SUSD unit has helped to create an environment where staff are encouraged to talk about pressure ulcers and consider strategies that are based on best practice and up-to-date evidence in order to prevent ulcers from occurring (Elliot, 2011). It is recognised that there are areas for improvement and, by observing practice so closely, other issues have emerged that have not necessarily been the focus of this study but are nonetheless important and have implications on the delivery of care (Polit & Hungler, 1997). Ongoing work is needed around reassessment of wounds and completion of wound care documentation in order to provide objective evidence of continuous management. Further discussion is also needed around the care of patients who are seated to address the issues highlighted around chair height, redistribution of weight, and pressure-relieving cushions.

Involving staff in the process of change has been challenging, however, education and congruent leadership has helped with the transition by motivating individuals to change and feel part of the change process. There are still those who will only change at their own pace (Rogers, 2003), nonetheless, they have a professional requirement to continually update after qualification and, through the influence of others, will recognise they have a part to play in improving their own knowledge and skills in order to improve practice (Nursing and Midwifery Council, 2008).

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The development of theory in narrative family therapy: A reflective account

Jo Wilcox

Abstract
In this paper I will discuss the position of narrative family therapy within the history and context of the broader church of family therapy and systemic practice. I will then consider, critically, the implications for the development of my own practice as a children’s community learning disability nurse using narrative therapy ideas.

“Experience is not what happens to a man; it is what a man does with what happens to him”
Aldous Huxley (193, p. 5)

Keywords
narrative therapy; family therapy; systemic practice; reflection

What narrative therapy?
Stories and narratives have existed for as long as humans have had language. They have brought meaning to the world, and have allowed for history and tradition to be related through generations. How we respond to stories, or narratives, is the concern of narrative therapy; both the ones we create ourselves but also those that are ascribed to us by others, culture, and wider society. Through narrative therapy, in collaboration with a therapist, it is suggested a person can discover and re-author their own problem-saturated stories (White & Epston, 1990).

I was initially overwhelmed by the variety and breadth of models and theories to choose from, but during the last two days of my family therapy and systemic practice training many things started to make sense. I was able to consolidate my understanding of the history and context of family therapy; this in turn allowed me to consider more fully my own epistemological position and current practice in relation to a number of family therapy developments and models. I realised that many of the ideas in narrative therapy not only felt very coherent with my philosophical stance, but also mirrored aspects of how I currently work. I have also considered how I could better incorporate these ideas in a more ontologically secure way into my practice that recognises the origins of some of my thinking regarding work with children and their families. It has allowed me to see the nuanced differences that there are with some other aspects of how I work with families that at first sight may appear to be narrative in nature but are actually based within a different theoretical frame.

Narrative therapy resonated very much with the philosophy of working with people with learning disabilities, and reacquainted me with Goffman (1961) which is a key text when considering the effect of ‘total institutions’ and that disability is a construct created by society rather than an objective truth. The other aspect that drew me to this model was its collaborative nature, which is how I currently work. It also fits with the use of person-centred planning: a predominant philosophy in learning disabilities practice (Department of Health, 2009) whereby clinicians support people with learning disabilities to make their own decisions about their lives no matter how disabled they may be judged by society.

The development of narrative therapy
Narrative therapy was co-developed in the 1980s by Michael White, based in Adelaide, Australia, along with David Epston, based in Auckland, New Zealand (Carr, 2000). White and Epston were very influenced by the post-modernist and social constructionist movements.

The first development of family therapy was Minuchin’s structural family therapy followed by the second phase of constructivist family therapy that included both the strategic and Milan models. Narrative therapy was in sharp contrast to these two perspectives particularly in its stance against individual diagnosis and systems theory (Carr, 2000), and yet aspects of these models still inform parts of narrative therapy and are acknowledged in individual therapists’ personal development journeys (Hayward, 2003). Narrative therapy was also informed by wider sources such as post-structuralist philosophy, anthropology, and
feminist therapy (e.g., Carr, 2000). Narrative therapy is grounded in many of Foucault’s ideas around power/knowledge and also ‘truths’ that become such because they have been ascribed as such by society or political mores (Besley, 2002).

Etchison and Kliest (2000) ask why there is such a small evidence base with narrative therapy despite it being an established family therapy approach for more than a decade. Larner (2004) suggests that the way research is considered is so skewed towards empirical evidence bases that social constructionist approaches do not fit, or even strive to fit. As he says, narrative therapists tend to evaluate their efficacy through dialogue with individual clients rather than research studies.

There is an emphasis on language and communication in narrative therapy. Familiar words may be used with new or specific meanings and there may be very deliberate use of non-stigmatising terms that avoid traditional expert terminology (Besley, 2002). It is suggested that the problems that people present with come from a conflict between what they themselves believe about their own experience and dominant oppressive narratives imposed by others. Narrative therapy challenges the biomedical model that locates the problem within the person. Problems are viewed as separate from the person and there is an assumption that the person will have the strengths and capacity to change their relationship with their problem (Morgan, 2000).

Narrative therapy “centres people as the experts in their own lives” (Morgan, 2000, p. 4). Therefore the positioning of the therapist is important; rather than an expert they become a collaborator who acts as a consultant guided by the direction the individual wants to go. Therapy should not be concerned with beginnings and endings but with “creating space for a specific kind of conversation between participants” (Boston, 2000, p. 451) where the therapist is curious and comfortable ‘not knowing’.

In narrative therapy it is believed there can be many stories happening at the same time for a person both positive and negative. They will be to do with the past, the present, or the future and there will also be stories from wider contexts such as the family, community, and society. Narrative therapy aims to allow a person or family to re-author their stories so that they feel cogent with the way they live and so perceive things in a better frame (Carr, 2000). I find this a very useful lens to have when I am working with families where a disability is not going to be ‘cured’ or go away and where the family will continue to have difficulties. If they are able to consider an alternative story to the dominant one, they may find it less difficult to bear.

**Narrative therapy and my own practice**

When considering my own practice and narrative therapy I was very influenced by an article by Alice Morgan (2002). She discussed how she had been intimidated by the thought of a ‘pure’ model that she did not feel competent enough to adopt. She then started to notice what she was already doing that was within the narrative model and incrementally built on this. I liked this idea and started noticing what within my current practice I do and could develop.

**Positioning of the therapist**

There is much literature describing narrative therapy and its philosophical position (Carr, 2000; Morgan, 2000); however, there are still challenges to both its epistemology and its applicability. Carr (1998) suggests that it is important to be aware of the tension between the power that will be inherent for some clinicians working with a family and the need to take a collaborative position with the family that does not strengthen the oppressive dominant narrative. Due to the nature of my role it is difficult for parents not to come with a view of me as an expert in learning disability, autism, or behaviour, and sometimes they are actively seeking this. When I first meet with them I try to engender a collaborative approach that positions them as the expert with their child, or, with older children, them as the expert of their lives. I am there to ask questions and provide guidance directed by their needs.

I am mindful of the danger of a label or biomedical description defining an individual and their perception of themselves. Where I differ from the strict interpretation of a social constructionist, narrative therapy philosophy is in my belief that labels can sometimes be helpful to both the individual and the people around them in understanding the behaviour of that person and offering them appropriate support. This has been based on my experience working with parents and individuals with different conditions, and those with uncertain aetiology, and what they have said from both sides of the argument. In trying to show a different perspective to the ‘problem-saturated descriptions’ of the child with a disability I do, however, often offer a parent the chance to look at their problem with a different lens than the
The development of theory in narrative family therapy: A reflective account

Larner (2004, p. 19) describes narrative therapy as a collaborative and reflective form of therapy, the person’s language and agency is given priority rather than a particular model or technique”. I currently write my notes on carbonated sheets whilst I am with the family and am explicit that the copy I keep is what constitutes their notes. This allows for openness and for them to be able to hold a record of what we have discussed. I try to use their words and terms as I write; I also offer suggestions or ask questions. Particularly after reading some of the ways Epston (2008) writes to individuals and families, I feel this is something I could develop more fully.

Mapping the influence of the problem
Although narrative therapy is not focused on the problem, it does acknowledge its influence. This helps with identifying a person’s strengths, resources, and exceptions to the problem (Lambie & Milsom, 2010). This creates the context for externalisation. I have found that I am currently often “mapping the influence of the problem” (Guterman & Rudes, 2005, p. 4) with families, but was not aware it was part of this model as I was more familiar with exceptions to their problems, and I will also try to look to the future to help them plan their steps to new alternative outcomes.

Externalisation
I was surprised at how much externalisation I already do in my practice. Sometimes it is closer to the externalisation as described by narrative therapy practitioners (Epston, 2008; Morgan, 2002) but I note now that some other similar techniques which I may initially have taken for part of narrative therapy are subtly different and therefore work slightly differently, such as Social Stories (Gray, 2010), Comic Strip Conversations (Gray, 1994), or social scripts (Byng-Hall, 1995). I find for a lot of people I work with analogy, metaphor, and descriptions, supported with pictures or objects, can really help them to understand complex or abstract topics.

Where I have not used externalisation so much is with young people regarding their view of themselves as learning disabled (Lambie & Milsom, 2010) and I feel this is an area I could usefully develop for some of the young people I work with.

Unique outcomes and thickening the plot
Whilst mapping the influence, and subsequently externalising the problem, the therapist needs to be attuned to the person’s accounts of their strengths, resources, and when the problem is not occurring. They need to identify these points as ‘unique outcomes’ (Goffman, 1961) and provide ways to re-author new stories.

There are often many reasons for someone to have held on to a particular story of a problem for themselves and these problem-saturated stories will often have been developed over a number of years. The new story needs to be potent enough to replace the old one and this can only happen through developing detail or thickening new plots (Carr, 1998). This can be done using landscapes of action questions around the events, sequences, time, and plot, and landscapes of consciousness questions that relate to meaning, effects, evaluation, and justification. These two domains and their distinctions were first described by Bruner (in Carr, 1998). From this thickening of the plot, links need to be made with past events and then into the future and how things could be without the problem. In practice, I find this to be the most difficult to do. Indeed Harper and Spellman (2006) warn of assumptions being made in narrative therapy that a person can ‘magically’ replace old stories with new and believe them. Although I have often looked with families at exceptions to their problems, and I will also try to look to the future to help them plan their steps to new alternative outcomes, I have not followed this particular process explicitly.

Conclusions
I am interested to see how possible it is to integrate forms of family and systemic therapy further into my practice, but I am unlikely to solely use one approach. Larner (2004) cites the work of Miller and Duncan which suggests that the actual method or type of therapy used only accounts for 15% of its success. Larner (2004) also suggests that we need to be aware if using an integrative model of family therapy that different approaches seem to have success in different presenting difficulties. It talks of narrative therapy being more successful than behavioural approaches for psychosomatic conditions such as soiling.

Hayward (2003), in his response to critiques of narrative therapy, postulates that narrative therapists have often come to that point through a journey of beliefs in how to practice ethically and they may be clear that they want to work strictly within that model. These therapists can subsequently be criticised for not embracing the wider schools of family therapy. Yet Bowen in his introduction to Epston (2008) talks of how narrative therapy practice in Britain has managed, he feels, to encompass both a whole
model approach as well as practitioners using aspects of narrative therapy to enhance an integrated approach to therapy. I feel that using narrative therapy practices as part of an eclectic model will enrich what I can provide for families (Guterman & Rudes, 2005).

**Reflection**
This paper has allowed me to gain much greater insight into the general historical context of family therapy models and approaches, and where all the different ideas fit into that context. It is not linear, it is not easily defined. In fact it can be downright messy with overlaps, tensions, and dilemmas of epistemology. Many, if understood well, may offer the therapist the chance to creatively look at how to best support a family. This exercise has allowed me to be clear that I would not use a purist or singular narrative therapy approach. I feel this is also how it has essentially developed over time in that narrative approaches are very much incorporated into a more integrative model these days rather than used in isolation (Larner, 2004; Carr, 2000). What it has given me is a greater understanding of the development of narrative therapy’s history and its place in the wider context family therapy and systemic practice. I have been able to consider the issue critically through a variety of literature. On a philosophical basis, I would agree with Carr (1998) and Hayward (2003) that narrative therapy can be an ethical way of working and drives one to continually question that global truths are more valuable than local knowledge. This has allowed me to work towards creatively incorporating ideas, such as working with children and families to be ‘experts in their own lives’ or externalising, into my own practice.

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What to treat: Sleep or low mood? A case study

Dr Dinesh Khanna

Abstract
This case-report describes the use of Melatonin in the treatment of depression in a young person. A detailed clinical history identified sleep disorder as a precursor of symptoms of depression and initial treatment focussed on this aspect of the young person’s presentation. This approach was successful and the paper presents reflection upon the clinical decision making in this case.

Keywords
melatonin; depression; CAMHS; mood; sleep disorder; insomnia

Case description
A 15-year-old girl was referred by her GP with low mood, irritability, sleep difficulties, and lack of motivation. She was commenced on an antidepressant by the GP at the time of referral. She was then assessed by a Psychotherapist in Child and Adolescent Mental Health Services (CAMHS) and difficulties around school attendance were also identified. She was later seen by the author (Consultant Child and Adolescent Psychiatrist) with a view to assess and monitor medication. On detailed assessment it became apparent that sleep difficulties started prior to symptoms of low mood, lack of motivation, and poor school attendance. Further exploration of her sleep difficulties revealed that she was struggling with initial insomnia and disturbed sleep. She was hence finding it difficult to get up in the mornings, feeling tired and, therefore, unable to attend school. Sleep hygiene issues were discussed in detail. She also had other symptoms suggestive of mild depressive illness.

National Institute for Health and Care Excellence (NICE) guidance and medication options were discussed more in detail (NICE, 2005). The young person and her mother agreed that sleep was a bigger concern and this problem was impacting severely on her functioning. Given the difficulties, the young person was commenced on Melatonin (Circadin) and her antidepressant was gradually tapered off.

With her mother’s support, the young person attempted to put sleep hygiene measures in place at home. She remained consistent with medication and her sleep started to get better. Her mother also noticed an improvement in her mood, motivation, and confidence. She continued to have some moments when she would be irritable but these were around other social stressors.

At the time of submitting this case study for publication, the young person remains on Melatonin (2mg) at night. Her sleep has improved and plans to taper Melatonin off are being discussed. She has joined college this September and has moved into college accommodation.

Reflection
From the above case it becomes clear that gathering a detailed chronological history is paramount when thinking about medical management. In this case, most of the symptoms were suggestive of a depressive disorder, but the chronology of development of symptoms was suggestive that lack of adequate sleep was associated and possibly a cause for many of these symptoms.

A study conducted by Shireman et al. (2002) in Ohio suggested that many teenagers were prescribed new generation antidepressants without any clear diagnoses. The study also revealed that the number of antidepressant prescriptions rose with age in girls and reduced in boys. Rowe et al. (2004) suggested that GPs should prescribe antidepressants if psychological therapies have failed or if the depressive disorder is severe enough to put the young person’s life at risk. NICE guidance also suggests the use of psychological therapies as first line in mild to moderate cases of depression.

However, prescribing antidepressants or hypnotics like Melatonin may be more complex. A large multi-site study (Treatment for adolescents with depression study) has revealed that sleep disturbances are one of the common residual symptoms after antidepressant treatment in adolescents (Kennard et al., 2006). Emslie et al. (2012) found that adolescents with insomnia were less likely to respond to Fluoxetine than those without insomnia. However, they found that younger children who had insomnia responded better on Fluoxetine than those without insomnia.

Sleep disturbance can be one of the symptoms of a depressive disorder, or it could play a precipitating and/or perpetuating role.
It is important to identify this to ensure the right treatment is commenced in adolescents presenting with a complex mix of symptoms. One may consider commencing young people on an antidepressant and also a hypnotic, however, there should be clear clinical rationale for this and a detailed discussion with family would be essential.

Consent
Consent for the publication of this case study was obtained from both the young person and her mother. Consent was given using the format used for the publication of case studies in the British Medical Journal, (http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/patient-confidentiality/patient-consent-fo) this required that the case study is as fully anonymised, that the young person and her mother are to have read the article, that they have understood where it would be published (both as hard copy and on the internet), and who might read it and that they have given written consent.

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What to treat: Sleep or low mood? A case study
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