The Diversity & Adversity Edition
Dear Readers,

Has it really been nearly a year since the last issue? Wow, time flies when you are busy!

The website continues to thrive and the LiveChat is now busy most evenings and at various other times during the day, and even at weekends! By popular request Campton has taken on the role of lifechat host. Our twitter feed over 1500 followers, so many thanks to Fleur-Michelle who provides the majority of content. Despite deleting all accounts that have been inactive for more than a year We now have over 5800 members. There are over 84,000 posts of content on nearly 9000 topics. Most of the wiki entries have been viewed more than 3000 times, with some having been viewed over 30,000 times!

Our tracking with Google Analytics shows that in the last financial year we had over 9 million page views. We had over a quarter of a million different people visit the site, and the average visit involved viewing 12 pages of content. These huge statistics mean that the site has attracted some advertising, which is much-needed to subsidise the costs of running the forum (which I’ve paid for out of my own pocket for the past five years). Hopefully the adverts are relevant and not too intrusive. They include some university courses, recruitment agencies and a provider of professional indemnity insurance as well as some job opportunities that are only advertised on this site.

Advertising income allows us to retain the autonomy and independence I have always held up as vital for a site like this. I’m proud that our little site continues to grow and has gathered a loyal community of users, but I don’t want to become complacent as there is always room to grow and evolve to better serve the needs of our users.

This year we also completed the fundraiser for Kids Company, and I was able to make the donation of £250 in person when I met Camila Batmanghelidjh at a conference in May. We also studied stress over the course of the year, asking users to rate themselves on our stressometer when they logged in. We didn’t anticipate the scale of data we were collecting, so the 16,000 ratings will need some time and effort to analyse! We also ran a personal development day in which we had a lot of fun, prepared for interviews and raised £350 for the neonatal unit at my local hospital. I’d like to take credit for the fantastic success rate of our delegates, but really I think they were a self-selected sample of highly motivated applicants.

Once again, it has been a year of great change, both in the NHS and for me personally. There continues to be pressure on staff within the NHS, with volume of service sometimes appearing to take priority over the quality of provision and the well-being of employees. The relentless pressure for cost-savings has eroded CPD budgets and frozen much recruitment, with vacancies often being frozen or services restructured with less or lower banded posts. The prevalence of organisational change and restructuring, and the amount of staff who have been TUPEd to other services also continues to increase. There are continued moves to cut admin support and to reduce the demand on premises, which mean that staff are being expected to do their own letters, record their own contacts into the database, and often to work from several different locations, doing their admin on the road or from home.

In terms of clinical psychology specifically, there are trends in a number of domains which are beginning to show. As an expensive profession without the power that medics have (in terms of their strong voice in negotiations and statutory minimum figures per head of population) we have been a profession which has shown the stress within the NHS more than most, with bandings being particularly affected. This means that career progression has slowed, fewer high-banded posts are advertised and many people feel there is little scope to move on. There has been less choice of posts for newly qualified staff with those available often being temporary contracts, or in some case bank contracts with no guarantee of hours. More trainees have accepted employment outside the NHS, or had to make compromises about location, client group or pay.

As I mentioned last issue, I made the decision to part company with my NHS trust as part of their restructuring, I can honestly say that a year down the line I haven’t regretted this decision once, nor looked on NHS jobs for vacancies (except to keep an eye on the bandings generally available with a view to recruiting my own staff). The trickle of court expert witness work I had done for...
As a decade has allowed me to expand into a limited company to provide expert clinical psychology expertise not just in court expert witness work, but also in offering assessments, therapy, consultancy, training, research and anything else that seems to apply our skill-set in an interesting way (see www.lifepsychol.co.uk). I’ve been busy writing a book about attachment for adoptive and foster parents, and tendering for some research grants. I also spent five months as Clinical Director of a new parenting charity, before discovering that politics and clinical service provision don’t always have common goals even when they appear to follow the same agenda.

As well as myself, my company now employs a full-time newly qualified CP, a full-time assistant, a part-time receptionist/admin and a few contractors on an ad hoc basis. I expect this will increase again over the course of the next year. I’ve had to learn about VAT, payroll, insurance, contracting, policies and all kinds of things that are new to me. It has struck me how sheltered from all of this I was as a clinician within the NHS! I’ve also had to think about how to protect my income in event of serious illness, how to protect my family from financial hardship in the event of my death, and what I am going to do in terms of a pension for when I retire. However, it seems that I am doing this well enough, as my income has remained as good as when I was in the NHS and I’ve not had trouble paying my employees.

We are shortly moving to larger and nicer offices where we will be the sole occupants of a small building (somewhat like a small terraced house), rather than renting serviced offices in a giant office complex. I’ve been on eBay buying the furniture we will need (as we are moving from furnished to unfurnished premises) and it has reminded me how hard the recession is biting to see the amount of second hand office furniture available from businesses that are no longer trading. And so many people are currently unemployed or having to take lower paid or less enjoyable work. It makes me thankful that my skills are so marketable, and that I had the safety net of an established reputation in the marketplace. I can’t imagine being anything other than a clinical psychologist, but I am glad to be an entrepreneurial one as it has given me a lot of choice in what I want to do that other people don’t have at the moment.

I’ve also been able to create a completely different culture of work than that which I left. We have been able to buy all the laptops, equipment and furniture needed, to provide bright spacious offices with a desk and storage space for each member of staff. We are able to offer flexible working hours and scope to influence the type of work we tender for. There is plenty of free parking, we don’t struggle to book clinical spaces, we can allow time for conversations with each other and for CPD. We have a bonus scheme related to annual appraisals and the profitability of the business with the scope to earn a bonus payment once a year of up to 5% of your salary. Best of all we often go out for lunch together with the business paying the bill! It is sad that a list of such simple basic things is now a selling point relative to the NHS. However, as a small business I cannot match the NHS pension, or the amount of annual leave, or the fantastic sick and maternity pay, so I have to compete in other ways in order to attract fantastic staff (and not just those who would struggle to find jobs or career progression elsewhere).

Anyway, I shall continue to report back in the members’ section of the forum how my adventures outside the NHS progress. Feel free to ask questions, I’m quite candid about my experiences.

This issue of Aspire has again been nearly 12 months in the making, though as ever we hold the aspiration of producing 3 issues per year in future. We have focused this time on adversity and diversity, which has really generated some interesting content, though we have also kept some of our regular features. We have some personal accounts of different aspects of work in different contexts and a fantastic contributed article from a service user organisation. As always, we are keen to have additional articles submitted by forum members, whether on your daily professional life, your journey or an accessible digest of some research you have been involved in, or an article about working with a particular model or client group. You can PM me through the forum or email the forum email address: clinpsyforum@gmail.com

Agree or disagree with any of the content of this issue? Have some additional information or points to make? Feel free to post any comments about the content of Aspire on the forum. Let’s continue this conversation. If you want to get more involved in Aspire or the site just drop me a line. We have an ‘Action Group’ of volunteers that want to be involved in the broader activity of the site, and always value people with the time and energy to contribute. Hopefully we will produce the next issue sooner than a year from now as it is already well underway...

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Insights from the Other Side

Interview with a course selector

The fifth in our series of anonymous interviews with the people who decide which applicants gain places on clinical training courses

1) You are a course which uses a computer based test to screen candidates for interview, what makes a test answer shout ‘yes’ or ‘no’ in the first instance?

I would think ‘yes’ if the person has clearly thought about their answer before writing it down, and when answers are clear and concise. Also, good grammar and writing style helps.

2) Who short-lists and how reliable is the process?

Our process is tried and tested and seems quite reliable, but we are constantly reviewing its effectiveness.

3) Do you think we are doing enough to encourage diversity?

I think most courses are now are doing more in terms of promoting diversity and encouraging it within the application process, but there is still quite a way to go.

4) Do you think there will be a move towards more courses using selection tests in the future?

Yes, I think that more courses want to get on board with this. We have found that it is a quicker and reliable selection process.

5) There are big changes afoot in the NHS with cutting back of services and downgrading of posts. Is this impacting on training courses?

I would say not at the moment, but none of us can be sure what is going to happen in the future.

6) Are you trying to equip trainees for a ‘new world’?

Yes, I think that courses are constantly adapting to fit with the kind of work that we are able and expected to do as clinical psychologists.

7) Do you think the same number of training places will continue to be funded?

In the near future, yes.

8) Is there any risk to trainees of moving from a salary to a bursary, or of training becoming unpaid or even self-funded?

I believe that this should not be a risk for trainees already on the course, or who have been offered places for this year.
9) Is the employment picture after training still optimistic?

Yes. Although many of the new posts are now temporary 12 month posts, there are still jobs out there and posts are being renewed!

10) How do courses view people who go on to work abroad or in the private sector?

I think that the courses are just happy that their trainees have found jobs in this climate.

11) Is being part of training as satisfying as a more clinical role?

I personally like both roles. However, after going through the application and training process myself, it feels useful to be able to have an influence upon the development of future training.

12) How do you think you would fare if you had to go through the selection process now?

Haha, probably not so great! As part of an interview panel training day we had to roleplay interviewees and that was quite scary. However, I would like to think that I was selected for the right reasons, so hopefully, fingers crossed, I would get through.

13) Do you have any advice about what to do or not to do at interview?

To do - when answering questions, primarily address the person who asked you the question, but also give some eye contact to other panel members. You can also have a moment to think before answering questions rather than rushing into them.
Not to do - don’t use client’s real names or identifying information.

14) Are interviewers sympathetic to interviewees who are very anxious?

In my experience, yes. We have all been there before and understand how stressful the interview can be!

15) To what extent (if any) do you think that people can be coached for interview?

People can be coached, but when they are, people’s answers may appear fake and rehearsed (especially if they are asked to expand upon answers and they struggle). It is often best to have a few ideas of how you could answer questions and do some preparation, but not to plan answers word by word.

16) Is there anything more courses could do to see a realistic and rounded picture of how that person will fare on the course and as a clinician?

I think this is something that courses are trying to achieve, and new types of interview tasks are added each year. Perhaps this is a piece of thesis research waiting to happen..

17) Have you got any embarrassing or amusing anecdotes about your own career development that might amuse or reassure applicants?

I split my trousers just before an interview, and then had to wobble about from one interview panel to another.

18) Do you think IAPT posts prepare people well for being trainees?

They can do, yes. I think that it depends upon what people take from the post, and how they feel that they are able to use this in their future posts. However, we take people from a wide range of backgrounds and value diversity in experiences.
Adverse Questions

Is mental healthcare valued in the wider public sphere?

A report on the Channel 4 News website of the 25th of November 2011 claims that mental health services are in line to be hit hard by the proposed government cuts in the National Health Service. This makes the question of the public perception of what mental health workers do and how much they are valued extremely timely and relevant.

So how informed are the public on your profession? Do your neighbours, friends or family honestly know what it is you do? What skill sets you make use of, or what training you’ve done to get where you are? Do they know how your service can help both people in need and save the tax-payer money?

I’m not trying to be flippant, these are salient questions. It stands to reason that any democratic government will be more content to make cuts in those public services where the outrage is less vocal, a smaller media footprint can be assured and any potential loss of associated votes are thereby minimised. ‘God bless democracy’, as they say in America.

In an attempt to get an idea of public opinion on the subject, I had the idea of asking my neighbours, friends and family an adverse question. One which would allow me to find out if they would choose a mental health professional if he (or she) was pitted against those working in physical healthcare. I know, I know, this is unfair, but only to the interview participants, if the truth be told. If mental health professionals really want to know where they stand in the public sphere, I think a few very adverse questions are necessary.

So I put the following query to my ‘convenience sample’ which comprised four well educated, intelligent and articulate people of disparate age, ethnicity, gender and marital status.

The Adverse Question.

‘You have been tasked with trimming your local NHS trust wage bill by £65,000, they have provided two options for you to choose between; three recently qualified Registered Nurses with one year of experience each, and one highly qualified consultant Clinical Psychologist with twenty years of experience. The nurses all work on adult wards and frequently on shift duty. The Clinical Psychologist specialises in children and young people and frequently works unpaid on compiling large reports for work. What service would you cut and why?’
When I put this query to the participants I was struck by how they favoured a wide variety of the implied arguments. Two preferred to choose the nurses over the psychologist on the basis of numbers. One making the entirely valid point that there would be ‘more opportunity for more people. The same amount of money... more people.’

Another chose the psychologist on the implication of their experience, even while admitting that the numbers argument would be a consideration for them. ‘I’ve never had any experience with the mental health side but I have had experience obviously with nurses, so from an emotional thing I would go with the nurses, obviously, there’s three people there rather than one... I value experience... it’s a tough one I’m torn between head and heart. I would probably keep the psychologist.

The final participant made their first decision on the similar basis of personal experience. The first thing that I’d say about this is that if I had to make a decision immediately I’d be in favour of keeping the three nurses... but if I had to make a decision I’d make it in a biased way I suppose... based on the experience of somebody being in hospital and not having enough nurses... I’d say keep the Nurses.

What was interesting; although not at all surprising for me; was that everyone participating acknowledged that, to a large extent their own lack of knowledge in regards to mental health had a direct effect on their judgement. Without personal experience or a deep understanding of the mental health services the only argument they could make was biased toward what they did know.

So I put to the participants an argument, a principally economic argument, to see how the addition of more information would affect their decision making process and gauge whether or not it would help to alter or entrench their initial position.

**The Economic Argument**

**For keeping the psychologist.**

According to the House of Commons’, Children, Schools and Families Committee Looked after Children Report of 2008-09 (third report – p.21), it costs £2,428 per week to place a child in residential care; that’s £126,256 per year. If the child enters a residential home at ten and leaves at 18, that becomes a sum total of £883,792.00 and the cost easily exceeds a million pounds if the child enters residential care at the age of nine and leaves at maturity.

A Consultant Clinical Psychologist working in the Child and Adolescent Mental Health Service whose expertise keeps one child out of the residential system for one year (let alone seven or eight) has more than saved their own cost to the wider social sphere.

**For keeping the nurses.**

The simplest principle of economics to grasp is that of supply and demand. Supply will obviously exist where there is a demand and this is no less true in the realm of healthcare. Releasing three nurses from ward duty could well have one or two effects; the first being creating a demand that someone else will be only too happy to satiate; in the supply of agency nurses.

A Deadline News report from the 13th of July 2011 points out that the cost to the NHS of placing agency nurses can be distressingly high. It notes that in the NHS Orkney Trust an agency nurse was paid £41,527.16 for five months employment, which is the equivalent of £95,000 a year. According to the same source, the same NHS trust spent £78,000 on two agency nurses to cover 209 shifts. In an article of the 30th of December 2009 the Telegraph noted that ‘one trust was paying agency nurses £146 per hour, around ten times the rate received by full-time staff’.
The consensus of the participants on receipt of this knowledge was that the argument for the nurses was more obviously sound. ‘First of all the cost of agency nursing is extremely high... they have to keep up the nursing standards... so keeping those three nurses would be in line with that.’ This position was backed up by another participant who recognised that ‘If you are paying an agency nurse that much and you’re looking at reducing the number of nurses what is the point? It is a straightforward issue...’

However, the one participant who initially chose the psychologist stuck with their decision despite this consideration, noting that ‘if you strip it down to a purely economic thing; that makes more sense... the economic impact of the nurses is a quite straightforward thing, but (with) the Clinical Psychologist it (sounds) a lot more complex about what else will be affected by his not being there.’

Of all of the positions taken from consideration of the economic argument, perhaps the most striking was the most pragmatic, that the experience of the psychologist may provide for more opportunities in the wider world. ‘I work in Electrical Engineering, they have their professionals, they can find a job in Electrical Engineering, they can also find another job in computers, so that is another way of judging this question. If it is easy for them to find another job and to contribute their knowledge in another area then I’d prefer to cut him (the clinical psychologist).

After concluding the economic arguments then; all four participants had stuck with their initial decision; it was a case of Nurses Three, Psychologist One. So I converted the economic arguments into social principles; to see if a wider understanding of the effects of change in the social sphere might help them in the process of coming to a different decision.

**The Social Argument**

**For keeping the psychologist.**

The House of Commons’, Children, Schools and Families Committee Looked after Children Report of 2008-09 (third report – p.93) argues that many children will enter into residential care with no criminal history but leave with one due to poor management within the system, as incidents that could be easily resolved by a parent or foster parent are frequently dealt with by the police in residential care, thus ensuring only that the child is more likely to leave care with the associated social stigma of a criminal record which can make finding work and building relationships on the outside world a lot more complex.

According to the ‘Couldn’t Care Less’ report from The Centre for Social Justice (2008 – p.11) twenty-three percent of the prison population is comprised of people previously in care, and according to the same centre’s website half of all prostitutes were once in the care system. These are shocking statistics considering that according to the aforementioned report those previously in care comprise only one percent of the population. So it is not difficult to understand the argument that in keeping one child out of the care system the Consultant Psychologist may not only be saving that child but also be keeping that child from spiralling into a life of crime in adulthood that has serious social effects on us all.

**For keeping the nurses.**

In the RCN report: a ‘policy position on evidence-based nurse staffing levels’ (p.2) it is concisely argued that there is a direct link between nursing levels and the outcomes that patients can expect. Most notable is the point that ‘hospitals with well staffed wards have lower mortality rates’. It is therefore severely disquieting that a Nursing Times report of 18th of November 2011 noted that the NHS Chief Executive has admitted that many managers in the NHS are ignorant of the nursing levels on their wards.

A Nursing Standard editorial of October 2011 entitled ‘Safe staffing levels should be mandatory’ makes it quite clear that the United Kingdom currently has no mandate in place to make suitable nursing staff to patient ratios legally enforcable; which makes management ignorance a little more understandable but not at all less potentially fatal. So the case is clear, registered nurses at sustainable levels save lives and the government hasn’t a mandate to ensure it when staffing levels are due to be cut.
In reply to these arguments, perhaps one of the most salient points was again made, when one of the participants pointed out the disparity between the known and the unknown, knowing what the nurses did make a difference to how they felt about the question. People are simply more likely to come into contact with the physical health side of the NHS and the argument was; from that point; always going to be loaded in the nurse’s favour. Having said this, the one participant who chose the psychologist from the start claimed that:... I think I’m going to stick to my guns and keep the Clinical Psychologist because... I value experience and long term solutions... Mental health issues are more of a longer burn... I assume, but it’s a very uninformed response, more based on what we’ve been discussing... I’ve never used Mental Health services and I don’t know anybody who has.

For almost all of the participants, the economic implications were still the most prevalent concern, with one claiming that ‘I do see a very clear picture... one is a general health issue and the other a specialist (issue)... If you only have so much of a budget and you have to share it out you have to think of the general public first of all, bearing in mind that the majority of people are admitted to hospital for physical health problems. I would still have to go with the nurses but I am actually getting closer to believing (in) the importance of the Clinical Psychologist... he’s becoming more prominent the more the argument goes on but... because of the cost of agency labour... I’m going to have to stick with the nurses.’

So from start to finish most of the participants held on to the positions at all key points of the interview that they had held on hearing the initial question. However, the social argument actually helped to alter one participant’s viewpoint with them musing that now... ‘I would change my mind... to change a human mind and provide them with at least a good childhood... it’s much more than a money issue... the mental damage could affect their whole lives, so this kind of thing cannot be managed by money, I’d keep the clinical psychologist’

Another postulated however that while the nursing role may, to their mind, have no more cost-effective alternative; mental healthcare can (at some levels) be community driven. While sharing their experience of working in a charity for young people they mused that; ‘we look after children from 10 to 21. Basically we try to involve them in sporting activities... I’m just trying to give an example to show that there are a number of different things that can be done to keep children from committing crime... the alternative... could be cheap.

We end the interviews then, with a draw. At the end of the day, two participants would prefer to keep the psychologist and two others the nursing staff, and I can, in my own mind understand all of the positions taken. For the most part, the participants made decisions based on their pre-existing knowledge or from the information provided that most chimed with their personal beliefs. Hardly surprising this; as I’m sure you will agree; but this does highlight a potential problem for mental health professionals.

The public can see the end result of what a surgeon, a medic or a nurse do and the majority of them have first-hand experience of the service. It may even be fair to say they have it easy by comparison. There are obvious physical ramifications in cutting the human body. The scar left on the skin by the operation and the disgorged appendix once removed offer tangible evidence of the value of a physical health professional to a member of the public. This is not true of the mental health side. The scars involved there are much, much deeper and to the eye are largely invisible. The only mitigation for this is information, on what you do, why you do it and the benefits of keeping or even bolstering access to the mental health services.

If in the greater public sphere there isn’t at least a base knowledge of the economic or social benefits of mental health work then it is highly unlikely there will be a suitable public backlash against cuts to the service. Indeed for those participating in these interviews the arguments of using agency nurses seemed clear, and it is very likely that previous media exposure to this concern had helped formulate opinions in this regard; when it came to the argument of a false economy in mental health however many struggled with placing it into a socio-economic context and this much larger context is extremely important here. Mental health work often doesn’t save money in the same space where the cost is made evident; that is, inside the NHS; this means that the government can lay claim to cutting those services that don’t pay for themselves within the smaller institutional context of the National Health Service.
So the axe is hovering over the heads of mental health workers; and the perversity of the cuts are laid out quite concisely in The Barclays Wealth report, ‘Early Interventions: An Economic Approach to Charitable Giving’ (2011 - p.6). Here it postulates that common emotional and behavioural concerns such as ‘chaotic’ family environments, ‘children with conduct problems’ and ‘employment difficulties due to mental health problems’ could potentially cost society over one hundred billion pounds over the course of a year; but these savings are disproportionately made in the social welfare services, in local authorities; and if the report is correct; ultimately in the legal system. That’s an awful lot of money that could be saved effectively across a wide gamut of services by bolstering rather than cutting access to mental health services.

I must admit that I hesitate to concur with the above report when it muses that the concerns outlined above ‘are not causes with which the general public has strong emotional connections...’ I have to disagree, but only on the basis that an emotional connection requires a base understanding of the implications that cuts to the mental health services could have in the public sphere. The problem for the mental health services is not so much the public’s ability or desire to emote. To my mind at least, it is one of understanding the wider implications in costs and benefits.

The bad news is that cuts are most certainly coming in the NHS and if the news reports are to be believed they are coming to the mental health services in particular. The good news though, is that however statistically irrelevant the interviews may be; and however obvious a conclusion this is; we can at least confirm that people’s minds can be changed on this subject, people can learn and given the potential cost to them as taxpayers; they really should be given the opportunity. The simple fact of the matter though is that the argument needs to be made and it needs to be made by those of you in the profession, because surprise! No-one else will make it for you. They can’t; in all probability they don’t have the requisite knowledge. But you can tell them, why not talk to your neighbour, your family and your friends? It may not seem much, but it sure is a good place to start.

I will admit here, in a somewhat ironic conclusion that the socio-economic argument I presented for the psychologist was probably not as well formed as that which I presented for the nurses. It is also possible that I failed to make the argument as lucidly or as powerfully as I should and; if levelled; I may even accept this criticism as being entirely valid. Despite the fact that I have spent some considerable time surrounded (at least metaphorically) by mental health professionals, I’m not all that convinced that even I know as much about what you do as I do those in physical health and if that is the case, then; to be fair; that may not entirely be my own fault.

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**Call for reviewers of educational and health-related tests**

The British Psychological Society is currently seeking expressions of interest from those who would like to be involved in reviewing tests used in educational and health related settings. Recently reviewed tests in this area include; Raven’s Educational, Wechsler Adult Intelligence Scale IV (UK) and Wechsler Memory Scale IV (UK).

The Society’s Psychological Testing Centre independently reviews tests that have been submitted by test publishers and distributors across educational, health-related and occupational domains. All our reviews are independently reviewed in accordance with the EFPA Review Model for the Description and Evaluation of Tests.

**Who can apply?**

If you are a Chartered and/or HPC Registered Psychologist and have significant knowledge and practise in the use of psychometric tests in educational and health-related settings, please contact ayshea.king@bps.org.uk to express an interest in applying.

Remuneration is at a rate of £150 per test reviewed and each test review is allocated an ISBN number.

**Deadline:** 31 July 2012

To find out more about the test reviews please visit our website www.psychtesting.org.uk. For an informal chat about the position, please phone Ayshea King on 0116 2529923.
The Rumour Mill

Ian Barkataki continues his foray into the urban legends of clinical psychology

Rumour: “You have to include certain buzzwords.”

Answer: FALSE!

Every industry has its own jargon, and clinical psychology is no different. Certain phrases and terms are regularly used as handy shorthand to certain ideas, signifying a shared understanding of concepts. As a consequence of this, impressive sounding phrases and technical buzzwords start to be regularly used and incorporated into everyday practice. Usual suspects include “Reflective”, “Core competency” and “scientist practitioner”, but there are a whole host of others that are commonly introduced as the field moves on. Naturally, the introduction of new phrases has in turn been met by an increasing belief that specific buzzwords must appear on application forms to stand any chance of success. Firstly, there is the rule of ‘show, don’t tell’. Rather than being told “I am reflective” an employer or selector would far rather see actual evidence of your reflection within the writing of your personal statement. Instead of proclaiming yourself to be a “team player”, actually come up with instances where this is evident. Not only do you save vital space, you actually paint a picture of the person behind the application form. In the same way that Stephen Fry doesn’t go around proclaiming how clever he is (he just is), you too have to demonstrate the characteristics you want to get across by “being” rather than just “saying”.

Secondly, if you are not sure what a buzzword actually means there is a high possibility of it backfiring hideously if it is not used in the correct way or your evidence doesn’t back it up. There is the apocryphal tale of the person who wrote they took an “empirical and scientific” approach to life but then went onto say their hobbies included tarot cards and horoscopes. It doesn’t even have to be that extreme. Just listen to trendy parents trying to get down with the kids to get some idea of how small the distance is from using a phrase appropriately to misusing it horribly. Policy and practice, as well as language, move quite fast and nothing says “Haven’t done the reading” as much as name-dropping schemes or initiatives that were axed when Tony Blair left Downing Street.

Bear in mind that due to their increasingly common use, buzzwords have become a form of verbal camouflage. In the small world of psychology, phrases are circulated and recycled rapidly. Using them can almost guarantee your application blends into the sea of others who all use exactly the same phrases. By all means, show that you have all those wonderful underlying abilities, thoughts and attitudes but let’s leave the buzzwords to the management consultants and MBAs for now.
My Inspiration
Would we have the courage?

Ruthie

In June 2011, world-renowned clinical psychologist and researcher, Marsha Linehan disclosed that in her late teens and early twenties she was hospitalised and put into seclusion for extreme-self harm, slashing her arms, legs and mid-section with sharp objects and burning her wrists with cigarettes. She felt out of control and totally empty, “like the Tin Man”. Looking back on her experiences, she would now give her younger self the diagnosis of borderline personality disorder.

The gulf between the person Marsha was and who she wanted to be felt enormous, leaving her desperate and suicidal. She described the experience as “hell” and made a vow that when she got out she would return to get others out. A spiritual experience led Marsha to conclude that she was acceptable as she was and she came to say, “I love myself.” By accepting herself as she was she found the strength to weather her emotional storms and develop healthier coping strategies. Radical acceptance of herself and her struggles formed the basis of her therapy.

Ambitious and hopeful, she decided to work with patients who were chronically suicidal and whose self-harming behaviour was the most extreme. She called local hospitals requesting, “Send me your worst!” The hospitals were only too happy to oblige and so Marsha developed Dialectical Behaviour Therapy, which has now helped millions of chronically suicidal and desperate people throughout the world.

The stigma associated with borderline personality disorder meant that Marsha did not share her personal experiences until very recently, when a patient, spying the scars on her arms asked, “Are you one of us? I mean...are you like us? Because if you were, it would give all of us so much hope.”

It turns out that Marsha is indeed “one of us” and her story is one of compassion and hope. From being suicidal in a seclusion room, Marsha is now an internationally respected clinica-
A Week in the Life of

A Drug and Alcohol Support Worker

I work in a low-secure hospital for patients with long and enduring mental health problems. Many have concurrent substance misuse problems. My supervisor, the Drug and Alcohol Therapist and I comprise the hospital’s drug and alcohol (D&A) service which is open to all patients, regardless of their background and relationship with drugs and alcohol. Much of our work involves psycho-education and CBT to help patients understand the risks associated with substance use and mental health and develop strategies for maintaining a robust recovery. We have formed strong links with abstinence-based self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and hold weekly AA/NA meetings at the hospital. Volunteer senior peers also regularly visit the patients and form an integral part of the service; indeed, possibly the most important.

Monday

Monday’s begin, as most Mondays do, with a quick check of my emails. With nothing of interest the next task is to call each ward and enquire about any substance use by patients over the weekend. Next I call the Monday volunteers. They run 12 Steps workshops for patients interested in the AA/NA philosophy of abstinence.

The volunteers are recovering alcoholics and addicts and so are able to normalise patient’s experiences, role model a life after substances and provide genuine hope for sustained recovery. I book taxis for the volunteers and sort the relevant paperwork before a quick run through the week ahead with my supervisor. Afterwards my supervisor runs the 12 Steps group for the female complex needs ward, while I make some last minute tweaks to the material for the D&A group on the female ward. After the 12 Steps group we begin the D&A group, which all patients are invited to attend.

The group goes well and I leave with a few questions from the patients: is salvia related to cannabis and what is DMT? (No; and a typtamine with potent psychoactive properties found in trace amounts in humans and mammals.) After the group I get lunch, and then begin writing notes, which will take most of the afternoon. Having to write entries for 15 patients it’s easy to see how doctors develop such terrible handwriting! Finally I collate information on a patient’s engagement with D&A for an upcoming Care Programme Approach (CPA: an MDT meeting with patient, mental health professionals and stakeholders to discuss the treatment plan) report. I’ve my own reports to be doing but these can wait for another day.
Tuesday
I begin the day by finalising the D&A handovers for ward rounds later this morning, then review the material for the group on our male rehab ward. After running the group my supervisor and I debrief and agree a few refinements for tomorrow’s group on the male complex needs ward. I write up the patient’s notes, which thankfully doesn’t take as long as there are fewer patients on the rehab ward. After a brief lunch I attend a HONOS (Health of the Nation Outcome Scale) meeting. Normally the attending nursing professional would give a quick verbal summary of the patient’s presentation which would allow the scoring of most of the scales. Unfortunately the attending nursing professional only started working on the ward yesterday so we have to read through the patient’s file to find the information. This means it takes us nearly an hour to score two patients! Thankfully the ward manager arrived and with her help we were able to complete the remaining five in the next hour. On completion, I quickly flee the scene.

Wednesday
Today began as did yesterday: with ward rounds. I finalise and print the handovers before preparing for the D&A group on our male complex needs ward. The material, with adjustments, goes OK. I’m a little disappointed patients aren’t engaging more with the material, especially because the topic was specifically requested by them. I’ll have to think about how I can make the session more engaging. Since starting I’ve been trying to think about ways of making our groups less didactic, more interactive, varied and fun. It’s challenging, but some ideas have proved effective, like a role-play we did recently to illustrate ambivalence as a normal part of the process of change. After the group I see a patient who is trying to stop smoking. Following this my supervisor and I discuss again the plans for next week before I grab a bite to eat. After lunch I write notes, book taxis for tomorrow and collate info for another report, before inviting select patients to the hospital’s Hearing Voices group. I sit outside in case anyone needs to use the loo. Glamorous it is not, but it does give me some regular reading time for my Motivational Interviewing interests. The end of Hearing Voices concludes my day.
**Thursday**

Thursdays are usually long, busy days. We run two D&A groups and facilitate an on-site NA meeting. Every other week we also have a senior peer visiting the patients on the female complex needs ward. Unfortunately this week she is unable to attend. I spend the rest of the morning writing a report for a patient’s CPA before heading up to our on-site step-down unit for the D&A group. The group goes well and I quickly write notes before heading for some lunch. Following this I call our NA volunteer. He didn’t answer my call the previous day and hasn’t answered the latest call so we are a little concerned about him. Next we run our group on the psychiatric intensive care unit (PICU, pronounced, bizarrely, P-Q). Due to the nature of this ward - short stay and mainly concerned with getting patients stable via medication - we approach these groups with an open mind and a flexible agenda. After the group - you guessed it - more notes! Our final task for the day is to facilitate the NA meeting, though we’ve still not heard back from the volunteer. We decide to run the group anyway, as it’s the first of the New Year and many patients were looking forward to it. The plan is to sit down, have a coffee and talk amongst ourselves. It’s not ideal, especially as we have a patient attending for the first time; however, despite the facilitator’s absence it was an excellent group. One of the patients offered to share (talk about the effects that substances have had on their life), which went well and also prompted spontaneous contributions from many other patients, some of whom rarely speak up during meetings. I’m always a little nervous about running these groups in place of a service-user - it feels fraudulent, disingenuous. Seeing it work like this reminds me it’s not all bad.

**Friday**

I arrive, make a cup of tea and start preparing for supervision with the Unit Psychologist. We discussed some research we are trying to get off the ground and my current feelings of enthusiasm and frustration, as well as a specific aspect of my group work: fully involving my co-facilitator in the delivery of the material. The psychologist shared his thoughts about planning the group material and his experience of some creative co-facilitation techniques. We also discussed the patient who’s trying to quit smoking and some potential complications such as frontal lobe damage and cigarettes being used to groom him before being sexually abused when younger. Afterwards I talked with my supervisor, about the Staff Smokers group later that morning. One of the staff, who hadn’t attending in some time, has since the New Year successfully quit smoking and has reached the seven day milestone. Sadly, this isn’t the result of a New Year’s resolution; actually he was so hung over on New Year’s Day he couldn’t face the prospect of having a cigarette! Still, whatever works... With an influx of staff as the sun reaches its apex the Smokers Group becomes the Group for the Implementation of the Recovery Model (GIRM) and with them a lengthy debate ensues over the rolling out of the Recovery Star at the hospital. We overrun by 15 minutes but did manage to wrangle out a plan. Next, we lunch at a local hotel and said goodbye to one of our Activities Co-ordinators. The remainder of the day was spent planning our activities in the D&A groups in the weeks ahead before heading home for a weekend of relaxation.
I knew only a little about Motivational Interviewing (MI) at the time of starting my current role. Through some internet-based research I had discovered the underlying principles: express empathy, develop discrepancy (between the client’s current and desired situation), roll with resistance and support self-efficacy; however, I was keen to know more. I felt strongly that empowering clients to become active agents in their recovery from mental distress was an important part of the therapeutic process, especially in the psychiatric hospital in which I work, where patient motivation can be low. I began researching further into the approach and, with the help of my supervisor, started learning about how MI can help people to make intentional, meaningful life changes. I have since found MI useful in my work and believe it can help resolve therapeutic issues found in many settings. Herein, I hope to outline the foundations of MI, share some thoughts from my learning and for the curious among you, suggest some further reading.

What is Motivational Interviewing?

Before I began, I thought of MI as a way of working with clients that would increase their motivation to engage in therapy, consequently promoting change and helping clients to overcome their problems. Since reading the second edition of the seminal Motivational Interviewing: Preparing People for Change, I have modified this description slightly. In fact, it is summarised so succinctly by the authors, I will quote them directly. Motivational Interviewing is “a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence,” (pg. 25).

Miller and Rollnick state they have drawn heavily from the work of Carl Rogers in ensuring that MI is client-centred in its approach. It is non-judgemental, views the client as expert and requires from the therapist genuineness, empathy and unconditional positive regard. Where MI diverges from traditional client-centred counselling is in its directive nature. In MI, the therapist actively guides the client throughout therapy in order to allow the natural process of change to occur unimpeded. MI acknowledges the importance of developing strong reasons for change, internally meaningful to the individual. We can financially reward our children for doing well in their exams (external motivation), but they are better motivated by a personal desire to succeed, perhaps wanting to go to University (internal motivation). Finally, and perhaps most importantly, MI is concerned with resolving ambivalence, which we will look at in more detail below.

A World of Change

To understand how MI facilitates change, we should first look at how people do change, and what goes wrong when people find themselves unable to do so.

Change is normal, healthy and happening all around us. We change every day, slowly but inexorably transmuted by the experiences of life. Many of these changes are imperceptible; some are conscious, intentional adaptations in pursuit of specific goal. We might choose what to cook for dinner, watch on TV or which book to read. These are generally straight-forward choices; it is unlikely we agonise too long over the decision and, once made, there’s a good chance we’ll stick to it. But what about the decision to apply for a new job, reduce our alcohol consumption, or get married? Sometimes the change process doesn’t flow so readily and, in some cases, can become stuck.

For Miller and Rollnick, getting stuck is seen as a problem of ambivalence: feeling two ways about something. We want to apply for the new job and, at the same time, we don’t. Ambivalence is a normal and healthy part of change. During most decision making we may feel ambivalent for a short period of time, but life events or cognitive...
restructuring generally tip the balance one way or another. However, in some cases the ambivalence may not get resolved, and that individual may be unable to move forward with change.

A useful metaphor for considering ambivalence is the decisional balance. On one side you have the factors maintaining the status quo, on the other, those that encourage change.

While the scales remain balanced, the status quo is maintained. Change is enabled by making the factors promoting change more salient, i.e., enhancing the perceived benefits of change and costs of maintaining the status quo. Similarly, you can promote change by reducing the potency of the factors maintaining the status quo, i.e., by reducing the perceived costs of change and benefits of the status quo. Sufficiently tip the balance and the maintenance of the status quo becomes untenable and change should follow. The basic concept of ambivalence and its resolution is the principle which underlies MI: help a person to resolve their ambivalence and you will facilitate change.

Understanding how integral ambivalence is to the change process allows us to reframe traditional therapeutic challenges such as motivational issues. Lack of motivation, poor completion of homework tasks and ‘defensive’ or ‘resistant’ clients can be re-interpreted as symptoms of unresolved client ambivalence. Clients who are poorly motivated or fail to complete homework may still feel ambivalent about change, and consequently are unlikely to work hard at something they don’t entirely believe in. Ambivalence can also be helpful in interpreting client ‘resistance’ or defensiveness. Attempts to advise, persuade or counsel a client who then becomes ‘resistant’ can be regarded as indicative of ambivalence. In advocating for change we are assuming one side of the client’s ambivalence, that of change. In response, the client will attempt to balance the argument by defending the status quo perhaps by offering reasons why the current situation isn’t really that bad or why change actually isn’t that important.

**Facilitating Change**

One of the foundations on which MI is built is the observation that as an individual advocates one position or another they become more committed to it (Self-Perception Theory, Bem, 1967; 1972). MI attempts to facilitate change by encouraging clients to talk in a way that promotes change, thereby becoming more committed to and increasing their chance of successfully making the change.

MI is described by its creators not as a collection of techniques but a way of being, a way of communicating. The basic idea of MI is to communicate with clients in a way that elicits talk that promotes change (“it would be nice to lose a few pounds”) or discourages the maintenance of the status quo (“it’s so embarrassing, running out of breath from walking up the stairs”). This is known as ‘change talk’. The more the client advocates for change by using this language, the more they believe in change and the more likely that change will take place.

The role of the therapist is to elicit change talk from the client through a process of selective reflection: listening to the client and responding with statements that reflect what the client has just said. For example, the therapist can repeat, rephrase,
paraphrase, or reflect feeling. Using this technique the therapist can identify change talk and respond in a way that encourages more change talk. The more change talk a person utters, the more salient change becomes and the more likely change will result.

**Reflections on learning**

I work in a substance misuse service with a well-defined treatment pathway that promotes abstinence from drugs and alcohol and discourages alternatives such as controlled drinking/using. Our philosophy exists to give the patients the greatest chance of avoiding relapse; however, patients don’t always agree with abstinence, especially from alcohol. Sometimes I find it challenging to reconcile the client-centred philosophy of MI with that of our service. Ultimately, I have to be careful about when I do and do not use MI at work, as it is critical it remains a client-led, not service-led process.

Miller and Rollnick talk about the ‘righting reflex’: the desire within all people to put things right. They caution the novice practitioner to suspend their righting reflex when working with ambivalent clients, as it often leads to common MI pitfalls, such as taking sides and prescribing solutions. I have at times found this aspect of MI challenging. Sometimes the solution to the client’s problem, or a potential pitfall to their plans, appears to be obvious. Restraining myself from sensitively and respectfully critiquing their plan or presenting an alternative, before the client has asked for my opinion, has been difficult, especially when I repeatedly hear the same risks in clients plans.

**The Beginning at the End**

MI has proved helpful for my work in substance misuse, but I look forward to utilising it in many settings. It can be used in isolation or as an adjunct to other therapies such as CBT. Indeed, evidence suggests that a brief MI intervention prior to commencement of other therapies can improve client outcomes (McKee et al., 2007).

While I have focused this article on the role of importance in the change process, this is only one aspect of motivational interviewing. Change takes place when a person is ready, willing and able. Change cannot occur if the client is unwilling to change, and is unlikely if someone feels no confidence in their ability to do so. Both confidence and willingness can be supported by discussion and selective reflection.

Furthermore, I have barely scratched the surface of the techniques available within MI. I hope my account has not been too diluted. If you have been interested in this brief foray I highly recommend you look further into the subject. MI can be an effective intervention in its own right, but perhaps most importantly it can inform and adjunct many other therapeutic approaches. To find out more I suggest Miller and Rollnick’s book as a good start. There are also many resources available at [www.motivationalinterview.org](http://www.motivationalinterview.org).

**References**


‘Madness: A Very Short Introduction’ by Andrew Scull

Linda Piper

‘Madness: A Very Short Introduction’ is part of the Very Short Introductions series, a collection of short books on a range of topics, written by experts in those fields. Scull is a Distinguished Professor of Sociology and Science Studies in the US; in this book he aims to examine the cultural and social aspects of the changing perceptions and treatment of madness in the Western World. Each chapter approximately covers a historical time period, starting with ancient Greece and finishing in the current day. For each notable time period, Scull provides a thorough account of ‘madness’ in literature and art, as well as discussing the religious and medical theories of the time about the causes of ‘madness’ and the best way to treat those deemed to be ‘mad’.

From the outset, Scull immediately acknowledges the vagueness and changeability of the definition of ‘madness’, and while admitting the need to use it for the purposes of the text, promises to expand on it throughout the book. Despite this, he continues to use the term without expanding on what it means in each historical context. For the most part, it seems that ‘madness’ refers to psychotic illnesses, depression and anxiety, but mental health issues encompass more than these diagnoses and it is not clear where the line is drawn. This is disappointing as the perception of what constituted ‘madness’ at different times would have added depth to the historical account. (It also had the irritating side-effect of forcing me to use mental inverted commas every time I saw the word!)

To begin with, the book feels a bit like a collection of lists of references to ‘madness’ in literature, with minimal discussion around how the representation of ‘madness’ in art and literature reflected the perceptions of it in those times. However, as the availability of historical sources increases over time, the book starts to pull together in a more easy-to-read and informative way. Scull gives a balanced account of the complex interactions between politics, economics, social aspects, religious influences and medical theories, and the resulting impact on the poor individuals unlucky enough to be designated ‘mad’. A lot of detail is devoted to the various types of institutions used to house, incarcerate and treat the ‘mad’, and black-and-white illustrations and photographs serve to highlight some of the unpleasant aspects of such places.

This is very much a book for people interested in the history of medicine and psychiatry. In an account spanning at least 2000 years, a heavy slant towards the role of medical psychiatry is inevitable. However, rather disappointingly, the last chapter focusing on the modern treatment of the ‘mad’ continues along this vein. The role of psychology in the treatment of ‘madness’ is reduced to a passing reference to the ‘...cheaper and heavily feminized professions of clinical psychology and psychiatric social work’. Scull’s own opinions on psychiatry are made clear towards the end of the book which, rather than celebrating the advances made in the treatment of those with mental health issues, finishes on a negative note bemoaning the influence of drug companies and the failures of care in the community programmes. Perhaps ‘Clinical Psychology: A Very Short Introduction’ is needed.
I’ve been in the fortunate position to know that I’ve wanted to work in mental health from the age of 16. In 6th form I took Psychology as an A-Level, and found discussion of mental health absolutely fascinating (schizophrenia especially). That people could have these types of experiences and the subsequent behaviours that came from them, and that I could actually work in this type of field astounded me!

So I went to University, obviously taking psychology, and really got to grips with clinical psychology, working out how to get in, what I needed to do and what the road ahead looked like. Alongside all the extra society based stuff I did, I managed to talk a PhD student into letting me do her data collection for her (which was surprisingly easy for some reason…) – my first research assistant post! It was unpaid, hard work and only tentatively linked to Clinical Psychology – but there it was, my first foot on a (giant) ladder.

It gave me a great crash course in conducting REAL research, and subsequently being named and thanked in the published paper was a great feeling which has stuck with me since. On top of this, my 2nd year project was given an undergraduate scheme grant to continue it further, which resulted in me presenting my study results to the Vice Chancellor and senior academics of the University. This was rather terrifying at the time, but was a great “in at the deep end” moment of explaining psychological principles to non-psychologists, an important skill for the career.

My big break came in 2009, when I overheard another student I knew (but not too well) talking about how they had managed to pick up an honorary assistant psychologist post at a local rehabilitation hospital, and I leapt onto them, eventually managing to get a contact number. I spoke to the Consultant Neuropsychologist and, after he agreed to meet with me, I started on one day a week working with young adults with traumatic brain injuries. I stayed in post for 2 years, throwing myself into the clinical work, writing a book chapter and helping host conferences, as well as finishing my degree (2.1) and Masters (Research Methods – Pass). I gradually upped my days to the point where I was working for 3 or 4 days a week and doing my MSc work in the evening. I loved every moment of it, I loved the team and I loved the client group – and it’s an area I want to return to eventually.

As my MSc finished, and my debit cards/overdrafts were as stretched and broken as they could be, I
I had to leave my university bubble and the work environment I had grown comfortable in (and it was genuinely heart breaking to leave), and managed to get another big break - my first paid assistant post working in Older Adult, mostly within a memory assessment service. Whilst the work itself wasn't too dissimilar from what I had done in my honorary role, the environment was so much harsher; a team currently in a bad place, with less support available clinically. Reflecting on it, it was a post that didn't have the same visceral, upset feeling upon leaving. There were times throughout where I hated going into work (something I had never before experienced whilst working in psychology), but it was an important post for me. It toughened me up and really developed my ability to work independently. More importantly, it gave me my first proper look at the mechanism and organisation that surround our work, and the environmental pressures evident.

It was after this that I took my first step into the private sector world of psychology, which I had once again managed to fall into by 'being in the right place at the right time'. Getting talking to a Consultant Clinical Psychologist who did private work assessing children and families for the legal services, I casually said that if they wanted a bit of free labour, then to consider me for future work. This off the cuff comment led to a few days of work with both them and a Clinical Psychologist they knew (also in expert witness work) whilst completing my MSc and rehabilitation work. As my older adult job was winding to a close, this psychologist was expanding their private work, and the opportunity for an assistant post appeared and I was asked to join (in my mind, I was “headhunted” because I am suitably fantastic). It was definitely a different environment to what I had come from, with a better atmospheric feel and a chance to really spend a lot of time with my supervisor, leeching as much information as possible. There is a lot more freedom in terms of what to focus on because several work streams run in parallel most of the time.

The work was initially a lot darker and harder to digest than I had previously come across, working outside of traditional healthcare settings and coming face to face with a lot of the more harrowing social circumstances that surrounded people was different to a more biological/neuropsychological focus from my previous work. In addition to this, working with children now was especially challenging (and anxiety provoking), whereas before I had developed a social skill set (which could realistically be boiled down to being very polite and sounding well spoken) which is especially useful for older adult, was now almost completely useless against teenagers and children. This skill set is still developing (with a couple of tricks picked up thus far), but I still have that ‘irk’ in my stomach just before I open the door! In addition to this, I’ve managed to get my foot back into the NHS, with a smaller part time role in a CAMHS Looked After Children service – mostly focused around differential diagnosis of childhood conditions, which I’m excited about really getting into.

That’s my career so far – what I think is a good mixture of work and luck, experiences which have a range of different levels of enjoyment, roles, responsibilities and people, which have all contributed to shaping the person and psychologist I one day hope to be. The application for the DClinPsy is submitted, and I’m quite excited to see where my psychology life will go next!
Clinical Vignettes
Ian Barkataki

Life in psychology moves fast and the path to qualifying is filled with adventure and happenstance. Out of the hundreds of stories out there in the naked city, here are some of the people you may meet, or may even have been, on the journey.

No 1. The work experience girl

You know that she is in the building the instant you enter it. She practically seems to radiate those happy, happy, joy, joy vibes no matter how inappropriate the situation. She is a cocktail of 3 parts Prozac, 1 part sugar and mixed with a dash of the swot that sits at the front of the class, thrusting their hand up going “Ooh sir, me sir!” She may be the daughter of the manager’s hairdresser, perhaps from the local college on day release, or even nowadays a graduate seeking that first foot in the door. Whoever she is, she is the combines the enthusiasm of a Scout leader with the “Who are you?” of a temp.

Yes. It’s the work experience girl.

You turn up to work on a Monday morning lamenting the all too quick passing of the weekend. She is there fresh as a daisy, the office tidied, all appointment entries neatly logged and a brief list of messages lying accusingly on your desk. You smile wanly, but before you can even put your coat on the hook, she is bounding around like a puppy whose master has just returned home after a 2 week hunting expedition. Theoretically she is working under your supervisor, who is mysteriously always just popping out, which allows her to delegate to you the task of ‘showing her the ropes’.

“Gooooood morning, have you got anything interesting happening today?” she says eagerly. You continue to get settled in the office trying to balance a cup of coffee with a pile of notes. “Not today Jessica, just a couple of people to see, and then I have to write up something”. Initially you welcomed it. You loved not having to tidy-up, do boring photocopying and having someone offer to make tea every 10 minutes. You soon realised that your bladder can only hold so much and that the office doesn’t really need to be too tidied, as it then becomes too confusing for you.
You try in vain to rack your brains for something for her to do. She is gone in a few weeks, so it’s not like an audit or something substantial can be dreamt up to keep her busy. In fact, you don’t have the heart to tell her it’s just paperwork and pencil sharpening duties until September. Perhaps the photocopier will help her get a tan? The duty nurse comes in, smiles hello, then spots Jessica and makes a quick turn into the female loo. There is only so much she can talk about her job, and she had reached the limit sometime in early July.

Mercifully you do have work that morning, but on your return to the office, Jessica has managed to attach onto the team’s social worker, Ethel. “Where did you do your degree? What A levels did you get?” Jessica asks like demonic unrelenting Michael Parkinson. Ethel, a 49 year old Welsh woman who trained as a social worker in the dim and distant past, left school at 16 and has little idea of the world of work experience or exams. Out of her depth, she gratefully smiles as you come back into the room and says “Well it’s been lovely talking but I really do have to go”.

You feel bad, you know that everyone goes through the same hoops and crosses the same milestones. Its only that you wonder does she have to do it with such great gusto, as if she was on a trip to Disneyland rather than a your beige, fluorescent lit office. So you smile, and are nice, and just wish her well. It could be worse, you heard a consultant last week on the other team treating his placement student like a scullery maid in Downton Abbey, with unending trips out for Diet Coke, dry cleaning and arranging dining reservations, sort of a healthcare version of the Devil Wears Prada. At least we are all nice to Jessica and try to answer he questions the best we can. And don’t impose on her photocopying skills too much.

Still it’s the summer and there is only a few weeks to go, and you feel slightly empathic when you accidentally over-hear your supervisor on his mobile outside your window saying “It’s this team! You wouldn’t believe the amount of hand holding I have to do...”
I was finally diagnosed with borderline personality disorder shortly before my 27th birthday, after 10 years of contact with various mental health professionals and numerous alternative diagnoses. Being told I had borderline personality disorder proved a double-edged sword. For years I had known that whilst I displayed symptoms of other problems, I never really felt that they could account for the pervasive and intense sense of emptiness, hopelessness and misery that dominated my life. The relief of finally fitting a diagnostic criterion that explained my symptoms was immense. On the other hand, I was not prepared for how controversial and deterministic the label could prove.

For those unfamiliar with borderline personality disorder, it is a highly distressing condition in which individuals have a pervasive pattern of instability in interpersonal relationships and self-image, and severe difficulties regulating emotions, demonstrating sudden and severe changes in mood or ‘state changes’.

It is surprisingly common, affecting approximately 2% of the population (Swartz et al. 1990), and can be shockingly severe. Studies have estimated that people with a diagnosis of borderline personality disorder account for as many as 20% of psychiatric hospital admissions, whilst suicide rates stand at approximately 10%. (Zanarini et al. 2001; DSM-IV, 1994).

Self-injuring behaviour or suicidal ideation comprises a core diagnostic feature of the disorder and can be triggered by events which seem benign to others but which prompt feelings, memories or sensations from past traumatic experiences. Too often the problems of borderline personality disorder are compounded by stigmatising attitudes based upon the assumption that self-destructive behaviours are manipulative or attention-seeking in motivation.

For example, I have at times experienced treatment from health care professionals that has ranged from inappropriate (upon discharge from a crisis team I was once asked to ‘start behaving myself’) to downright neglectful (being denied a vomit bowl in A&E after a serious overdose). It perhaps goes without saying that this kind of behaviour served only to increase my sense of isolation and psychological pain, but it seems crucial at this point to emphasise that the severity of my difficulties has tended to go hand-in-hand with how appropriate my treatment has been. When treatment has been relevant and well-suited I have flourished, but inappropriate treatment has had a massively destabilising effect.

In January 2009, the National Institute for Health and Clinical Excellence (NICE) published guidelines for the management and treatment offered to people given the diagnosis or experiencing the difficulties often associated with the diagnosis of borderline personality disorder. This emphasised the need for specialist and multi-disciplined services, staffed by highly skilled and trained psychiatrists, therapists and nurses (NICE, 2009). The report partly aimed to debunk the myth that people given the diagnosis of personality disorder are untreatable by recognising and emphasising their complexity, suggesting that historical failures of recovery may be related to a general misunderstanding of the difficulties termed personality disorder within services.

My own experience of clinical psychology over the course of my illness has been incredibly varied. At best, I honestly believe therapeutic intervention has saved my life. At its worst, it has had a destabilising effect, dramatically increasing the severity of my borderline personality disorder. Having spent much time reflecting on the reasons why my experience has been so varied, I concluded that a good therapeutic ‘fit’ can only be achieved when the following conditions are met.
Effective treatment depends on clear diagnoses:

Before being correctly diagnosed as having borderline personality disorder, various healthcare professionals had diagnosed me with depression, anorexia and even atypical bipolar disorder. Anecdotal stories of misdiagnosis amongst those experiencing difficulties associated with borderline personality disorder are common. Within the existing mental health system where diagnosis determines treatment pathways, incorrect diagnosis may account for the familiar pattern of long-term intermittent contact with mental health services often seen amongst people with difficulties linked to personality disorder. Certainly, I chose to end the therapy I received for anorexia early as I felt it was somehow ‘missing the point’, and failing to fully account for my feelings and behaviour.

Effective treatment depends on the treatment model:

This of course relates closely to diagnoses – treatment can never be appropriate without a clear understanding of the problem – but even once diagnosed I have found that certain approaches have ‘fitted’, whilst others have felt left me feeling frustrated and embarrassed. A couple of years ago, following a long stay in an acute psychiatric ward, I had a brief admission to a therapeutic community, which closely adhered to practises of psychoanalytic psychotherapy. This included strictly timetabled sessions of individual and group therapy, guided by patients (as they were referred to) with minimal input from therapists. For me, this meant spending a mortifying 50 minute session with my therapist twice a week, sitting in silence desperately racking my brain for something to talk about. Group sessions were no better; four of us would sit in a circle, looking at the floor hoping someone else would talk. Therapists gave nothing of themselves to patients; they never entered the living areas, or used their first names. During review meetings, I was referred to in the third person and never addressed directly. As a result I felt worthless, labelled as nothing more than a disorder with little hope for a ‘normal’ life, and discharged myself after only 6 weeks.

After leaving this therapeutic community, I began using a specialist outpatient service within my local Trust, which provided me with individual and group cognitive analytical therapy. Cognitive analytical therapy differs from traditional psychoanalytic approaches, as the therapist and service user work collaboratively to identify thoughts, emotions and motivations that contribute towards a particular problem (in my case, prolific self-harm). Cognitive analytical therapy also identifies ‘reciprocal roles’, which refer to problems between individuals, rather than solely within the patient. Engaging with this model was hugely beneficial for me for a number of reasons. Firstly it takes a methodical approach, beginning with information gathering and the formulation of a cognitive analytical therapy diagram. This detailed the patterns of my problematic behaviours (for example cycles of feeling contemptuous, followed by binge eating and self-harm) and suggested a number of safer ‘exits’ from these cycles. Having a detailed diagram that I could refer to during sessions helped me to make sense of my wildly fluctuating moods and seemingly uncontrollable impulsive behaviour. Secondly, the concept of reciprocal roles meant I felt less passivity regarding my diagnosis. Where psychoanalysis felt deterministic, labelling me as a disordered person, laying the burden of ‘being mentally ill’ firmly at my feet and increasing my sense of hopelessness, cognitive analytical therapy described me as an active participant in my environment and gave me back a sense of autonomy over my life.

Effective treatment depends on appropriate relationships:

As a ‘pervasive pattern of instability in interpersonal relationships’ (DSM-IV, 2000) forms one of the core diagnostic features of borderline personality disorder, it is perhaps inevitable that this will include difficulties in the clinical and therapeutic relationships of service users. From a clinician’s perspective, a service user with a diagnosis of borderline personality disorder can be challenging. We might actively seek treatment, but quickly become ambivalent and drop out. We struggle with relational boundaries; typi-
cally someone with borderline personality disorder may form fast and intense relationships with others, and then experience crushing disappointment when that person doesn’t live up to (unrealistic) ideals. This disappointment can easily turn to contempt. In the past, I have begun a course of therapy believing that it will provide a ‘magic cure’ for my diagnosis casting the therapist in a ‘saviour’ role. This belief is not pragmatic; there is no quick fix for the difficulties associated with personality disorder. Logically, I have known this is the case but have still blamed my therapist (DSM-IV refers to this process as ‘extremes of idealisation and devaluation’). Over sessions, I became increasingly angry and contemptuous, refusing to engage fully and eventually dropping out.

Other times upon meeting a therapist, I have immediately jumped to ‘devaluation’. This has happened when I have perceived the therapist and me as similar (female, mid 20s and the outset of her career). Possibly the therapist provided too much of a ‘mirror’ for me, highlighting my intense dissatisfaction with myself. I feel it is more likely that a younger (and arguably less experienced) therapist speaks to my deep-seated worry that there is in fact nothing wrong with me, and I’m just a manipulative attention seeker. When my therapist is older, I perceive them as ‘better’ therapists, picked to work with the most challenging patients. The therapist adds gravitas to my condition and allows me to feel validated.

So what does this mean for the relationship between clinical psychology and personality disorder? It is obviously complex - my therapeutic successes have relied heavily on my personal preferences with regards to both therapy model and therapist. Other people may find the structure of cognitive analytical therapy too prescriptive, and prefer a more exploratory approach. For example, I have no doubt that some of the service users who were part of my therapeutic community benefitted immensely from their admission.

We can definitely conclude that treatment for people given a diagnosis of personality disorder will never be simplistic or straightforward; one size will never fit all. However, I do hope that sharing my experiences adds support to the growing belief that whilst borderline personality disorder may not be curable, when treatment is appropriate it can be successfully managed and individuals with this diagnosis can lead positive and fulfilling lives.

Clare is a service user researcher with Emergence. Emergence is a service user-led organisation supporting all people affected by personality disorder and the difficulties associated with these diagnoses, including service users, carers, family and friends and professionals.

Visit our website for more information: www.emergenceplus.org.uk

References:


The Road Less Travelled

Laura Tozer

I write this article not from a cosy office somewhere in the UK, but from ‘Arco Iris’ or the English translation, ‘Rainbow Centre’ in a small town in Peru called Urubamba.

Yes, I have travelled 6,320 miles from my home in England to volunteer for a UK NGO; Kiya Survivors. I stumbled across Kiya Survivors whilst doing a Google search, looking for charitable organisations who would give me an unforgettable experience working with children very much in need in the developing world.

With two degrees; an MSc and BSc in Psychology under my belt, I started working in an NHS adult mental health service. By this time, I was 24 years old and with commuting the 2 hours to London and back every day, life was becoming quite weary. I decided I needed to do something different. I wanted to meet new people and use my skills to help others who had not been as fortunate as I had. I knew I wanted to work with children, so I decided to get a job working at my local special needs school where I worked for 9 months. This proved to be invaluable preparation for a very different experience overseas.

When I first came across Kiya Survivors I knew instantly this was the charity I wanted to work with. I liked their morals, their aims and ambitions and the reality that they had created a fantastic place for children entirely on their own merits.

Kiya Survivors works with children with special needs and children who have been abused, abandoned and neglected. The charity was founded by Suzy Butler in 2000 after she came across a young boy with autism who had been abandoned and left on the streets of Peru. She soon realised there was a chronic lack of facilities to look after children with special needs and hence Kiya Survivors was born. Kiya means ‘New Moon’ in Quechua, the local indigenous language and signifies a new beginning. For me it is the perfect name to represent what Kiya Survivors offers; a new chance and opportunity for children to make the most of life.

For Kiya Survivors, the focus is not solely on the children, we work holistically to improve all aspects of a child’s socio-economic situation. The role of the parents is put at the forefront of improving the children’s wellbeing. We recently had a ‘Parents Day’ where many parents came to the school and worked together in groups discussing their experiences of parenting a child with a learning difficulty. It has to be acknowledged that many parents do not have the help and support we are lucky enough to have in England. They do not have access to a social welfare fund but rely entirely on family and friends to help support them and their children. Having the extra challenge of a child with a learning difficulty can prove too much at times and it is at these times that the many different services provided by Kiya Survivors are needed the most.

Due to precious public donations, sponsorship and public fundraising, Kiya Survivors is able to go in to the community and work with parents and families identifying strengths and difficulties
and assisting families to finding solutions to problems. We recently hosted a campaign where we travelled to the more isolated, indigenous communities to spread the important message of dental hygiene. As part of the campaign, we handed out toothbrushes and toothpaste; simple everyday items we take for granted back home but to these children it was like we had given them the most precious of gifts. It is true that what we gave these children was not just presents, but the gift of love, hope and support; something far more important than anything you can see or touch. The aim of these Outreach projects is to find new families and support existing ones who need the help of Kiya Survivors. The team identifies what help can be provided and how to make that help sustainable.

The Kiya Survivors team at the Rainbow Centre consists of social workers, a psychologist, teachers and of course, volunteers. Everyone has a different role and responsibility, but we all work together as a team to provide the very best for the 50 children and their families Kiya Survivors currently supports. When you first arrive at the Rainbow Centre, there is not a hint of tragedy or sadness but a collective feeling of joy, happiness and above all hope. Hope that one day every child can lead a full and successful life without constraints and regardless of disability. When we go on outings, our children are often the subject of stares and sideways comments, mainly because of a lack of understanding about children who may look or act differently. Children with special needs were always thought to be ‘the Devils children’; a horrific analogy by anyone’s standards and Kiya Survivors is trying to change this preconception by showing the community the amazing achievements our children can accomplish. The Rainbow Centre leads all the other schools in marches around the ‘Plaza de Armas’ in Urubamba when celebrating special occasions and as a result the children are becoming more accepted by the local population. They are now able to hold their heads up high knowing there should be no barriers to life. In the past, the team had to knock on people’s doors when following up rumors that a special needs child was inside; now, parents knock on Kiya Survivors door, asking for help and for an education for their child.

The ‘Rainbow House’ was founded in 2008 and immediately had five very grateful occupants. Subsequently a sixth child joined the Rainbow House after both her parents died. The Rainbow House is not an orphanage where children come and go but it is a home that Kiya Survivors has created to give these six children a stable and loving environment supported by two ‘tutoras’ who act as substitute mothers. Kiya Survivors also supports each child through school and work, providing not just financial help but the love every child needs and deserves.

I hope that one day no child should be impoverished or suffer at the hands of those meant to protect them, but for as long as this occurs, Kiya Survivors will be there to help, for their support knows no boundaries and their care is limitless.

For more information please visit: http://www.kiyasurvivors.org
Why don’t older adults utilise mental health services?

Older adults have been shown to be at increased risk of developing common mental health problems such as anxiety and depression. Many potential factors affect the mental health of older adults. These include physical health problems, hospital admission, chronic pain, substance and alcohol abuse, low mobility, lack of independence, bereavement, poverty, social isolation, retirement, fear of death, caring responsibilities, living in care homes and an increased risk of abuse.

However, many older people do not access clinical psychologists, crisis home treatment services, drug and alcohol teams or psychological therapy services (Health Care Commission, 2009). Despite the developments in national policy and mental health service provision accompanying the Improving Access to Psychological Therapies (IAPT) programme, older adults continue to receive psychological treatment at lower rates than any other age group. Data from IAPT sites report that only 4% of patients are over 65 (DoH, 2011), with rates as low as 1.45% in some areas of the country (Cobb and Shepherd, 2010).

No Health Without Mental Health (DoH, 2011) made older adults a ‘special interest’ group alongside other under-represented sections of the population. National targets for IAPT services are to increase the proportion of adults over 65 accessing psychological therapies to 12%, based on prevalence data for mental health problems in this population. In addition to the moral argument for equal access to services for older people, the burdens of mental health problems on the NHS must also be considered. Mental health problems in older adults have been shown to increase demand on GP’s and hospitals, inhibiting recovery from physical health problems. To enable older adults to make full use of mental health services and address the individual and national impact of these problems, it is necessary to understand barriers preventing older adults from accessing services and establish ways to overcome them.

The reasons why older adults do not utilise mental health services as much as younger people are unclear. Burroughs et al (2006) suggest access to services is affected by organisational, practitioner and individual patient factors.

Organisational barriers

Mental health problems may be undiagnosed and under-treated because of the unavailability of psychological interventions, with practitioners feeling unable to offer any support or resolution for issues they identify. Despite the push in recent years for increased access to psychological therapy services, older people may find the available services inappropriate or unacceptable. Many primary care mental health services do not offer psychological therapies to older people and refer directly to specialist services, even though care should be based on clinical need and not age (DoH, 2005).

The historical influence of deinstitutionalisation and the move to primary care mental health may affect engagement in older adults. The dropping of terms such as ‘insane’ and ‘neurotic’ has been positive, however terms such as ‘mental health’ and ‘depression’ remain commonplace in the NHS despite...
their negative connotations to older adults.

**Practitioner barriers**

The lack of older adults accessing mental health services may also be due to GPs not recognising or managing depression appropriately, failing to refer to mental health services even if they present with similar problems to a younger person. GPs and mental health practitioners have been found to have poor knowledge and skills about how best to treat older adults (Burroughs et al., 2006). GPs rarely have time to discuss psychological complaints in a short consultation. Older patients often present with vague physical complaints (e.g. insomnia, low energy, memory loss) and co-morbid chronic health conditions which cloud the aetiology and diagnosis of a psychological problem.

GPs and mental health professionals may assume older adults have irreparable or complex problems and would be reluctant to engage in therapy. Depression may be assumed to be part of the ageing process and a justifiable response to loneliness, illness or life events. Therapeutic nihilism, the feeling that nothing can be done, has been identified in attitudes of mental health professionals, lowering patient and practitioner expectations for success. (Burroughs et al., 2006). Discussions of death and ageing can also increase a therapist’s personal anxiety.

**Patient barriers**

Another potential barrier to diagnosis and treatment is that, due to negative attitudes towards mental health problems, many older adults choose not to discuss symptoms with their doctor. Attitudes towards mental health problems are often outdated, based on knowledge deficits or assumptions that may be half a century old. Older adults are less likely to recognise a mental health problem, often lacking insight into the psychological causes of their physical symptoms. Mental health problems may be seen as unavoidable if they are considered a response to ill health, ageing or grief.

Many older adults grew up in a time when psychotherapy was not readily available and have a poor understanding of the effectiveness of psychological treatments and the relative infrequency of institutionalisation. Fear of being hospitalised or losing independence may prevent older people from discussing their problems. Therapeutic nihilism has been found in older patients as well as practitioners, with passivity and lack of faith in treatment evident. Emotional problems may not be considered a legitimate illness to ‘bother’ a GP with. Combined with a stoic approach to life and a high threshold for distress, a lack of knowledge may prevent older adults from accessing mental health services (McMillan et al., 2010).

Stigma is one of the main factors affecting utilisation of mental health services by older adults (O’Conner et al., 2010). Social norms around coping with adversity, developed in the 1930-40’s amidst the Second World War and the subsequent economic depression, may contribute to attitudes towards mental health problems. They are often considered shameful and associated with personal failure and spiritual inadequacy, grounded in a culture of psycholog-
ical treatments being humiliating, self indulgent and a sign of weakness (McMillan et al., 2010). Qualitative research into attitudes held by older adults suggests a personal responsibility, managing by “picking oneself up by the bootstraps” instead of “feeling sorry for yourself” (Switzer et al., 2006, p1208).

Being ‘mentally ill’ in the first half of the 20th century generally meant being psychotic, dangerous or suicidal. Older patients may reject or deny a diagnosis due to negative connotations of labels such as ‘mental health’, ‘depression’ or ‘anxiety’. Underpinning these issues is fear and avoidance of mental health services. Additionally, help seeking behaviour and service utilisation may be affected by a patient’s culture or religious beliefs.

What can we do?

My recent literature review studying the attitudes of older adults towards mental health services found mixed results. Whilst some literature suggests negative beliefs are a barrier to access, a significant amount of research is emerging suggesting a positive shift in the attitudes of older adults. Clearly this is a complex issue. Mental health services may be failing to make psychological interventions accessible to older adults or older adults may not be utilising what is available. In practice, patient, practitioner and organisational barriers may be interacting to prevent access to services. The importance of liaison, training, mental health promotion and psychoeducation must be realised if barriers such as those discussed are to be challenged.

Anyone who works with older adults must remember that old age should be viewed as a time of strength and resilience, not necessarily involving slowing down or being less happy with life. Health professionals should not be afraid to discuss how it feels to age and support older people manage anxiety around death – whilst remembering that many older adults will not worry about it. By challenging assumptions about the ageing process and conducting careful assessments which incorporate physical and somatic problems, mental health practitioners can help older patients to formulate, understand and manage psychological distress using effective and appropriate interventions. Helping older adults manage mental health problems will have a positive effect on the NHS as a whole, whilst promoting the independence and wellbeing of people in later life.

References


Miles was referred after a series of incidents in which he got would walk into the road in the path of traffic or cut himself, usually when he had been drinking. From the screening assessment that had been completed it seemed these episodes were associated with suicidal ideation, but were not life-threatening. They were often triggered by minor disappointments, like not being invited to social events colleagues at his workplace were discussing. Miles felt that he would never amount to much in life and had never lived up to family expectations. His father had committed suicide in prison when Miles was 7, after being convicted for a series of violent offences. Miles had witnessed his father being violent to his mother, and recalled how his mother would criticise him and slap him if he cried or was upset, telling him he was a baby and his father would have been ashamed of him, and he would never be a real man. He denied having any relationships or romantic interests, and said most of his friends were people he spoke to on the internet rather than in real life.

Perspective 1

Dr Russel Ayling is a clinical psychologist specialising in sex and relationship therapy. He works in private practice (Metrotherapy), as well as on the course team for the doctorate in counselling psychology at London Metropolitan University. He is also training as a psychoanalyst at The Site for Contemporary Psychoanalysis.

I work from a contemporary psychoanalytic perspective that makes use of Freudian and post-Freudian thinking, with a heavy relational (post-Kleinian) angle. I believe that early relationship dynamics get repeated in the relationship with the therapist, and can be explored and worked through in that relationship. Lacan believes that the unconscious is structured ‘like a language’, and language is important in the way that I work. My early ideas on this vignette come from the language used within it - and my associations to this - and take the form of curiosities, associations and possible hypotheses that I would want to explore in my early meetings with Miles.

From the referral, I am interested in symbolism of the self-harming behaviours. Both walking into traffic and cutting are violent acts, and I wonder whether they represent a desire to attack an absent ‘other’, turned in on himself. Use of sedating substances is a common way of managing angry feelings, and it’s possible that, having seen a violent father (and experienced a violent mother), he doesn’t find it acceptable to be violent to others. Given the degree of violence and attack in the material, I would be expecting to see this in my relationship with Miles, either as overt anger towards me, a counter-transferential anger in me towards him, or an excessive ‘niceness’ or subjugation/placating response towards me. His reaction to me in the first few minutes of the first session, perhaps to a silent beginning from my side, would be interesting. He might equally find this containing (similar to the distance of the Internet) or stressful, so I would be ready to speak if the silence proved too difficult for him.

I would be interested in exploring the ‘minor disappointments’ in some detail. My fantasy is that being overlooked by others is a powerful repetition of how his needs were overlooked by parents who were too busy fighting. His sense of not amounting to much and not living up to expectations could originate from an early inability to win the attention of his preoccupied parents. I wonder if ‘couples’ are therefore useless (at best) and dangerous (at worst) to him, and being in a couple as an adult feels not worth his while either for him or for whoever he might be attracted to. Miles’s early experience...
of ‘unmanly’ emotions being disallowed by his mother, makes me wonder whether he will be able to share his feelings with me, and whether he will struggle to know what to ‘do’ in therapy. He may well attach intensely and painfully to someone who is interested in him, which could frighten him and cause him to fight the developing therapeutic relationship.

The idea of not being a ‘real man’ makes me wonder about Miles’s feelings for his father. It might feel that he has ‘lost’ his father to his mother and there may be real rage towards the mother for taking him away from Miles. I wonder too if he has unanswered questions about his father’s ‘real’ feelings for him, whether he has a sense of what being a ‘real man’ is; particularly what the ‘real man’ was that his mother wanted. Perhaps his father’s violence towards his mother might have been in response to her questioning or attacking his masculinity, in the way that she did to Miles. This idea of ‘real life’ (as opposed to the Internet) could be relevant here, and I suspect the Internet might allow him a space where he need worry less about others’ expectations and being too much or not enough for others, where he can control what people see of him, and potentially be his ‘real’ self without fear of violence to or from online others. If face-to-face work proves too intense for Miles, it might be that online therapy could be a way for him to explore his difficulties more gently.

Perspective 2

Dr. Ruth Ann Harpur-Lewis is a clinical psychologist working in an NHS community mental health team. She works with clients with severe, enduring mental health problems and personality disorders. She completed specialist training in Cognitive Therapy at the Oxford Cognitive Therapy Centre. She primarily uses CBT in her therapy work and incorporates Young’s schema therapy for complex cases.

The first thing I would want to do is find out what Miles would like to get out of therapy. Because stepping out in front of traffic is potentially life threatening, I would want one of those goals to be helping Miles to develop better coping strategies for when he is experiencing strong emotions. Other possible goals for therapy might be developing better relationships with his work colleagues or making friends other than through the internet. I think it is important to set goals at the beginning of therapy because it instils hope and conveys a belief in the client’s ability to get there. I encourage my clients to dream bigger dreams that inspire and motivate them. The journey might be long, but each small step is progress in the right direction. I try to predict and prepare for setbacks and work with clients to learn from them so they can continue to make progress. Safety takes priority because death or serious injury is a sure fire way to put an end to the dream.

Formulation is at the heart of what we do. It is not a one-off event but an on-going process throughout therapy so bits of the formulation would be elaborated over time as we focus on different areas. Miles and I would work together to link his early experiences (witnessing domestic violence, his mother’s criticism of him when he was upset etc) to his core beliefs/schema and his current difficulties. I expect his core beliefs and schema would be along the lines of “I am unacceptable/weak/a failure” and “Other people are dangerous/violent/abusive”. I would also be particularly interested in Miles schemas about emotions (e.g. emotions are a sign of weakness). My guess is this is leading into some conditional beliefs/assumptions of “If I feel emotional, then I am weak/unmanly/a failure and other people will reject me” and/or “If I get close to someone, they will see what a failure I am and will reject me”. Miles is probably employing safety behaviours of avoiding emotion and intimate relationships (e.g. through substance abuse, stepping out in front of cars, keeping his work colleagues at a distance). All of these behaviours are likely to reinforce Miles schema level beliefs. For example, he probably does get shouted at by irate drivers if he is getting drunk and stepping out in front of cars when upset and he doesn’t manage to build relationships where he can feel loved and valued as he is.

I also think it is vital to consider peoples’ strengths and resources and build these into the formulation. I’d notice that Miles manages to hold down a job and I’d want to know what else he manages to do. I’d explore his motivation, his perception of his strengths, his skills and his values - all of which we can build on to work towards his therapy goals.

In terms of intervention, I think developing a safety plan with Miles about how he will manage upset would be helpful. This is often a gradual approach. People don’t usually go from drinking and stepping out in cars to having a cup of camomile tea and a warm bath. Perhaps he could agree to drink only at home or to ensure he takes a taxi home. I would want to know if there are DVDs that Miles could have on standby if he is upset as a form of distraction. Perhaps there are activities that he finds more helpful such as sports or listening to loud music. This would be done collaboratively with Miles drawing on his strengths and resources and anything that might have worked for him in the past.

I would be happy for Miles to contact me between sessions if he was upset so we could work through what is going on in the moment. This has two advantages. One, we can assess and formulate how negative thoughts, difficult emotions and unhelpful behaviours are maintaining each other in the moment and consider coping strategies that may help. Two, this is a
perfect opportunity to Miles to find out what happens when he shares his upset with someone and test his belief that sharing emotions leads to rejection or punishment. Between session contact is always on the understanding that I work 9-5 and will probably not be immediately available but often I’ve found if they know I will call them back, people can often hold on until I do. In terms of suicidal ideation, I would also want to know what it is that keeps Miles going and to capture that in a meaningful way for him. I’ve often had people record video messages to themselves, take pictures of things that remind him of what he values in life, or have objects or pieces of music that somehow represent this to them. I think it is important to use all the senses in this as far as possible to make it more emotionally salient than a list of “reasons to stay alive” on a piece of paper.

In terms of working on Miles relationships, I would be very aware that therapy might be the first time he has formed a relationship with someone face to face where he is expected to be open about his experiences and his emotions. This might be extremely anxiety provoking for him and given his belief that if he shows emotions, he is weak/unmanly and will be rejected, I would want to be open and collaborative with Miles about this. For example, agreeing together that he will tell me and I will check out with him if the session is getting too difficult. The therapeutic relationship might also become a place where Miles can test out some of his beliefs. He can discover whether or not I reject him or seem disgusted if he shows distress. It would be important to think together about how Miles can start to test out his beliefs and develop more satisfying relationships in a wider context. For example, Miles might predict that because his colleagues think he is weak/unmanly, if he expresses an interest in a social event, they tell him not to come. If this was the case, Miles could test this out by asking his colleagues if they want to join him for a social event. Hopefully, this would allow him to discover something new about other people and himself and give him the opportunity to develop friendships with his colleagues.

This way of working can be challenging and Miles will have to draw on his strengths and his courage to progress towards his goals - this is why the goals have to be really worthwhile and inspiring so that the client is really motivated to get there. In therapy, I hope Miles would be developing new and healthier schemas about himself, other people, emotions and relationships and as a result develop better coping strategies for difficult emotions and more fulfilling relationships. Given the importance his relationship with me as a therapist might have for him, I would also want to be talking about ending well in advance of the actual ending to help Miles prepare and to ensure that Miles is developing healthier relationships with other people. I would not even attempt anything with Miles if I thought I had less than 6 months.

Last, but by no means least, I would consider some more schema imagery orientated work to help bring a healthier adult perspective to bear on little Miles’ experience. For example, adult Miles might stand up to his mother, or restrain his father or in some way intervene. This is a complex area and not something to do without specialist supervision. This is extremely emotional work for both the client and the therapist so I would only be heading in that direction if it seemed helpful and a solid therapeutic alliance had developed.

Caption Competition

Thanks to Gilly for this month’s winning caption, which made us all slightly nauseous…

“Mark was a true Freudian when it came to spicing things up in the bedroom.”
The Mysterious Third Sector

by Helen Galliard

What is the mysterious third sector?

How does it relate to gaining experience in psychology?

This article focuses on the place of the voluntary sector in mental health services and will highlight some examples of psychology related posts. The strengths and limitations of partnership working between the NHS and the voluntary sector will also be briefly examined.

Increasingly, in the current economic climate, the third sector is an invaluable source of support for people with mental health issues. The term ‘third sector’, sometimes also called the voluntary or community sector (Department of Health, 2004), refers to organizations that fall between the public and private sector. It includes local community groups and charities, as well as foundations, trusts and social enterprises. Such organizations often play an important part in providing support to vulnerable groups, and they often bridge gaps in statutory services. Third sector organizations may provide a range of services which include; but are not limited to; talking therapies, drug rehabilitation, sexual health services, palliative care and social support.

Primary Care Trusts (PCTs) are encouraged to include third sector organizations in planning care, the overall aim is that they can become equal players in planning and providing services (The NHS Confederation, 2010). Correspondingly, the Department of Health awarded charities a total of £3.6 million in 2011 which recognizes the role of the third sector in delivering services (Department of Health, 2011). This echoes the Department of Health (2004) recognition that no one organization (even one as large as the NHS) can meet all the needs of the people who use it all of the time. Therefore, the third sector is an important element in offering an alternative to the NHS.

An important aspect to partnership work involves the NHS working with the third sector via local strategic partnerships (community planning partnerships in Scotland and local service boards in Wales). It can also mean PCTs commissioning mental health services or working with the voluntary sector to deliver a service. As a result, there are opportunities for enthusiastic aspiring Clinical Psychologists within the third sector. Indeed, there can also be benefits to working within the third sector.

I have had experience of volunteering within the NHS, however much of my paid experience in mental health has come from the third sector, although in my roles I have often worked with NHS staff. I have therefore always been interested in the intersection between the two sectors and the opportunities in the third sector that may get overlooked by aspiring Clinical Psychologists.

I currently work for a mental health charity which delivers various services, many of which have roles suitable for psychology graduates seeking experience. For example, within the charity there is a service providing one-to-one cognitive behavioural therapy by Guided Self-Help Workers (these roles are similar to IAPT Low Intensity Worker roles). There is also a large team of Support Workers providing outreach care and supported accommodation as well as a team of Development Workers who manage befriending volunteers. All of these roles provide contact with service users with a broad range of mental health issues, as well as including various kinds of contact with the NHS.

In my role as a Development Worker, I do a lot of front–line support work with service users while they wait for psychological therapies, or if
they have disengaged with statutory services. As the organization I work for has a focus on the recovery model of mental health, people may see the support we offer as more helpful to them and a valid alternative to the medicalised treatment they see as available via the NHS. This is especially the case when there are long waiting lists for talking treatments. However, it may also be that our support is an adjunct to the support they receive from the NHS and therefore the two can work in tandem to support an individual’s recovery.

As part of my role, I have also been involved in working with the NHS including: contact with Clinical Psychologists, Occupational Therapists, GPs and CPNs (among others) to improve access to self-help information on mental health services and to promote service user involvement. This experience has let me see first-hand how each of these groups deliver services and has given me the experience of working with Clinical Psychologists, which I have really enjoyed. As a consequence I have built up a good relationship with the people I work with in the NHS. I think that if you are keen to learn and develop your role in the voluntary sector by utilizing opportunities to work alongside the NHS, it is possible and also perhaps gives you a broader view of service delivery.

One of the benefits to my role is that I have had the freedom to develop my work to include co-delivering CBT based support groups for people with mild–moderate anxiety/depression. This was something that I wanted to gain experience in and was permitted to pursue. I am not sure that this would have been quite so easy to do within statutory services where roles are often more specifically defined. Also, the voluntary sector often has the flexibility to provide adaptable and innovative approaches to service delivery because most organizations are a lot smaller than the NHS which allows faster change to be implemented. In addition, third sector organisations are generally independent from government policy. Although it is worth pointing out that sometimes voluntary sector providers are obliged to fulfill multiple grant provisions for a service, so have to ensure they meet specific quality standards and this may mean there are some limitations.

As mentioned, it often seems as if the voluntary sector fills a gap because people see charities in a very different light to the statutory services available in the NHS. The difference in orientation may be a draw for some service users due to the difference in focus between medicalised treatment to that of the recovery model of mental health, (although this is generalizing as more recently NHS services have become more recovery focused). An alternative view is that the NHS can utilise knowledge about services available in the voluntary sector to help plug gaps in what is available on the NHS. This may be dependent on where a service is located however, and there may be far more voluntary services in a city than in rural areas.

Sharing information and partnership working between the NHS and voluntary sector makes sense in many ways, for example the shared focus on improving wellbeing. However, partnership working can be challenging. Although there is not much research on this area, Lester et al. (2008) interviewed voluntary and NHS staff working on an Early Intervention Service Partnership for young people experiencing a first episode of psychosis. They used the constant comparison qualitative method to interpret the data and found that shared working
could be useful. However, barriers included differences in culture including perceptions of risk. The ability to have time to foster relationships with other organizations could be an issue.

Generally, voluntary organisations work with statutory services as far as possible and often their work is funded by the public sector. However, occasionally there can be a sense of the different agents involved not understanding each other’s roles and motivations particularly well. I have come across mental health professionals in the NHS who are somewhat condescending about the voluntary sector because they see their workers as not generally being within a specific professional group, say occupational therapy or nursing so doubt the usefulness of their approach.

Such an attitude may mean that experiences of partnership working are not particularly positive, especially if the voluntary sector workers are treated like second-class citizens. Lester et al. note that often this kind of attitude was seen early on in working together, however after time attitudes shifted as both sides saw the complementary nature of joint work. To make an alliance successful, more structured partnership work seemed to be advantageous, perhaps because this gave a formal agreement of what needed to be achieved. Joint training was also helpful as was the use of complementary, rather than conflicting roles for each organization.

Anecdotally, I have also heard the NHS staff I work with say that having contact with the voluntary sector is especially useful when people present with issues that aren’t significant enough to warrant referral to secondary services. From my own perspective I can certainly see that being able to use all services available to an individual is helpful. Accordingly, I am an advocate for partnership working despite some of the challenges.

In summary, the third sector can offer aspiring Clinical Psychologists a wealth of useful experience, which includes contact with service users, delivering interventions and working alongside NHS staff. It also helps to broaden your knowledge of service provision, which can be very useful in reflecting on the strengths and weaknesses of an organization as large as the NHS.

References


Psychkus

Some of our more creative members put together these Psychology related Haiku’s for your entertainment!

A lively forum
our e-magazine Aspire
and a place to chat
Five reports queuing
past the service best practise
and still my phone rings

The conveyor belt
brings too much to keep up with
so when can I write?

On the ferris wheel
sitting tight, uneasily
enjoying the ride

A spring in my step
A degree in my pocket
minimum wage?... ok

I sit in ward round
bored of medical jargon
what is clozapine?

Lack of participants
time is ticking
I’m in thesis hell.

Which is more vital,
clinical or research skills?
whichever I have.

Am I opium,
for the masses? Keeping them,
happy in their holes.

‘nurse ratchett’ haunts me:
patients in the brick mother
contained or controlled?

character limit
bane of my application
I am more than this

Nail those theories and
models reflect your minds off
yes you can do it

Don’t put people in
boxes we’re told funny that’s
what we’re all doing here

Picking courses from
hats more likely to succeed
than the logic used

Where are all the jobs
Gone to the site in the sky
I suspect, like steve.

Amazing how quickly
enthusiasm long faded
returns after change

Worked so hard and so long
for this...
working so hard, with little re-
ward
much learning to do,
how can I possibly fit,
More into my brain!

With thanks to: apprentice, Bicycleclips, Chixta, clueless, Gilly, Keep Calm 1985, Kentucky_freud_chicken, nettyb, Miriam.
Aspire

Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing’

Tom Merrill reviews a new biography of R.D. Laing

‘Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing’ is a fascinating and well written book about the formative years of the Scottish psychiatrist R.D. Laing. Laing, who is perhaps one of the most famous and controversial psychiatrists of the last century wrote extensively on mental illness, particularly the experience of psychosis. His first book; ‘The Divided Self’, published in 1960 when Laing was only 32, articulated the view that therapists should attempt to understand psychosis from the point of view of the patient. Laing’s radical views challenged the psychiatric orthodoxy of the time, characterised by the neurobiological model of mental illness and the use of treatments such as ECT and insulin coma therapy and brought him much fame and popularity during the 1960’s.

The book chronicles Laing’s early career from his time in medical school until the publication of his first book in 1960. The author, Dr Allan Beveridge, a Consultant Psychiatrist at the Queen Margaret Hospital in Dunfermline, bases his exegesis on a wealth of previously unexamined archives relating to Laing’s private papers and clinical notes. The book is divided into two parts and reflects perhaps two of the most important issues facing anyone working with the mentally ill, namely, what is mental illness and how should one treat the mentally ill?

The first half of the book considers Laing’s development as a psychiatric theorist. With extensive reference to Laing’s notebooks, Beveridge shows Laing as engaged not only with contemporary psychiatric theory but also with an eclectic range of other disciplines such as philosophy, literature and religion. The names and theories alluded too may not be familiar to all readers of the book, prominent among them existential writers such as Kierkegaard, Nietzsche and Sartre. However, the book prompted me to investigate these thinkers further and has consequently expanded my understanding of mental illness from a philosophical viewpoint.

The second half of the book examines Laing’s clinical notes to shed light on his engagement with psychiatric patients, firstly in the British Army, subsequently in the psychiatric hospitals of Glasgow and finally in the Tavistock Clinic in London. While there is considerable mythology surrounding Laing and his treatment of psychiatric patients, the notes reveal what Laing was actually doing in clinical practice, and how his emerging theory of mental illness interacted with day-to-day therapy.

While Laing was a psychiatrist I would recommend this book to any aspiring clinical psychologist (as well as trainees and practicing psychologists) because it gives an absorbing account of Laing’s struggle in his early career to understand and conceptualise mental illness which is something I think anyone working in mental health can appreciate. While it is sometimes difficult to keep track of the various theorists and theories that influenced Liang, diligent study rewards the reader with an intriguing and broad-ranging interpretation of the causes and consequences of mental illness.
The Wechsler Intelligence Scale for Children (WISC) is a staple in every child clinical psychology department's psychometric test cupboard. It is a standardised test of cognitive ability for children aged 6 to 18 and is currently in its 4th edition, with UK norms. The WISC comes from a long lineage of Wechsler tests dating back to the 1930s and fits within a family tree of very well standardised intellectual assessment kits aimed at pre-school and primary children (WPPSI –III), children (WISC-IV) and Adults (WAIS-IV), and the abbreviated scale (WASI-R) along with tests of Memory (WMS-IV) and individual attainment tests (WIAT-II).

The Wechsler tests set the gold standard for psychometric assessment, in terms of their history, careful norming, well established test protocol and their well-made robust materials. Each test comes in a smart looking black or burgundy suitcase, backpack or satchel that is robust enough to weather the test of time. The materials include large colourful spiral bound books of stimulus materials, coloured blocks, manuals and various different record forms. The instructions tell you exactly how to deliver the assessment in the most reliable and valid way, how to score and interpret the results and all about the statistical properties of the test, so these are a must read, even though they might appear boring or daunting.

The tests are structured not just to give an overall score of how a particular individual does on the task, but also how he functions compared to the norm group, and whether he performs differently dependent on the task demands. There are predominantly visual tasks (like spotting what is missing in a picture), predominantly verbal tasks (like asking what the meaning of various words are), tasks requiring speed (like crossing out all the animals in a grid of pictures), tasks requiring memory and concentration (like repeating sequences of numbers). Each task or factor can be compared to the norms, but also compared to the other factors in the individual's profile, giving a remarkably helpful sense of whether scores are consistent or whether he has strengths and weaknesses in his profile.

Whether or not you believe in the principle of intelligence testing or giving people scores that sum up their abilities might be subject to debate, but I believe that such tests also provide a huge amount of invaluable qualitative information if you observe and record it properly. If I have administered the same test in the same way to a hundred people, then I begin to have a sense of what normal behaviour is in that scenario. It makes it much easier to pick out individual idiosyncrasies. I can observe the client's social skills, their attention, their body posture, their willingness to comply with a task that may not be directly related to their presenting problem, their motivation to persist when tasks are boring or challenging, their motor skills when handling materials, their handwriting when putting their name onto the record form and how well they appear to comprehend instructions. I can see if they have particular strategies in their problem solving or whether they need visual or sensory aids.

The WISC is a staple in my test repertoire, and tells me a lot about the children I assess. As well as their IQ score I can look at their behaviour attention and social skills during testing, and I can then use the results as a baseline against which to consider other issues such as development, life skills, social skills, language, theory of mind, literacy, memory, their parents and schools’ expectations.

So I tend to think of the Wechsler tests as being like white rice in a meal – it would be a bit limited alone in isolation and would be bland if it was all you had over and over again; but that isn’t the best way to use it. I think that the WISC provides a background and complements all the other components of the assessment, such as other tasks, observations, questionnaires, interviews, play or the reports of others and allows us to make better informed clinical judgements.

In terms of price it is a big investment for an individual practitioner, but certainly a worthwhile one for a department.