CHI: 2104673933

Health&Social Care
North Lanarkshire

IONA WARD
BECKFORD LODGE
CAIRD STREET
HAMILTON
ML3 0AL

Date: 03.03.21
CHI No: 2104673933

Dear Colleagues,

Formulation Meeting for Mr Andrew Shaw

Date of Meeting: 24.02.21

Present:

Christopher Morrison (Staff Nurse), Caroline Watson (Charge Nurse), Kevin Jamieson (Occupational Therapist), Dr Isobel Campbell (Consultant Psychiatrist), Dr Caroline Brodie (Clinical Psychologist)

Purpose of meeting:

The formulation meeting took place to review Mr Shaw in light of his recent transfer to Iona Ward, Beckford Lodge, on 25th January 2021 and his significant level of distress, emotional dysregulation and persistent, distressing and derogatory auditory, visual and tactile hallucinations. It was the opinion of the current clinical team that it would be helpful to have a fuller understanding of Mr Shaw's formulation, specifically from a Cognitive Analytical approach, in order to gain insight into his difficulties, experiences and relational responses, from an attachment/relational approach. It was agreed that this would also be helpful in informing ongoing management of his mental health and risk. It is the team's opinion that Mr Shaw's current difficulties are underpinned by his significant trauma history.

Formulation:

Presenting difficulties / violence risk
Mr Shaw presents with a psychotic illness which takes the form of auditory, visual and tactile hallucinations. He has a history of self-harm including suicidal ideation. He reports having experienced hallucinations since the age of eight, when his mother passed away. It appears that his psychosis is directly related to his experience of significant childhood trauma, developed in order to protect himself from these traumatic experiences and maintained by the beliefs that he holds - that his voices would not abandon him, like people in his life did.

Mr Shaw holds fixed beliefs that his voices are external to himself and has paranoid thoughts that the voices know information about him. He reports continuous, intense and distressing auditory

hallucinations, which will most often be derogatory and persecutory in nature. He notes that they intensify when he is distressed, at night and if he is with people he does not trust. He describes having 10-20 voices and they may all be speaking to him at once, which can be overwhelming and he has to work hard to manage. He has experienced command hallucinations including commands which led to him attempting to take his own life when in prison.

He also presents with fluctuating low mood and agitation, which he relates to the voices; when his voices are more intense, this impacts his mood, but equally, when his mood is low, he finds it more difficult to cope with the hallucinations. His presentation is further underpinned by his difficulties developing trusting relationships. His physical health is also of note and he is morbidly overweight, describing his diet as a result of eating for comfort, to reduce distress.

Predisposing factors / what makes him vulnerable
There are a number of factors which may have increased the likelihood that Mr Shaw would develop the difficulties described above. He reports a history of significant childhood trauma. He witnessed domestic violence and parental alcohol misuse from an early age. His mother died when he was eight years old, and he witnessed her death; she had a cardiac arrest and it is believed this was following an argument with Mr Shaw's father. Following her death, Mr Shaw lacked any parental care and his father's alcohol use increased. He was physically and sexually abused by his older brother, and Mr Shaw believes that his father knew yet failed to intervene and protect him.

Considering attachment, Mr Shaw has a history of insecure attachment and his childhood was marked by instability, neglect and harm. This is all likely to have led to a lack of sense of safety and security, feelings of abandonment, with significant mistrust towards others, specifically care givers. It may be that his mother was his secure base and his one safe person, and her death left him feeling alone and vulnerable. It is likely that he developed a belief that people either abuse or abandon him. There is also evidence that Mr Shaw experienced abuse when he was moved to a residential school, further maintaining this belief.

It is significant that his first experience of auditory hallucinations followed his mother's death. He reports one of the voices being his mother, and it is likely that he developed voices as a way to cope with her death and the trauma associated with losing a parent (and witnessing that loss), without any adaptive coping strategies, skills to regulate his emotions or adult giving him comfort. Further, the relationship between trauma and derogatory voices is well documented, underpinned by shame, and it is likely that shame attached to the horrific experience of abuse perpetrated by his brother, neglect by his father, and abuse at his school, will have made him more vulnerable to developing, and continuing to have, psychotic symptoms.

It is likely that the nature of his attachment relationships and lack of stability and safety, did not enable him to develop strategies for managing his own emotional experiences. He describes regularly seeking safety from abuse by hiding in a car, and driving and crashing his brother's car when he was 11 years old, which led to involvement by SW Services and his removal from the family home and an end to abuse perpetrated by his brother. It seems that he developed an association with cars and safety; believing that cars keep him safe, unlike people. Further, it is possible that during a period of abuse, neglect and loss, he found his identify with cars and voices and began using these maladaptive coping strategies in order to get his needs met, instead of trusting in people. It is likely that this formed a template for relationships and coping styles, which has continued in his adult life.

Furthermore, Mr Shaw's brother had significant mental health difficulties and completed suicide around 10 years ago. It is not known about the mental health needs of other family members however this may indicate a biological predisposition to mental health problems or vulnerabilities.

Precipitating factors / triggers
Mr Shaw's mental health difficulties and risk appear to have been triggered by a number of factors. Mr Shaw's offences appear to be in the context of psychotic symptoms and maladaptive coping strategies,

specifically believing and experiencing cars to be safe, and to be tangible and predictable. He describes low mood as contributing to his psychosis and ability to cope - when his voices are more intense, this impacts his mood, but equally, when his mood is low, he finds it more difficult to manage the hallucinations. It is unclear whether suicidal ideation was a factor in his index offence, however, it is indicated that hopelessness and the presence of command hallucinations in relation to self-harm heighten his symptoms, and reduce his ability to cope. He describes cars as allowing him to feel free and untouchable (rather than a victim and vulnerable), and it seems that his beliefs about himself, the world and others, as a result of the significant trauma he has experienced, without the emotional strategies to cope and heal, underpin his mental health difficulties and risk.

Perpetuating factors / what maintains his difficulties and risk(s)

There are a number of factors that maintain Mr Shaw's difficulties and risks, including the frequency and intensity of auditory hallucinations, lack of understanding of psychosis and the association with trauma, difficulties with trusting others (although this can of course be protective too), lack of adaptive coping strategies to cope with distress (driving cars), emotional dysregulation, low mood, negative view of self, the world and others, feelings of shame.

It is likely that the impact of his trauma history and poor attachments on his ability to form new trusting relationships have negatively impacted his capacity (and willingness) to seek help and learn new ways of coping, thus contributing to deterioration in his mental health and increased risk. His guarded style of relating to others has been further maintained by his negative sense of self; feelings of shame, believing that he is to blame for his voices, that he is a bad person and that nobody would understand his experience. Indeed, his internal model of a safe and healthy relationship is limited. There is also evidence that he disengages from services (and therefore relationships) before he is abandoned, which affects the care and treatment he has received, further impacting on his wellbeing and the opportunity to gain understanding of his mental health difficulties.

The team identified reciprocal roles that are maintaining his difficulties (see diagram 1 below). When Mr Shaw feels criticised, or perceives criticism or judgement, he may respond by being critical towards others and this may escalate to frustration and refusal to engage. This can therefore hinder the development of relationships, Mr Shaw's feelings of trust, and his general engagement in care and treatment. Furthermore, when he feels unsafe, he can respond by not trusting, and this has the potential to split the team as he responds by trusting some staff but not others. In addition, the team recognises that he shows a vulnerability, which can present as a 'victim role', and brings out empathy and compassion from others, evoking an eagerness to protect him. This has the potential to encourage dependency on care and support.

Protective factors / strengths

Mr Shaw has a number of protective factors in relation to his mental health difficulties and risk of violence. He is engaging in psychological therapy, which he has not done previously, and has shown openness and commitment to this work so far. He has indicated that he wants to learn new strategies to cope with his symptoms, to reduce distress and as an alternative to using cars in order to prevent future offending. Although he struggles to develop trust, he engages well with the clinical team and shows warmth to staff and peers. He will seek out staff for support and has been trying to develop therapeutic relationships since his admission to Iona Ward. Mr Shaw demonstrates a keenness to understand his difficulties and is beginning to develop insight into psychosis and the relationship with trauma, and risk. He is motivated to engage in his care and treatment plan and, despite feeling frustrated by his enduring symptoms and fluctuating mood, he is future focused and reports feeling hopeful that he is getting help now.

Recommendations:

Based on the above formulation, information from background reports and the team's assessment of Mr Shaw's presentation so far, the below recommendations have been identified:

- A consistent trauma focused approach to Mr Shaw's care and treatment, and to our understanding and formulation of his difficulties and attachments;
- Safety & stabilisation work to continue and be reinforced by all members of the clinical team in order to increase his sense of safety, reduce distress and offer adaptive coping strategies;
- Awareness of potential for team splitting due to Mr Shaw's dependence on some relationships and withdrawal from others – information sharing within the team is fundamental and a whole team understanding of his formulation and to increasing safety;
- Careful consideration given to endings due to potential feelings of abandonment resulting in emotional distress, increased psychotic symptoms and disengagement eg. Ending of support, staff leaving or reduction in level of contact. Strategies include: preparing Mr Shaw for the ending, acknowledging his feelings however distracting from rumination, highlighting other positive relationships and validating his own strengths and coping strategies;
- Encouragement of daily activity to offer distraction and build up meaningful activity – involvement of OT where appropriate.
- A trauma-based therapeutic intervention to be considered when appropriate i.e. once emotionally safe, with strategies to manage intensive work, with a focus on psychosis – such as CBT for psychosis from a trauma perspective – considering identity, what replaces voices?

Compiled by

Name Dr Caroline Brodie
Title Clinical Psychologist

Date of report completion 03.03.21

Cc.
Dr Isobel Campbell, Consultant Psychiatrist
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Diagram 1:
Reciprocal Roles for Mr Shaw
Based on Cognitive Analytic Therapy (CAT)