Clinical Psychologists’ experiences of exploring and addressing ‘context’ in formulation and intervention

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2013 cohort
Background: What is context?

- A suggestion from physical health (Dahlgren & Whitehead, 1991)
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“individual circumstantial and life event related factors (including housing, employment, health, poverty etc.), immediate and wider community relationships and wider socio-economic, cultural, environmental and political factors (including inequality, discrimination and power)”
Where is the problem... where is the solution?

- Recent interpersonal and social difficulties, predisposing context of unsatisfying relationships and dysthymia, maintained by rumination and a lack of contact with positive reinforcement

  **OR**

- This is a person who has had the cards stacked quite badly against them. They are living in a tiny damp flat which they are desperate to get out of, but can’t. The flat is overcrowded, they don’t really have much choice but to stay in and ruminate all day because they can’t afford to get out and do anything else
Where is the problem... where is the solution?

• Deliver individual therapy

OR

• Help them get a bus pass...

... “I’ll be able to get out with one of my children, and we’ll be able to get to the park, and I’ll just be able to get out of the house, and I won’t be sitting in there, you know spending all day ruminating, and I won’t be kind of looking out of my window onto effectively, a not very nice environment. I can just go a couple of miles down the road with my kids and, you know maybe even meet a friend for a coffee.”
Intervention Options?

• Individual intervention
  - Comfort, clarification and encouragement (Smail, 2005)
  - Support “empowerment” and self-advocacy
  - Support relevant skills e.g. assertiveness, problem solving

• Provide practical help/advocacy

• Change the context causing difficulty/prevent the difficulty
  - Community psychology/critical psychology
  - Media and policy engagement
Barriers

• Avoidance of context (Boyle, 2013)
  - Viewed as “unscientific”
  - Outside of the remit of psychology
  - Creating feelings of helplessness Vs confidence in therapy
  - Needing to ally with the medical model (limited formulations and focus on individual intervention: locating problems in individuals)

• Limited resources and service pressures
  “paymasters choose their pipers’ tunes” (Smail, 2010, p.458).
Study aims

• To investigate what clinical psychologists understand by ‘context’ and how this is explored and approached in practice.
Methodology

• Eight clinical psychologists interviewed

• Semi-structured interviews approximately 60 minutes duration

• Qualitative methodology: thematic analysis (Braun & Clark, 2006)

Three themes developed:

1: Justification for working with context

2: The need to work with context beyond the therapy room

3: “My context is their context”: influences on the ability to work with context
Findings
Theme 1: Justification for working with context

Fundamental importance
- to understanding and alleviating distress (formulations)
- To understanding and addressing “engagement”
- Intervention works (CAT, solution focused, family therapy... Smail) including practical help

Fundamentally appropriate
- “it’s a mental health professional's role (...) I see myself as that as much as a clinical psychologist”
Findings

Theme 1: Justification for working with context

• Yes, other professionals may be better placed to help
  BUT
  If they aren’t available then it become necessary for me to act, and therefore appropriate

• Maslow’s hierarchy of needs

• Responding to risk/harm
Findings

Theme 2: The need to work with context beyond the therapy room

• Prevention:
  “It’s not good enough to know what we know and to just sit around waiting for people to come into our doors traumatised 20 years later”

• Community work:
  “proper psychology. Somebody is kind of out there really kind of helping people within their circumstances.”
Findings

Theme 2: The need to work with context beyond the therapy room

“Speaking up”

• Engagement with policy and media

• “Bringing the profession into disrepute”?

• Troublemaker?

• Efforts to influence their own service context felt more accessible

E.g. joint working, contributing formulation/psychological thinking at every opportunity
Findings

Theme 3: “My context is their context”: influences on the ability to work with context

- Service setting
  - How medically driven the setting/team are
  - Inpatient settings better resourced
  - Primary care settings less flexible/more pressure/more protocol driven

- Impact of cuts
  - Increased restriction on roles, higher caseloads and priority to reduce waiting lists
  - Pressure to prove outcomes in a competitive market, linked with service priority for “bums on seats” individual therapy
Findings

Theme 3: My context is their context”: influences on the ability to work with context

- “Skills and knowledge vacuum”
  - Lack signposting information and understanding e.g. of benefits
    “sometimes it can be easier not to think about it or really talk about it with people because what do I do with the information that comes up?”
  - Lacking training/models
    “a trap that I fall into quite often, and I think other psychologists fall into, is that we consider those contextual factors but then you’re always looking for the underlying internal factor that makes those things difficult”
Findings

Theme 3: My context is their context”: influences on the ability to work with context

• Validation
  - Within services: support from supervisors, managers, colleagues, service structure
    “my boss said “that was a really useful piece of work! Why do you feel you’ve got to do something that looks like CBT?”
  - Outside of services: groups, social media: “psychology tribe”, like minded individuals including service users
  - From the profession as a whole: DClinPsy training, BPS being more vocal
Recommendations

• Models to increase confidence and validate, especially for practical help (Maslow, risk, attachment)
• Signposting information
• BPS: validate working with context, influence service/policy/funding priorities, context included in DClinPsy training
• Support to “speak out” (e.g. Psychologists Against Austerity recommendations (PAA, 2016), use of formulations in teams (DCP, 2011))
• Employ welfare workers
• Training e.g. benefits
References


THANK YOU FOR YOUR ATTENTION AND ANY QUESTIONS?