

**Results** Children and families unanimously placed a high value on the quality of the event in terms of:

- Therapeutic value
- Facilitating dialogue which acknowledged the loss of the person who had died
- Making meaningful memories
- Reducing the sense of isolation within families

Staff and volunteer experience was enriched through their involvement.

**P144 MEET MR FOUL! AN INNOVATIVE APPROACH TO GET TO THE HEART OF DISTRESS: A THERAPEUTIC TOOL TO WORK WITH PATIENTS IN 'EXTERNALISING' ILLNESS, SYMPTOMS AND THEIR CONSEQUENCES**

Kimberley McLaughlin. *The Hospice of St Francis, Berkhamsted, UK*

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**Context** Introduced to the field of family therapy in the 1980s, 'externalising' practice aims to enable people to realise that they and the problem are not the same thing. Externalising the problem encourages a separation from the problem - 'the person is not the problem, the problem is the problem' (White 2007:9). A space is created between the person and whatever is troubling them. Often problems become 'internalised'; with patients seeing illness as something wrong with them, that they or something about them is problematic.

**In Practice** Externalising helps us to shift self-blame. A patient living with Parkinson's disease said 'I'm so pathetic, so incompetent and such a burden...'. Externalising questions helped to reshape the relationship with Parkinson's e.g. 'How long has Parkinson's been influencing you?', 'What does Parkinson's tell you about yourself?', 'When is Parkinson's not so strong?'. Questions enabled collaborative exploration of the effects and tactics of problems and helped to reduce their influence.

This encouraged separation from the problem, the patient began to see her symptoms as external to herself. Contributing to this process was her renaming Parkinson's as 'Mr Foul Disease'. Self-blame decreased and 'Mr Foul' became more manageable and less powerful. A sense of relief was experienced as the patient realised she was not the problem and became more able to reconnect stories about herself as 'capable, insightful and determined'.

**Discussion** Externalising conversations can be flexible, creative and encourage patients to use their own problem-solving strategies, skills. They provide palliative practitioners with a tool, which positions them alongside their patients' problems, jointly exploring of new ways of relating to illness and symptoms rather than a position of expertise.

**P145 LIFE STORIES: REBUILDING SELF ESTEEM THROUGH SHARING AND RECORDING BIOGRAPHICAL STORIES**

Doreen Pattenson, Miranda Quinney. *The Peace Hospice, Watford, United Kingdom*

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**Introduction** In 2012 we were approached by a local storyteller. We experimented with a simple programme, offering patients the opportunity to tell their stories on an informal basis and produced a series of summaries of the stories they told. We are now piloting a closed group version of Life Stories offering a 5 – 6 week course of story sharing sessions to day patients and

patients in the community. The results observed to date have been overwhelming – we want to share these with you.

**Aims** The aims of Life Stories are to provide a space for reflection and story telling for patients who are low in mood or anxious.

**Methods** The weekly 1.5 hour sessions are facilitated by the storyteller and attended by the social worker. Each session is structured using common life experiences, e.g. seasons, senses, celebrations. Using a mix of group, individual and pair work, all participants are invited to explore the theme and its meaning for them before sharing a related life story with a session partner. Next the stories are shared out loud with the whole group giving the facilitator a chance to record them all.

**Results** The reaction of the patients and their families to this experience is very positive; patients visibly brighten and do not want to leave. They report enhanced feelings of wellbeing, happiness and a generally improved quality of life. A family member reported: "my mother is talking again and painting again – thank you".

**Conclusion** Positive feedback from patients, their carers and hospice staff suggest that Life Stories workshops should be made available as part of a patient's individual care plan and be a regular part of the hospice day services.

**P146 WHO MATTERS TO ME? - USING ECOMAPS IN PATIENT ASSESSMENT & CARE**

Bernadette Gallagher. *St Joseph's Hospice, London, UK*

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When doing good quality assessments for patients at St Joseph's Hospice it was recognised that genograms did not tell the whole story – so I looked to Ecomaps

Dr Ann Hartmann developed the ecomap as part of her social work practice in 1975. Initially it was used as a tool to show family life but Dr Hartmann then recognised that it was a useful tool to show a diagrammatic picture of a person's life and helped clients view their situation from an outside perspective.

The term eco is derived from the Greek ecology - the pattern of relationships between plants, animals & people to each other & their surroundings.

The ecomap is a graphical representation of an individual or family and their interaction with other people & their environment. It is underpinned by the Systems Theory as described by Pincus & Minahan (1973)

- Informal Systems e.g. family, friends & neighbours. Providing emotional support & advice.
- Formal systems e.g. clubs, societies & other groups that can provide support.
- Public systems e.g. hospitals, schools & local government.

The systems theory is useful in looking at an individual's systems (their support network) to recognise & promote strengths and to sustain relationships that are under strain, it is at the heart of person centred planning. It is therefore used for assessment, planning & intervention.

The ecomap is as individual as the person and a positive is that it can show spiritual domains that are very important to the person to help cope with illness this can include transpersonal beings (angels, demons, ancestors).

Ecomaps are now included in St. Joseph's Hospice Core Assessments & each patient's ecomap will be displayed in our