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Diversity reflections

The 'C word'

What makes a case complex?

DCP Awards

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Clinical Psychology Forum

Clinical Psychology Forum is circulated monthly to all members of the Division. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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Editorial

Stephen Weatherhead

AS ALWAYS, there are some excellent articles in this month's CPF. With this in mind I have some exciting news to share: this year's DCP conference will bring with it a new award, the Clinical Psychology Forum Award!

The CPF Award is designed to promote excellence in writing about clinical psychology practice, professional issues or current research. It will be given to the best article in CPF over the previous 12 months (April to March), as decided by the CPF team, which is made up of academics and clinicians, who between them cover the roles of reviewer, columnist, regular features coordinaton, editor and administrative assistant. The award prize will be:

- Full expenses for the DCP Annual Conference (registration fee, travel, meals and accommodation) paid for by the Division.
- An award lecture delivered at the DCP Annual Conference.
- A £200 book token.
- A framed certificate.

The award is given on the basis of the following criteria, which is consistent with the criteria of the article review process in CPF. Marks out of five will be given for:

Innovative quality: This may, for example, be a new way of working, a new political or ethical challenge for the profession, novel research methodology, or a new way of applying clinical psychology.

Research quality: High standards from a methodological and evidential perspective. This applies to audit and evaluation as much as it does to traditional research.

Academic quality: Researched, and considered in the context of available literature. Given the low word count for CPF articles, it should be succinct, focused and respectful in tone and style.

The process for deciding the winner will be:

1. The Editor selects one article from each of the previous 12 issues on the basis of the criteria above.
2. The 12 articles will be considered and scored by each of the CPF team.
3. The top three articles will be discussed at the mid-year CPF meeting and the award winner chosen by majority vote.

I'm sure you don't need any encouragement to write for CPF and that it is enough of a reward to see your article published and potentially impacting on clinical psychology practice. It's nice to be able to offer a little bit extra recognition though, so I'm sure you'll be happy to join us in congratulating the very first CPF award winner in December. Hey, it might be you!

Ste

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Re: Universal NHS services under threat

I write after hearing Professor Allyson Pollock speak about privatisation of the NHS (her talk is available at www.nhsbill2015.org).

Professor Pollock is not affiliated to any political party. She trained in medicine and is Professor of Public Health Research and Policy at Queen Mary University, London.

Key points were:

- The NHS was abolished under the Health and Social Care Act 2012. The Secretary of State for Health no longer has responsibility for ensuring healthcare on the basis of need.
- NHS structures now allow market forces to operate within it. Clinical Commissioning Groups do not have a responsibility to provide universal healthcare.
- The NHS is moving towards a US model of healthcare. However, in the US there are 60 million people who can't afford care. Half those declared bankrupt in the US are in debt because of medical bills.
- Marketising health is expensive. NHS admin costs were less than six per cent for 40 years, but are now thought to be 30 per cent. Privatisation leads to costs associated with transactions, monitoring contracts and returns to investors. These are not the principles which the NHS was founded upon.
- The narrative that the NHS is unaffordable is a political decision. Hospitals and GP services are being threatened with closure and it is unclear who will care for those affected patients (see Archer, 2014, for an example).
- Private companies are pulling out of contracts when they are unprofitable – see Serco, Concordia, United Healthcare (Iacobucci, 2014; Archer, 2014; The Centre for Health and Public Interest, 2013).
- Keep our NHS Public is consulting on the NHS Reinstatement Bill, which seeks to reverse the 2012 Act and protect it from the Transatlantic Trade and Investment Partnership.

Psychologists need to consider our role in highlighting changes to the NHS and how these may impact on our duties regarding equal access to services, continuity of care, risk management and child protection. The NHS changes could impact upon public psychological and physical well-being. The reduction of public services could continue, as the government plans to cut 900,000 public sector jobs by 2018 (Oxfam, 2013).

Please visit Keep Our NHS Public (www.keepournhspublic.com) and National Health Action Party (www.nhap.org) for more information. Now is the time to campaign, before we lose our NHS for good.

Dr Khadija Rouf
Consultant Clinical Psychologist

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Experts by Experience Column

The development of psychological support for the Wales Inherited Bleeding Disorder service

Lynne Kelly

I am a haemophilia carrier, my grandfather was a haemophiliac and I have three sons with haemophilia. Haemophilia describes a group of inherited bleeding disorders in which there is a missing or reduced clotting factor in the blood. It is a genetic condition, usually inherited, but one in three children are born into families where there is no family history.

Haemophilia can be classified as mild, moderate or severe, with symptoms including bruising, prolonged external bleeding and bleeding internally into joints and muscles. Haemophilia A is a deficiency in clotting factor VIII in the blood and haemophilia B is a deficiency of clotting factor IX. The treatment for haemophilia is an injection into the vein of the missing clotting factor VIII or IX. This increases clotting levels to a normal range, stops bleeding and prevents joint and muscle damage.

It has been known for a long time that families need assistance in finding appropriate care and multidisciplinary input to deal with the consequences of the condition. The concept of comprehensive care for haemophilia was developed in the 1960s; the idea being to treat the whole person and family through continuous supervision of all the medical and psychosocial aspects of bleeding disorders.

My grandfather was a haemophiliac and in his lifetime the only treatment available was whole blood transfusions and cryoprecipitate, but he lived until he was 76 years old. In the 1970s factor concentrates became available from pooled plasma imported from America. This revolutionised haemophilia care, but the new treatment carried HIV and hepatitis C and 5000 haemophiliacs, many as babies and children, became infected in the UK.

It is as stressful for a newly diagnosed family who have no knowledge of the condition learning how to administer intravenous factor as it is for older people who have haemophilia and are dealing with arthritis joint replacements, and the effects of HIV and hepatitis C on patients, families and bereaved families.

When my first son was born with haemophilia in the late 1980s, the treatment was heat treated, but we were advised that non-plasma derived Factor was being developed which would be much safer than blood products. With the support of haemophilia doctors and our MPs, we succeeded in getting recombinant factor VIII in 1996 – one year before it was introduced in England.

This was a major breakthrough as it meant the new generation of people who had haemophilia were not exposed to the risks associated with blood products.

The next issue facing us was the loss of our Haemophilia Centre, which was merged with Adult Malignant Haematology… an unacceptable situation for everyone. Very poorly cancer patients undergoing chemotherapy treatments and noisy young children side-by-side, all added to the stressfulness of the hospital visit, which could often be daily, if you had a difficult bleed to treat.

It was obvious to clinicians and patients that this was unacceptable. We contacted our MPs and Welsh Assembly members and within two years, endless meetings and fundraising, the Arthur Bloom Haemophilia Centre in Cardiff was opened.

We thought we had achieved everything…

What could go wrong after we had managed to secure safe recombinant treatment and comprehensive/multidisciplinary care? Then disaster struck, with the death of family and so many friends with hepatitis C and HIV, psychological support was now needed for everyone affected by haemophilia.

By talking to affected patients, families and bereaved families from all over Wales, I started gathering patient experiences.

Some patients had never spoken about their condition. Some young mums were so isolated, they felt that nobody understood, some couldn't even begin to talk about having a child with haemophilia; they themselves were frightened of going to the hospital. Many were so afraid of allowing their child to lead a normal life that they had become overly protective and blamed themselves for every bleed that their child had.

The difficulties encountered by children with needle phobia, Portacaths, inhibitors, and the effects on siblings and partners who felt that haemophilia took all the attention, haemophilia seemed to interfere with everything.

Then there were older children and teenagers who were finding treatment regimes difficult. Most parents and carers learn to treat their child intravenously at home. This can be a huge step, to inject your child yourself, and needs a lot of support from haemophilia staff and co-operation from the child! Learning to self-administer treatment is extremely difficult to begin with, but fortunately, most families adapt to this, which helps cut down on hospital visits and disruption to family life. Lots of teenagers find treatment regimes difficult when they leave home and go to college or university. Many refuse to treat themselves and need help dealing with the consequences.

Some of the mums have dads, brothers or cousins who had died as a result of contaminated blood, and now have children with haemophilia themselves. Bereaved parents had lost children as young as seven to AIDS, some families had been split up and brothers and sisters separated and put into care when a parent died. Some families had lost up to three family members to HIV and hepatitis C. Some of the men with haemophilia who had contracted HIV had unknowingly infected their partners.

The stigma of those affected by HIV and hepatitis C means that there is still great secrecy and mistrust in the haemophilia community. Progress would have been impossible without the support of haemophilia clinicians from all over Wales. I had to ensure that we were all asking for the same issues to be addressed. I then asked all the patients, families and bereaved families I knew to contact their MPs and Welsh Assembly Members and tell their story.

And by accident we became a lobby group

In 2009 a group of us went to see the Health Minister Edwina Hart to outline the difficulties we were encountering.

Our Assembly Members continued to ask questions about the gaps in haemophilia care in Wales in the Welsh Assembly to keep haemophilia on the agenda. And then the Cross Party Group on Haemophilia and Contaminated Blood was established at the Welsh Assembly to keep up the pressure.

In 2011, the Health Minister set up a Ministerial Task and Finish Group to review haemophilia care in Wales. Chaired by Dr Chris Jones, Deputy Chief Medical Director for the Welsh Government, the group consisted of haemophilia centre directors, haemophilia nurses, physiotherapists, clinical psychologists, social workers and Welsh commissioners (the Welsh Health Specialised Services Committee or WHSSC), with patient representatives from all over Wales.

The following gaps in service provision were identified by the Task and Finish Group:

1. Psychological and counselling support.
2. Physiotherapy throughout Wales.
3. Consultant hepatology support for haemophiliacs with hepatitis C.

Funding was then allocated to psychological support by the Welsh Government. Four psychologists were to be appointed for inherited bleeding disorders. The All Wales Advisory Group, consisting of haemophilia doctors, nurses, physiotherapists, local health board and patient representatives, and chaired by the Welsh commissioners (WHSSC) were to ensure that the recommendations were implemented.

However, it became evident that progress was going to be impossible without continued engagement from politicians, clinicians and patients. We had further meetings with the Health Minister to impress upon her the urgency of appointing the psychologists. The funding had been allocated to the commissioners but it wasn't being utilised. The commissioners were blaming local health boards for lack of progress, and vice versa. The clinicians had no leverage, and again we had to go back to MPs and Assembly Members to ask for further meetings with the Health Minister.

Finally, after much pressure, interviews were arranged and four psychologists were appointed. Dr Anna Brazier leads the Cardiff Inherited Bleeding Disorder Service, with Dr Zoe Moss providing outreach to Abergaveny. Alison Gorman is based at Swansea Haemophilia Centre and Sali Burns at Bangor.

In conclusion

What I have learnt on my family journey is that as a patient it is essential to learn as much as possible about your condition to ensure you are well informed.

Patients need to engage with other patients and carers, at the hospital or through a patient support group or charity. It is so important to meet with others in the same situation. There is strength in numbers and there is no substitute for talking to others in the same situation.

It is essential to foster a good relationship with clinicians. I always have instilled this in my children… we used to say that the haemophilia doctors, nurses and physios were our friends, and I feel that this helped build mutual trust.

Working collaboratively with clinicians to ensure that we always have a clear message to take to decision makers about what we are asking for.

Quality of life for patients and their families is greatly improved when physical and psychological needs are met through comprehensive care/multidisciplinary care and we should make this our goal to ensure that patients have the best quality and most productive life.

Clinicians' input is often ignored by commissioners/health boards/government as they see the cost of the service increasing. We need to ensure that patients are involved throughout the commissioning process.

And finally, we need continued engagement with patients to ensure that the service is fulfilling their needs.

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Ethics Column

Wealth, social class and clinical psychology

Steven Coles

'Britain's divided decade: Rich are 64% richer, poor are 57% poorer.'
The Independent, 10 March 2015 (Morris, 2015, p.1)

RECENT REPORTS by Oxfam (2014a, 2014b, 2015a) and newspaper headlines led me to reflect on inequality, wealth and social class, and whether it was relevant to clinical psychology. The data reported on Oxfam's website was striking: 'Eighty people now own as much wealth as half the world's population, while nearly a billion people can barely afford to feed their families' and 'Inequality is rising: The combined wealth of the richest 1 per cent will overtake that of the of the other 99 per cent of people next year unless the current trend is checked.' (Oxfam, 2015b). The stark differences in wealth, and hence power, should prompt ethical reflection, but such global inequality might seem distant to clinical psychologists practising in the UK. However, inequality has been increasing in the UK since the late 1970s/1980s and wages (taking account of inflation) have decreased significantly during the recent economic crisis, particularly for younger people (Blanchflower & Machin, 2014). Oxfam (2014b) reported that within the UK, the five richest families were wealthier than the bottom 20 per cent of the population. Social inequality, wealth and people's place and status is relevant to me as a UK citizen; however, as a psychologist do I need to concern myself with social and economic issues? In reflecting on this I looked to the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008, p.2) for guidance:

> *Psychologists recognise that they carry out their activities within a larger social context. They recognise that the lives and identities of human beings both individually and collectively are connected across generations, and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members… the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity and morality prevail.*

My reading of the Universal Declaration is that psychology should give some thought to the issue of social inequality and wealth; in particular, the relevance of these issues to the people we work with. My specialist area involves working with people who hear voices, are suspicious of other people and at times have beliefs others find unusual. Read (2010) in a review of the area asked: 'Can poverty drive you mad?', and his unequivocal answer is that poverty is a clear causal factor in mental health, including 'madness', mediated through other factors in people's lives. He also cites evidence that inequality is an even more significant factor. The Marmot Review (2010) and the work of social epidemiologists Richard Wilkinson and Kate Pickett (2010) detail extensive research evidence that social inequality has an impact on a wide range of personal and community measures of well-being.

If social inequality matters, what can I, as an individual practitioner, and the psychological profession do about it? Arguably, psychologists are already intervening; for example, take the contrasting positions of the Improving Access to Psychological Therapies (IAPT) programme and a recent campaign, Psychologists Against Austerity. Publications by politically influential and prominent advocates of IAPT, Layard and Clark (2014a, 2014b, 2014c), whilst appearing to be driven by the motivation to alleviate distress, downplay the importance of the impact of the social world on psychological well-being. For example, the articles argue that 'dealing with the external' and the 'enormous progress' made in areas such as income, education and housing had not addressed psychological well-being and the malaise of industrial nations. Instead, they called for a turn to the 'inner person' as the focus of intervention and difficulties solved through the 'power of evidence-based psychological therapies'. Whilst Layard has discussed issues such as inequality (e.g. Layard, 1999), regarding mental health and therapy, the emphasis is on 'the huge social cost of mental illness' (Layard & Clark, 2014b) rather than how social problems cause distress. In short, their perspective on mental health is 'We have tackled the external problems but not the one inside… the evil of mental illness.' (Layard & Clark, 2014c).

A campaigning group 'Psychologists Against Austerity: Mobilising Psychology for Social Change' appear to hold very different assumptions to those of the IAPT proponents (www.psychagainstausterity.wordpress.com). They directly address how public monies are used in the UK and link cuts in public expenditure to increased poverty: 'As applied psychologists it is our public and professional duty to be speaking out against the further implementation of austerity policies.'

The campaign suggests links between economic factors and psychological well-being through five mechanisms: humiliation and shame; fear and mistrust; instability and insecurity; isolation and loneliness; and being trapped and powerless. Furthermore, there have been many (e.g. Moloney, 2013; MPG, 2012; Smail, 2001) who have critiqued mainstream psychology and IAPT not only for paying inadequate attention to the social world, but for concealing the relationship between society and its impact on the individual.

There appears to be a marked difference in emphasis regarding wealth and inequality between the IAPT programme and the Psychologists Against Austerity Campaign, and I'm sure others fall on a continuum between. How can we explain such differences? There are many ways we could look at this, from an evidential perspective, theoretical, or in terms of vested interests. However, I want to consider how our personal experiences shape our view of inequality; how our feelings about our sense of position and place in the world shape our attitudes to poverty and wealth. The *Universal Declaration of Ethical Principles* states that we should have 'self-knowledge of how one's values, experiences, culture and social context might influence one's actions and interpretations', and we often rightly consider this in terms of ethnicity, gender, disability, sexuality, and so forth. However, I think clinical psychologists need to reflect more on our social class (as well as how this intersects with other aspects of diversity).

The personal background and social class of a psychologist is one factor influencing how much attention is paid to issues such as inequality and poverty, and we need to reflect on how inequality has influenced us and our beliefs. My own experiences, growing up in a relatively financially secure working class family, shaped me and my views of class and wealth. I probably fell in the gap between friends whose families struggled financially and were relatively less privileged than I was, and middle class friends. With middle class families their ways of being at times felt unusual to me: I was unsure of some of the assumptions and rules of interaction, which could leave me feeling uncomfortable and having a sense of not fitting in. These experiences have provided me with a form of knowledge about how inequality shapes people. I witnessed very bright classmates from deprived backgrounds drop out of education due to poverty-related stresses (insecurity in housing, difficult neighbourhoods, etc). I also saw how for many of my middle class friends the main stresses came from being in the eye of a hypercompetitive culture, often focused through heightened expectations of their parents (see Horney, 1937, for a discussion of how culture shapes hypercompetitive personalities). Whilst some friends had material wealth, retrospectively, the 80's culture of competition, 'greed is good' and consumerism provided its own stressors. Being a father in my early twenties and regularly worrying about money problems, such as how to pay the gas bill and the guilt of using money intended for our young son's birthday, is ingrained in my mind and never to be forgotten. These experiences now give me a sense of empathy for the grind of counting pennies and pounds, and a sense of how it feels to be down-ranked in a culture that places great expectation and pressure on ideals around how we should look, dress and speak, and what we should have and consume. I also had the knowledge that I was lucky in having educational opportunities to escape that not everyone had open to them. I believe my lived experience is a form of knowledge that sits alongside, gives a sense of feeling to, and makes alive my scientific knowledge and theory of how culture, social and material resources shape individuals. I also believe that my experiences oriented me to think about the social world because it was prominent in how it shaped my life and those I cared about. Ultimately, it shaped and motivated my ethical stance to inequality and poverty.

The motivation to address inequality requires empathy and compassion for others. There is an interesting body of literature supporting the notion that our social class and personal circumstances is a factor (amongst many others) that shapes our attitude to the plight of others. This social-psychological research suggests that those with greater social power (higher social class) tend to have less empathy and compassion towards the distress of others – ‘turning a blind eye to the suffering of others’ (e.g. Kleef et al., 2008; Stellar, Manzo, Kraus & Keltner, 2012; Piff, Stancato, Cote, Mendoza-Denton & Keltner, 2012). The research suggests that those with most power and influence in the world, particularly the super elite of very wealthy people, are likely to have decreased empathy towards the majority, including the impact of social inequality. However, it should be noted that class is a multidimensional concept, and the relationship between class and ethical behaviour is complex, mediated by moral values, and should not be seen as a simple deterministic relationship (Trautmanna, van de Kuilenb & Zeckhauser, 2013). Despite this caveat, and my assumption that most psychologists are not part of a ‘super elite’, I do believe such research should prompt psychologists to reflect on how class influences our attitudes towards the distribution of wealth, particularly given clinical psychologists are relatively more privileged in terms of income than the average UK citizen, and often have more social power, given our educational status. How does our class shape our empathy towards clients who have less power and status? Does our social status and privilege shape our psychological models? Are our theories and practices blind to the realities of the less fortunate?

My view, based on life experience, evidence and theory, is that social class and the distribution of wealth has a great bearing on the welfare and well-being of the people psychologists try to support. This can be felt through the practical and everyday stresses of living with limited resources. Furthermore, we are all affected, directly and indirectly, by how our unequal and consumerist culture breeds a hypercompetitiveness and a sense of unrealistic expectation that leaves many feeling ashamed (e.g. Smail, 2001). These issues are of a cultural, social and material nature, which therefore necessitates that we look for solutions beyond individual therapy. Obviously there are restrictions to how, as individual practitioners, we achieve this, and we might be limited by our workplace in how we help the people we work with. However, I do believe we and our professional body need to work towards making the social-material world and the distribution of power and resources core to our thinking and practice. This is necessary if we are to be a profession that: is ‘committed to placing the welfare of society and its members above the self-interest of the discipline and its members’ (p.2); is sensitive and responsive to the local needs of communities; and acts with fairness and justice (International Union of Psychological Science, 2008). As a start, I believe as psychologists we need to:

1. Ensure the social-material world and its shaping of individuals is firmly embedded in our models and formulations.
2. Reflect upon how class and privilege has shaped our assumptions about individuals, society and the distribution of power.
3. Ensure that we are not providing the public and politicians with messages that undermine the importance of social inequality, class and wealth.
4. Develop ways of working that are more sensitive and responsive to the social-

material resources and needs of individuals and communities.

5. Write guidance papers for politicians and for the public on the impact of social inequality and its psychological impact.
6. Be honest about the limits of what psychologists can do and be open to the fact that some social ills require solutions that are social and economic in nature.

It is likely to be challenging for clinical psychology to take inequality seriously and will require us to examine our assumptions, our own prejudices and our vested interests. The opportunity is a richer understanding and better ways of helping the people and communities with whom we work. The risk of avoiding the challenge of inequality is that we are part of the problem, rather than part of the solution.

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Declaration of interests

I am one of the DCP's Ethics Coordinators and the UK DCP Honorary Treasurer. I therefore have a role in the strategic direction of the profession; however, the views expressed are my own and do not necessarily represent the perspective of the DCP.

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Cognitive behaviour therapy for adults with Asperger's syndrome: Thinking styles and executive dysfunction

Waseem Alladin & Natalie Holloway

This article provides an update on cognitive behavioural therapy (CBT) and Asperger's syndrome (AS), focusing on thinking styles that have not previously been addressed. More comprehensive guidance is included for practitioners working with adults with AS, with modifications to CBT.

LITERATURE regarding cognitive behavioural therapy (CBT) and adults with Asperger's syndrome (AS) is limited. Research to date includes a small number of case studies (Hare, 1997; Cardaciotto & Herbert, 2004; Weiss & Lunksy, 2010). Individuals with AS who are high-functioning or above average IQ are often not eligible for learning disability or autism specific services and there is shortfall in AS specialist provision in adult mental health services (Weiss & Lunsky, 2010). With the high prevalence of anxiety and depression (Spek et al., 2013), it is disappointing that research into CBT and AS has not developed further.

Thinking styles

How one interprets and thinks about events affects how one feels and subsequently influences actions and behaviour. CBT aims to change maladaptive thinking styles. However, certain thinking styles, which can be very rigid in those with AS, may be difficult to challenge. Whilst insight can be taught or increased during therapy, a subset of individuals with AS have difficulties in executive functioning. Self-monitoring and self-awareness are necessary for behavioural flexibility and regulation. Individuals with AS may have impaired capacity for self-awareness and reflection (Jackson, Skirrow & Hare, 2011). Echoed throughout the literature is a focus on visual thinking, literal thinking and executive dysfunction in planning and organisation (see Paxton & Estay, 2007). However, emotion processing and flexibility of thought have not been detailed previously. Therefore, we will discuss the following:

- Difficulty perspective taking.
- Alexithymia (inability to identify, label or express emotions).
- Difficulty shifting attention.
- Categorical thinking.

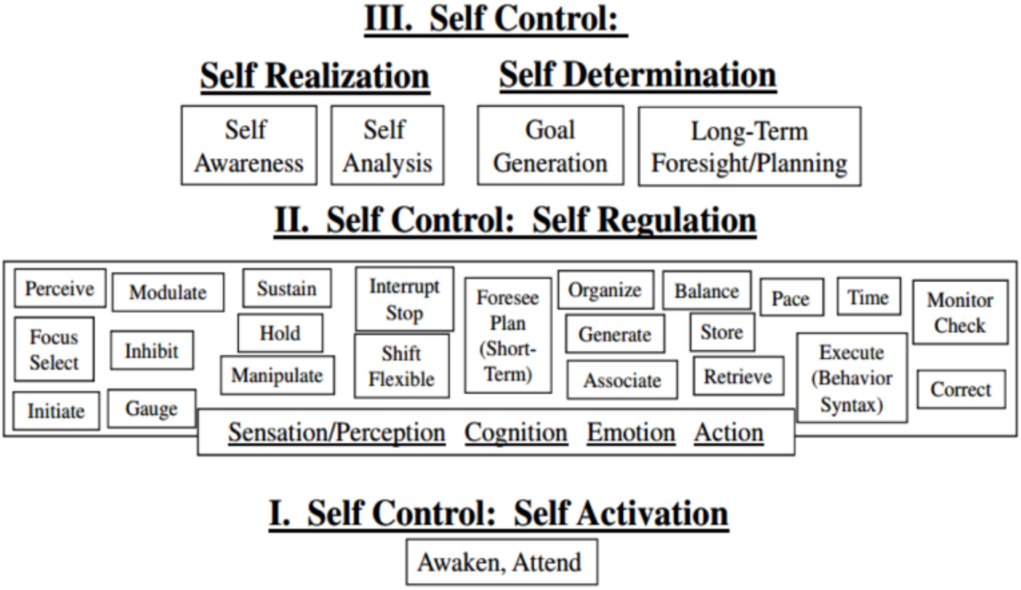
These can be conceptualised in terms of executive dysfunction; specifically, self-regulation (McCloskey, Perkins & Divner, 2009). In McCloskey's model, self-control is spread over three tiers, with self-regulation as the largest component (McCloskey, Perkins & Divner 2009 – see Figure 1). Cues function in varying degrees and combinations to direct within four domains: sensation/perception, emotion, cognition, and action. Effective functioning can fluctuate across different domains and between each of the self-regulation cues.

Difficulty perspective taking

Impairments in mentalisation, autobiographical memory and executive function can lead to difficulties in social reasoning (Abell & Hare, 2005). Client Z can intellectually understand others' perspectives when discussed but is not able to apply the different perspectives to his own situation either retrospectively or in the moment, suggesting dysfunction in the 'manipulate' cue. This commands working memory to manipulate perceptions, emotions, cognitions or actions that are being held in the mind or in the immediate environment (McCloskey, Perkins & Divner, 2009).

McCloskey describes a man unaware of the impact his actions have on others and unable to

Figure 1: The McCloskey model of executive functions



anticipate the consequences of his emotional reactions. It is suggested that 'forsee/plan' is affected in the domains of emotion, cognition and action (McCloskey, Perkins & Divner, 2009). However, this can be understood as alexithymia, which would indicate 'monitor' and 'perceive' dysfunction in the emotional and cognitive domains. If so, the person would have increased difficulty in predicting emotional consequences for himself and others.

Alexithymia

A sub-group of individuals with AS have alexithymia, presenting both emotional and social difficulties (Bird, 2011). Difficulty accessing and effectively describing emotions is one of the challenges faced when using CBT with this client group. They can experience feelings and understand them in others intellectually, but they may not express them in a 'typical' way or understand how certain emotions are experienced (Leather & Leardi, 2012). Research suggests greater difficulty in identifying and describing emotions compared to matched controls (Samson, Huber & Gross, 2012), poorer emotion recognition (Heaton et al., 2012) and impaired emotion processing (Hill, Berthoz & Frith, 2004). This does not mean people with Asperger's syndrome cannot show empathy: alexithymia is specific to the cognitive domain rather than the affective (Berthoz & Hill, 2005).

Weiss & Lunksy (2010) observed one participant's BDI-II scores increase over five sessions of CBT. Researchers attributed this to increased awareness of his mood and ability to consistently rate mood and symptoms. If so, CBT improved his ability to access and describe emotions, which is said to have contributed to a decrease in co-morbid anxiety. This supports research which suggests alexithymia can change over time and is not fixed. Alexithymia scores do not predict an unfavourable treatment outcome in CBT; rather, a reduction in alexithymia was associated with a reduction in depressive symptoms (Spek, 2008). Therefore when alexithymia is considered and addressed in CBT, one of the challenges then becomes a strength.

Client Z presented with symptoms of depression marked by a decrease in personal care. Significant difficulties were reported by carers and Client Z appeared to lack insight into the problem. Client Z reported no fluctuation in mood whatsoever when completing mood diaries. However, when asked about specific difficulties during the week, Client Z stated 'I might be depressed' or 'I just didn't [go out]'. When depression symptoms were discussed, client Z would question why this was being discussed, appearing perplexed. Her inability to connect the discussion of depressive symptoms and the statement she made earlier suggest executive dysfunction. One way to address this is to utilise a more behavioural approach: be more directive in behavioural goals, make homework explicit, and use behavioural outcome measures. For example, two indicators that depressive symptoms had improved were that client Z began to: (a) regularly take care of personal hygiene, and (b) talk to a relative once a week (compared to a baseline of zero).

Categorical thinking

Categorical or 'black and white' thinking is often discussed as a difficulty for those on the autistic spectrum, yet it is something 'neurotypicals' are susceptible to. Only seeing the extremes and ignoring 'grey areas' is something that becomes more polarised when the topic is emotionally charged. This is also true in AS. Further, a lack of insight means the individual cannot see the contradiction, even when it is pointed out to them by way of evidence or consensual validation. This has been understood in terms of 'mind blindness' (Baron-Cohen, 1990), which suggests that 'neurotypicals' have the capacity to 'mind read' (i.e. to attribute mental states to self and others), whereas individuals on the autistic spectrum do not (Frith, 2001).

Rigid thinking styles and a lack of considering alternatives is suggestive of dysfunction in the 'shift/flexible' cue across all four domains (McCloskey, Perkins & Divner, 2009). This resonates with client X's rigid categorical thinking style. He held focused beliefs about what was within psychology's remit: 'psychiatry deals with medication so we don't need to discuss it in psychology'. In addition, he had an acute sense of right and wrong. However, once the therapeutic relationship was established we were able to suggest and shape alternative thinking styles and gradually include behavioural experiments.

Initially, Client X did not accept his diagnosis of AS and believed that symptoms of social anxiety were perpetuated by a previous diagnosis of 'schizophrenia' and could therefore only be treated psycho-pharmacologically. He showed little motivation to engage in psychological treatment, as he did not see how a diagnosis of AS applied to him. When completing an online version of the Autism-Spectrum Quotient (AQ; Baron-Cohen et al., 2001) a number of statements provoked client X to identify the problems in question. This allowed for psychoeducation regarding social difficulties, which individuals with AS can experience, and how AS symptoms can contribute to social anxiety. Following discussion, client X agreed that a diagnosis of AS was appropriate (whilst recognising that psychosis can exacerbate social anxiety) and identified therapy goals.

Difficulty shifting attention

Difficulty shifting attention involves two cues; 'stop/interrupt' and 'shift/flexible', primarily affecting the emotional and cognitive domains (McCloskey, Perkins & Divner 2009). McCloskey suggests that an individual could effectively use the 'focus/select' cue to direct their attention, but may experience dysfunction utilising the 'sustain' cue. Whilst most individuals without executive dysfunction revert to 'tunnel vision' during an argument, client Z had the additional difficulty of becoming 'stuck': unable to alter course. One way to indirectly challenge this perspective is to provide a structural intervention. For example, Client B was asked how he would gain someone's attention and replied that he could physically force them to turn and face him. To illustrate that this was inappropriate, without directly challenging Client B, the clinician stood behind their colleague and called their name (thus 'forcing' them to turn without applying any physical force). This quickly illustrated the point without risking a lengthy argument/discussion.

Figure 2 (adapted from Alladin, 2005) outlines difficulty in shifting attention by mapping executive functions (McCloskey, Perkins & Divner, 2009) onto attentional components of Sohlberg & Mateer (1987) and Mirsky et al. (1991).

Modifications to CBT

Therapeutic relationship

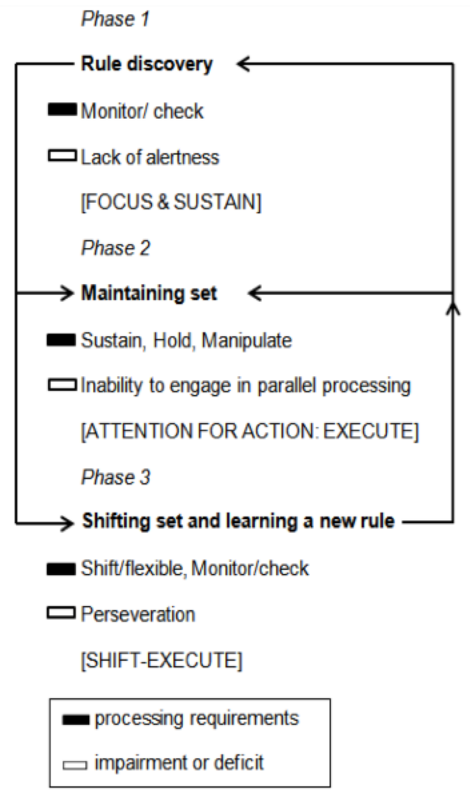
- The value of the therapeutic relationship must not be underestimated. The clinician has increased responsibility for building the relationship and psychological mindedness.

- Balancing rapport with keeping focus: Incorporating special interests, whilst helpful, can lead to distraction in session. When sessions become overly client-led clinicians need to be directive in focusing back to the cognitive model. Additionally, if the person has difficulty sustaining attention, there is need to direct attention more frequently.
- Be aware of subtle language differences: articulation may not match comprehension (see Gaus, 2011).

Practical considerations

- Visual formats are more compatible with AS as 'visual thinkers'; it can also help to maintain focus and motivation in session.
- For high distractibility, a focus sheet outlining the session can be placed on the table to direct the person to task.
- Asking a client to write agreements or sign them can serve as a concrete representation and can be referred to when modifying rigid thinking styles.
- Encourage bringing a diary to write homework and appointment times in.
- Anderson & Morris (2006) suggest avoiding metaphors due to AS literal thinking style. Whilst generally not advisable, the use of verbal metaphors with individuals with AS should not be a rigid rule. When a pictorial metaphor is presented (such as 'is the glass half full or half empty?') accompanied by a visual representation such as a drawing, it can resonate with the individual and their situation. However, the therapist may need to draw upon the comparison more explicitly and check the individual has understood the relevance of the metaphor.
- Those experiencing attentional difficulties or severe anxiety can benefit from shorter sessions.
- Contrary to conventional practice, set the clinic out with a table and chairs. This eases social pressures of the situation, such as making eye contact. The layout provides boundaries and defines expectations such as where to sit, without the person having to ask.

Figure 2: A task analysis of social problem solving: Conversational 'turn-taking'



Technology

Whilst the usefulness of computerised CBT for those with AS has not been evaluated, the benefits of technology are clear. Ways to incorporate technology include:

- Set homework to type thoughts, feelings and reflections rather than discuss in session if the client is struggling.
- Allow clients to fill in forms and questionnaires online.
- Typed summaries and cue-cards are useful to structure homework, focus sessions and reinforce learning.

Conclusions

CBT, with modifications and a greater focus on behavioural strategies, can be a useful intervention in AS for those with additional executive dysfunction that is often apparent in social interactions.

The therapists' knowledge of AS thinking styles is beneficial to help the person access and express their emotions and cognitions.

It is important to be aware of executive dysfunction in individuals with AS, to 'side-step' using inappropriate behavioural examples or be able to implement modifications to CBT.

There is a need to focus on symptoms specific to the client and identify current difficulties and goals to work on in CBT.

If motivation and insight are low, these can be improved by increasing flexibility of thought and gradually and gently challenging rigid thinking styles.

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Complex trauma: Applied psychology in a 'looked after children' therapeutic residential setting with education

Joe Grace & Lorna Stewart

This article outlines the theory of complex trauma. It considers how best to disseminate psychological theory in a residential setting for looked after children with behavioural, emotional and social difficulties education, and a fostering service attached.

OVER THE PAST two decades there has been rigorous research into complex trauma (Cook et al., 2005) and developmental trauma disorder (Van der Kolk et al., 2009). They contend that the glut of diagnoses that exist for young people who have experienced trauma across their development do not fully address the origins of subsequent behavioural, emotional and social difficulties (BESD). A lack of understanding regarding the cause and maintenance of psychological trauma could result in a lack of appropriate interventions that are supported by the evidence base.

It is proposed by the authors that a more structured approach to interventions – within therapeutic residential childcare with BESD education attached and a fostering service – is required. Understanding the theory that informs interventions for looked after children, the majority of whom have experienced prolonged trauma in the family home (Department for Education, 2012), can help formulate strategies that can be adapted across multidisciplinary teams. It is proposed that when providing therapeutic residential childcare and education the development of a core practice strategy, with a theoretical foundation centred on a biopsychosocial conceptualisation of complex trauma, can provide a coherent approach. Essentially, there should be a common language used across services that is clinically informed. This should engender greater multidisciplinary understanding and communication. In turn, this ensures that looked after children have boundaries and role models that remain constant whether they are within the residential home, in BESD school or receiving multidisciplinary clinical input (e.g. speech and language therapy, psychotherapy, clinical, educational and forensic psychology). Consistency of approach, a key factor when working with looked after children, is maintained through a shared clinical understanding of the function of behaviour as opposed to the focus on the behaviour itself, which often generates negative attributions.

Understanding of the function of behaviour as opposed to the focus on the behaviour itself.

A word on labels

From a psychological perspective it is important to ensure that the application of diagnostic labels in the workplace is informed by an understanding of what they actually represent. The possibility of labels being adopted as pejorative, increasing the risk of discrimination and superseding individual identity, has to be managed effectively (Ben-Zeeve, Young & Corrigan, 2010). There is a risk of young people being seen as having complex trauma. Viewing complex trauma as something that has happened to a young person is a more critically reflexive way of conceptualising the issues at hand. Also, there is no need to include the term 'disorder'. Therefore, the medical labels associated with trauma are conveyed in a manner that is always mindful of context and the normative psychological variation that exists in the general population that can be misinterpreted as pathology (British Psychological Society, 2012). Critically, this helps ensure that origins of maladaptive presentations in young people are viewed as the result of the negative actions of others, that continuing challenging behaviour is understood as a lack of agency, and that positive change is chiefly created through addressing environment and relationships. This helps reduce the possibility of the issue being conceptualised as predominantly part of the young person, and so, ultimately, some personal defect. This in turn helps reduce the tendency to blame the individual. An attempt is made to use the more helpful aspects of a medical conceptualisation provided in Van der Kolk's key paper (2005) to inform a biopsychosocial approach that firmly places the spotlight on relationships and systems as the key processes in originating, precipitating and perpetuating behavioural, emotional and social difficulties.

Setting

In order to identify clear theory/practice pathways, a professional and clinical multidisciplinary team working with looked after children have developed a core practice strategy. The team is part of a private sector service based in the midlands. It consists of two clinical psychologists, an educational psychologist, a forensic psychologist, three psychotherapists, one trainee and two assistant psychologists. This forms the multidisciplinary clinical team for two BESD schools with approximately 45 day pupils and a fostering service serving 16 therapeutic residential childcare homes. Overall, the organisation employs clinical, residential and educational staff and foster carers to meet the needs of the young people.

> *Challenging behaviour is understood as a lack of agency.*

Theory and application

The implementation of theory and recommendations for good practice are informed by the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE) guidelines. The eight key principles that inform these guidelines are all addressed to some extent, with principle four being most fully met. This principle is concerned with the nurturing of attachment and creating a sense of belonging (NICE, 2010). Informing the core practice model was Cook et al.'s (2005) seven domains of impairment.

The seven domains of impairment

Complex trauma across development can be categorised as seven domains of impairment (Cook et al., 2005). Each domain can be viewed as distinct yet simultaneously related to the others. This helps illustrate how diagnoses such as post-traumatic stress disorder, attention deficit hyperactivity disorder, anxiety disorder and eating disorders fail to explain the complex presentation of many young people. These young people are often looked after children, have been exposed to trauma across their development, are in foster care, or have BESD requiring specialist education.

Ideally, theory can provide a coherent reference point from which to disseminate clinical information at a multidisciplinary level. A comprehensive training package adapted for each discipline was developed that incorporates the seven domains of impairment. This models key elements of the initial clinical assessment format and the structure of the clinical plans for each of the young people. Recommendations for intervention were based on the playfulness, acceptance, curiosity and empathy model (PACE; Dan Hughes, 2006) and the six core components of trauma intervention (Kinniburgh, Blaustein & Spinazzola, 2005). The evidence base for understanding and treating young people who have experienced complex trauma can therefore help inform the practice of the whole organisation. The aim of the shared core practice model was to provide multidisciplinary continuity, more clearly identified goals across care, educational and clinical services, better communication, and ultimately, more effective overall care.

The clinical team's responsibilities are concerned with providing one-to-one clinical interventions, the training of care, fostering and educational staff, and consultancy on appropriate interventions in residential, educational and fostering settings.

Attachment

Typically, attachments are forged between six months and two years (Golding, 2008). Although psychological trauma inflicted by primary carers in the first two-to-three years of life is difficult to address, in later years it is possible to make positive changes. This is achieved by providing young people with a model of care that is consistent, empathic and sustained (Cross, 2012).

Attachment theory is provided as a specific piece of training to staff by the clinical team. The new complex trauma training package presented attachment within the seven domains model and explicitly linked it to other domains. New ways of recording information, informed by the core practice strategy, have been developed and have been incorporated into the training package. These can then be used by staff on a daily/weekly basis. It is hoped that the combination of regular training, frequent consultancy from the clinical team, and the practice of recording looked after children's behaviour within the new structure will promote greater levels of understanding and help develop more effective interventions. Specific interventions regarding attachment issues have been focused on developing worker self-awareness, so they are more able to understand the reciprocal nature of relationships and how they might unwittingly play into insecure and disorganised attachments. Improved reflective skills to monitor vicarious trauma in the workplace will help reduce the possibility of arousal in workers. Developing the skill of constantly verbalising the impact of looked after children's behaviour may help to develop their ability to respond appropriately at an emotional, social and behavioural level.

Biology

Trauma in an infant's development can result in a failure of the brain to develop the neural networks required for appropriate adaptation to the social environment (Teicher et al., 2002). Construction of self-narratives in therapy can help address this issue.

Many people can have difficulty conceptualising purely psychological concepts so provision of a medical explanation in this instance can be an effective way of developing empathy in some workers. By placing this explanation in the context of social interaction and complex trauma, it is possible to assimilate a medical explanation into a psychological one.

Affect regulation

Link interaction to the appropriate affect.

Many looked after children present with significant emotional issues. Their behaviour is indicative of an inability to label emotions correctly, link interaction to the appropriate affect and to empathise. Consequently, relationships with others are fraught with uncertainty and anxiety, which can lead to minor incidents being processed as major stressors. By placing this domain into the complex trauma model and explicitly linking it to all relevant paperwork from initial psychological assessment through to residential recording tools, it is possible to promote greater understanding across the workforce.

Dissociation

Dissociation can help explain self-harming and the apparent nonchalance or amnesia of traumatised children that sometimes follows serious incidents (Antai-Otong, 2008). By relaying this information to the workforce it should be possible to engender greater levels of understanding that re-conceptualise negative and unhelpful narratives around 'attention seeking', 'disregard for others' or 'lack of responsibility'. This is achieved by incorporating this domain into the complex trauma model. This slowly but surely creates a working vernacular that will shape opinion and behaviour at the level of service implementation. Essentially, this should be more empathetic and so more ethically sound.

Behavioural control

Trauma across development can result in children behaving in ways that are under or over controlled. Controlling behaviours are typically indicative of a disorganised/controlling attachment (Hughes, 2009). This domain is incorporated into the complex trauma model and is explicitly linked to the other domains, primarily attachment.

Young people can be unhelpfully labelled as having conduct disorder, oppositional defiant disorder, and so on. These labels place the issue with the child whereas a complex trauma conceptualisation can highlight the role of damaging families and an ineffective care system that can unwittingly perpetuate key problems. Over time, it is hoped that the importance of relationships and context will be so effectively relayed to the workforce that they will become implicit factors that support the new vernacular. This enables the balance of responsibility for change to move from the individual to the social. By implementing the cornerstones of the PACE model (Hughes, 2006), which places more onus for change with the caregiver, it is possible to co-regulate the young person's emotional state and improve emotional regulation.

Cognition

Exposure to trauma has been shown to impact negatively on cognitive processing. Some traumatised children are less flexible in their thinking, lack creativity and have issues with attentional capacity (Beers & De Bellis, 2002). The educational psychologist provides the key link to teaching staff on cognitive issues and contributes to initial recommendations for interventions that can be implemented across disciplines; historically, this information was limited to the educational staff. Including this domain in the complex trauma model can help residential workers make the link between trauma, cognition and behaviour. Developing the ability of residential workers to adapt their communication style to suit the individual child promotes greater levels of understanding and reduces the risk of inappropriate behaviour being negatively misinterpreted. For example, many looked after children have difficulties with their working memory and sequencing instructions; this can be misinterpreted as 'laziness'.

Self-concept

It is not a great leap to infer that impairment in six domains makes it more likely that the unifying domain of self-concept will be problematic. The internal working model developed in early attachments sets the template by which the individual measures their later selves and others. Past experiences dictate future predictions, and so a child that has concurrently viewed their desired secure base as a source of fear and derision is likely to develop a sense of self as useless and unlovable.

Conclusion

Good practice ensures that the clinical team reflects the needs of both the young people and the professionals who serve them. The skill-set required to meet this considerable challenge is best achieved by ensuring a variety of clinical disciplines are employed. This will ensure an approach to problem solving that enjoys the tension of multiple perspectives and helps avoid a dominant narrative that may inadvertently create a limited perspective.

The focus of this article has been to propose a new core practice strategy informed by the theory of complex trauma. It is hoped that by addressing the interplay of young people, carers, management issues and theoretical models, better outcomes can be achieved. Service development continues throughout 2014–2015 with a research project planned to determine its effectiveness.

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The new 'C word' and death anxiety: A trainee's experience of cancer psychology

Sari Harenwall

This short article shares some reflections and experiences in psycho-oncology as a trainee clinical psychologist. My reflections are focused around the topic of death as this has become strongly associated with the word 'cancer'.

MORE THAN a third of the UK population will at some point in their life receive a cancer diagnosis (Sasieni et al., 2001), but with this one diagnosis many more lives will be affected, both in the short-term and in the long-term. Many cancer survivors seem to be surprised when they finish treatment and they cannot go back to 'normal'; their world as they know it has changed, and they have to learn to live with the uncertainty of cancer recurring.

Cancer is one of those words that seem to instil fear in most of us and automatically trigger thoughts about death – which is why many people now refer to it as the 'C word'. As a trainee selecting cancer psychology for my elective placement, I was already aware of this and I braced myself for working with the terminally ill, as I knew this would result in me having to face my own mortality. I hoped that with time this would become easier, but I also hoped that it would not lead to indifference.

Clinicians mechanisms for managing distress

I remember observing oncology consultations early on in my placement, watching the different defences that appeared to be at play within the clinicians in order to protect themselves from distress when diagnosis was poor and there was little that could be done. In the medical profession the emphasis on 'cure' and extending life is obvious. When this cannot be achieved some oncologists seem to subtly reject the patient so that they do not have to deal with their feelings of helplessness, possibly so that they can move on to the next patient (I have chosen the word 'patient' over 'client' in the context of people being treated in a medical hospital as this is the commonly used terminology). Another way of dealing with patient distress seems to be to try and escape from the situation by clutching at straws of something that could potentially prolong their prognosis (such as additional tests), or using humour; others seem more able to sit with the discomfort. I am not criticising the medics; they are having difficult conversations with people who are facing the end of their lives, which no doubt brings their own awareness of death to the surface. As fellow human beings they are likely to employ various defence mechanisms to protect themselves from difficult emotions and their own mortality. However, research suggests that some of these defences (e.g. denial and projection), can backfire when excessively used, and the medics may instead come across as detached or less empathetic (Bernard et al., 2010). It could be argued that an oncologist has to deal with higher amounts of stressors than most other physicians, due to a significant amount of death and treatment failure, which may be why oncologists experience a relatively high rate of burnout (25–38 per cent – see Shanafelt & Dyrbye, 2012, for an overview). Therefore, medical colleagues need a way to care for themselves in order to alleviate stress on a regular basis, and thus protect themselves and the patient (see, for example, Kearney et al., 2009, and Shanafelt, 2005, for articles on stress and self-care in oncology).

> *Some oncologists seem to subtly reject the patient.*

Communication skills training

Nonetheless, recognition of the stressors in oncology has led to improvement in communication training. In particularly, training in 'breaking bad news' has improved greatly over the last 20 years, helped by national guidelines that make it a necessity for all senior cancer health professionals to have advanced communication skills training (e.g. Department of Health, 2000; National Institute of Clinical Excellence, 2004), a skill that intuitively seems to be beneficial for dealing with clinician stress and patient distress, although a clear evidence base for the efficacy of these guidelines is still lacking (see Paul et al., 2009, for a discussion and review).

Although I did not have much opportunity to talk to the oncologists between appointments and have very little experience and knowledge of what led them to their chosen career, I was able to take part in reflective practice with cancer nurse specialists. During these encounters I was inspired by their strong sense of calling; their determination and willingness to support people; not just practically but also in their emotional distress.

The role of clinical psychology in cancer care

I did at times feel like an intruder when witnessing the oncology consultations – which felt novel to me, as in my chosen profession being privy to peoples' most inner thoughts and feelings is my daily bread. There was something different about the experience of seeing the open wound from the surgery, watching the naked fear and vulnerability in the patient's eyes. I felt I had no right to be there. Nonetheless, however uncomfortable these encounters can be, the involvement of clinical psychology in medical settings is very valuable, and this is the place where my clients often felt traumatised and/or strengthened.

The naked fear and vulnerability in the patient's eyes…

So what can clinical psychologists do to support people who have been diagnosed with cancer and may fear or be facing death?

A quote which has been used that I believe captures what psychologists can do for people faced with the trauma of cancer, regardless of their prognosis, is that of Maggie Keswick Jencks. She was a remarkable woman who died of cancer in 1995. Her vision led to the Maggie's centres of support around the country. She wrote in her essay 'A view from the frontline', about living with cancer, that 'Above all what matters is not to lose the joy of living in the fear of dying' (Keswick Jencks, 1995, pp.23). It is not always an easy selling point, but if communicated sensitively, is often understood by the client and their loved ones. I have found mindfulness (e.g. Carlson & Speca, 2010) and acceptance and commitment therapy (ACT; see Hayes, Strosahl & Wilson, 1999) techniques and their philosophies helpful in supporting my clients to do so. That is, the non-judgemental and accepting stance to human suffering at the same time as pursuing valued living.

Speaking about the unspeakable

Another key text during my cancer psychology placement was an inspiring book on the topic of death, by Irvin Yalom, a prominent psychiatrist and existential psychotherapist from America. The title of his book *Staring at the Sun* (Yalom, 2008) is a comparison with the taboo surrounding the topic of death; we do not directly stare at the sun and we do not talk about death. Although we all know that we one day will die, we tend to deny this fact most of the time. This defence mechanism seems to serve its purpose until we are faced with the threat of death, or 'awakening' as Yalom calls it. The denial is broken down and more mature defences are required to adapt, as conscious ways of repressing death anxiety does not eliminate the unconscious awareness of it (see Letho & Stein, 2009, for a review of the literature). As a psychologist, acknowledging the impact of the situation without shying away from the topic of death, and being with the client in the moment, can help people feel understood and may help them integrate and conceptualise death in a less threatening way. If we can lead by example, acknowledging our own mortality, clients' can be strengthened to pursue a more meaningful life.

I am of course speaking of my own experiences when working with this client group, but other clinicians that I have spoken to also feel that being able to talk about death is crucial. I often use an analogy of the 'monster under the bed' when talking about fear and avoidance (including death): the monster seems to grow every time we do not look and our imagination is often far worse than reality (although this may not always be true). Talking about cancer and death anxiety often dispels some of the grasp it has around the client, permitting them to acknowledge and own their distress without it ruining or ruling the rest of their life.

One technique that I have often used is a diffusion technique borrowed from ACT, where the word is repeated until it no longer has the power it once had. I have found this very useful with the word 'cancer'. Another helpful technique is asking the person to describe what the word looks like in their mind. It is often a dark frightening image that gets painted. I then ask the person to play with it, change the colour, tug at different letters like bubblegum. Being able to look at it as a word, detaching it from some of its meaning, seems to be helpful for many who react strongly to the word. Particularly as, once you have been diagnosed with cancer, the everyday mentioning of it in soaps and other media becomes blindingly obvious (a phenomenon called observational selection bias).

…show my humanity by sharing and modelling my imperfections…

I have worked with many people who have had to face up to their death anxiety, and I do believe that having an open, curious stance to religious and spiritual beliefs about what happens after death is vital in those moments, as not knowing what happens after death can feel overwhelming. Putting fears into words can help the process of acceptance that death is inescapable. Ultimately, however, when the cancer has been cured and the client is expected to live for many years to come, it is also important to help the client remind themselves of that and start living again, having mourned the loss of a future, body part and identity that will never be regained. For others, they see the 'awakening' as an opportunity to grasp life with both hands and make the most of it. Either way, a person's outlook on life seems to change forever once they have been diagnosed with cancer; and to some degree, being surrounded by it on a daily basis, it has also changed mine.

On reflection – being contained as a container for cancer

Early on in my placement I was protected from working with those that were near the end of life, which made it a lot easier to deny and shield myself from death anxiety. I have become more resilient and robust by gradually facing more emotionally challenging encounters. This is comparable to a behavioural experiment where the goal is to be able to meet the client in the reality of death at the same time as not denying my own and not crumble.

Reflecting on clinical supervision may give further insights into the processes that supported me throughout this challenging placement.

Above all, feeling secure in my relationship with my supervisor, to the extent that I could be open and honest about my imperfections along the way, helped me fine tune my therapy skills instead of pretending that I was something I was not. I believe this then also transferred to the client–therapist relationship, in that I could confidently show my humanity by sharing and modelling my imperfections, learning together with the client.

Reflecting back, I think of the developmental attachment between a mother and a child. With my supervisor I had the opportunity to create a secure base where I felt contained and safe to explore the world of cancer. At first, I was closely monitored, guided and supported. I would not stray far from my comfort zone and often asked for my supervisor's advice and reassurance. However, as a trusting relationship built up between us her confidence in my ability enabled me to trust myself and my skills as a therapist, ultimately creating a sense of autonomy.

Her expectations, compared to some previous supervisors, seemed at first to be quite low. However, I see now that this focus on core therapeutic skills, such as being an active listener, communicating empathy and creating a safe space for the client to express their emotions, liberated me from 'shoulds' and 'musts' and supported my development and confidence so that I could then become more experimental and explore work outside of my comfort zone. This opportunity to be experimental within my sessions has been very important to me as a therapist as, with my increasing interest (and now grounding) in ACT, I constantly encourage the client to do the same. That is, to learn through experience by experimenting in the service of their chosen values.

Another key focus of our supervision was transference. My supervisor would often comment on the feeling in the room as I spoke of a particular client. Often, the comment would reflect a parallel process in therapy, which opened up further dialogue and opportunities for intervention. The openness in the relationship, the relatively 'low' expectations and the use of transference helped foster a trusting relationship that was ultimately very de-shaming. I mention both attachment and de-shaming here as these are things I aim to develop in therapy to help the client move on with their life and make room for new experiences.

I found myself in quite an unusual relationship where I was given the opportunity to explore ACT within therapy despite (and maybe because of) my supervisor having a grounding in compassion focused therapy. I say that it was unusual as in my previous experience most supervisors insists on their trainees modelling their way of working. Perhaps it was to do with her own security and maturity, as well as the strength of the relationship that could both hold and contain the 'unknown' of the closely related but different ways of working.

Towards the end of the placement the relationship seemed to turn more collegial and I found that our grounding in different models meant that she could also learn from my experience, which was a great compliment as I have the deepest respect for her ability both as a therapist and supervisor.

Reflecting back on the placement six months after I left it, my supervisor's words mirror my own experience, in that she felt quickly reassured by observing me live with two clients. She felt as though I was 'in tune with' the client and responded to them intuitively and respectfully. These observations led her to feel that the patients were 'safe' with me. This trust in me then gave her the confidence to allow me to apply my developing skills with more freedom.

Final words

Working in cancer psychology is not for everyone. For me personally it has been an emotional roller coaster, but with great rewards. The strength and resources within this client group as a whole far exceeds any other I have worked with. Many of my clients have inspired me to pursue my own values in the spirit of ACT by having to face my own mortality and helping me look at what a meaningful life is to me.

Although these are personal observations and reflections from my own experiences, through my eyes, I hope that it may help other trainees, as well as qualified psychologists who may be contemplating a career in cancer psychology, to get an understanding of some of the struggles and rewards that may be expected in this line of work.

Now that I have come to the end of my training I am pleased to have secured a job with Maggie's. Although I never envisaged at the start of my training that I would work in cancer care, I am delighted that this is where my training has led me. I am full of enthusiasm and hope that I can continue Maggie's quest in helping people focusing on enjoying life despite the inevitable fear of death.

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Dealing with diversity: Reflections from supervisory conversations

Sarah Helps & Aayesha Mulla

This article offers reflections from two perspectives on the challenges of dealing with prejudice and of keeping awareness of diversity central to one's development, both as a clinical psychologist and as a supervisor.

BURNHAM et al.'s (2008) and Roper-Hall's (2008) ideas about the social GRRAACCEESS are widely used as a framework for considering some of the multiple contexts through which we make meaning. These include: (G)ender, (R)ace, (R)eligion, (A)ge, (A)bility, (C)lass, (C)ulture, (E)ducation, (E)thnicity, (S)exuality and (S)pirituality (Burnham 2008, p.530).

Issues of diversity and equality have become increasingly important and are protected through directives such as Delivering Race Equality (DH, 2001) and Valuing People Now (DH, 2009). As clinical psychology trainees, we were encouraged and supported to think about issues of diversity across all aspects of our training. I (AM) have often used the different aspects of my identity to help me do this and have wondered whether moving between different facets of identity comes easier to clinicians that identify themselves as belonging to a minority because this has been their lived experience throughout their lives. As a female psychologist who identifies as British Indian and is a practising Muslim, the way I relate to the GRRAACCEESs may, I think, be different to the many of my peers who identify their faith and cultural backgrounds as different to mine. Having identified as an ethnic minority as well as a faith minority all my life, issues of race, religion and ethnicity have often impacted on me in a way that does not seem to have for some of my peers. According to Clearing House demographic data, in my intake year to clinical psychology training, 10 per cent of accepted trainees self-identified as non-white, for example. Additionally, having access to multiple cultural and religious ideas has perhaps also been an advantage when thinking about the way people draw meaning from different contexts.

Painful personal and professional experiences

Open discussion has been important in my (AM) work as some of the aspects of my identity are disclosed visibly; for example, by my hijab, the colour of my skin or my accent. The core skills we develop early in our training, curiosity, empathy and unconditional positive regard, serve us well when we are being respectful of difference, whether in therapeutic sessions, professional discussions or training.

However, there are times when people's actions can be quite painful or challenging for a variety of reasons. Such experiences have been repeated throughout my professional career (as well as my personal life). Personal attacks directed towards me have involved comments such as 'paki', or asking why my brother probably 'looked like a monkey', or refusing to speak to me because the person's family member was fighting in Afghanistan and it was '[my] fault'. In professional settings, comments have taken the form of racialised, offensive language. In a therapeutic context, I have tried to address comments I perceived as prejudiced in a way that was clinically helpful, by inviting an exploration of the meaning behind them. Using personal attacks to inform a formulation and intervention is not new practice and can provide useful insight into a person's psychological status.

In other clinical contexts, such as during a cognitive assessment or while visiting inpatient secure units to recruit for a therapeutic group, it did not feel appropriate to engage in detailed therapeutic conversations.

My responses, therefore, are informed by multiple factors in a multilayered way. At times, challenging comments come from colleagues, and these seem to fall roughly into 'well meaning mistake' or 'just plain disrespectful or unhelpful'. The difference between a 'tolerable and welcomed mistake' and a 'painful experience' is perhaps located in my beliefs about the actors' intentions or respectfulness. Again, I have addressed these in different ways depending on what I feel is the intention behind the comment. In the process of writing this paper, I have also realised that my way of relating to such comments has changed based on my level of qualification. As I have progressed through my career, my voice has become increasingly confident. Increasingly, I have felt it become more powerful, as I and others acknowledge my professional expertise. My responses to difficult comments from colleagues have ranged from helpless silence, to wanting to facilitate awareness of different cultural norms, to feeding back to senior staff within a Trust.

The most professionally challenging instance of a hurtful comment came in a session as a trainee clinical psychologist. During a cognitive assessment a young child expressed sexist, racist and politically extreme right-wing beliefs. At the time it did not seem possible to end the session prematurely or use the attack therapeutically. I was focused on 'just getting through' to the end of the session, until I was able to feed back to the team and we were able to think about how best to meet the family's needs.

Unconditional positive regard in the face of personal verbal attacks juxtaposes clients' needs with one's right to being safe in a workplace. My fear at the time was how to respond in a way that upheld the Society's ethical guidelines of not imposing one's own political views on a client, but also how to keep safe in the face of verbal attacks.

Thinking space in supervision helped me to feel less shaken by the experience; however, we were both at a loss as to what might be done differently if a similar situation were to occur in the future. I am not sure that I ever 'resolved' the conflict of unconditional positive regard versus clinician safety, but maybe the important thing is to keep trying and keep making mistakes.

Supervision of painful experiences

I (SH) vividly recall the moment when Aayesha described how a young patient had expressed strongly sexist, racist and anti-Muslim views during a psychometric assessment.

Aayesha and I struggled together to make sense of this or to know how to go forward in the clinical work. My immediate thought was for her well-being, followed by my wondering whether I had done the 'wrong thing' by asking her to assess the child who was visibly different in religious and cultural identity to her. But following this line of thinking seemed dangerous… Where could it end? I wondered about thinking in terms of transference and projection by the child, of feelings of inferiority and powerlessness, given the nature of the clinical contact, but I also worried about whether we were theorising about the racist comments in this way in order to minimise their significance.

Supervisory conversations before the incident had created a context in which connection, similarity, difference and my own interest in how my whiteness affected my practice, could take place. Within this, Aayesha had accepted my invitation to participate in discussions about our cultural and religious niches and how she had needed to protect herself from personal racist verbal attacks that she had experienced during previous placements.

Developing wider conversations

After discussing the incident, we both continued to struggle to think about how to continue to meet the needs of the child their family. In seeking the input of the multidisciplinary team, we were both puzzled by what we understood as the view of team members: that the child's comments should not be raised with the child or their family for fear of damaging an already tricky therapeutic relationship. For me (SH), this created an ethical dilemma of how to respect the views of the team and how to support the needs of different people in the system, while at the same time prioritising the needs of the child and their family.

What might help?

Neither of us felt that the incident had been satisfactorily resolved, it nagged at us both. Over time, we came to think of the following as things, in the local context of the trainee-supervisor relationship that might help when experiences of prejudice and other differences feel problematic.

The position of the supervisor

As a white, female, soon to be middle aged consultant clinical psychologist, I (SH) acknowledge the personal and societal power that I hold. I try to accept my responsibility to address how prejudice and racism can affect the experiences of the service users, trainees and clinicians for whom I am responsible. Pendry (2012) argues, in relation to supervisors of systemic practitioners, that it is the responsibility of the supervisor to address issues of race and racism at all levels. As in other areas of my practice, as a supervisor I try to be aware of my own prejudices and to both offer commentary on these and invite trainees to explore their own positions in relation to the GRRAACCEESS. I aim to facilitate a practice that privileges respect for diversity and a determination to address this, while acknowledging the potential inherent silencing effect of being a trainee in a position of being judged and evaluated.

Anderson (2002) describes the philosophy and practice of supervision as the creation of a collaborative learning community based on the 'three Cs': (C)onnect, (C)onstruct and (C)reate. This postmodern approach is based on the notion that knowledge is fluid yet personalised, and when sharing knowledge we cannot know what each participant brings to the sharing, how each participant will make sense of the sharing and what the outcome of the sharing will be. All we can know is that something will be socially constructed.

From this kind of supervisory position I think it is possible to use one's supervisory power, privilege and responsibility to keep the issue of 'race' (used in inverted commas following Singh & Dutta, 2010, in order to illustrate how the idea of biological generalisation on the basis of physical characteristics is problematic) on the agenda and as a live discussion. I try to model the risk-taking that this involves from my own position, sharing thoughts, ideas and experiences in this spirit of attempting to create a dialogue that could challenge silencing and prejudicial practice.

Start as I mean to go on

In the first couple of weeks of a placement, I (SH) usually initiate gentle conversations about the GRRAACCEESS. I try to locate issues of similarity (emphasising these to create a safe base) and difference as a central theme, to be woven into all conversations as the supervisory relationship develops. The discussions might become more open about how the GRRAACCEESS of client, trainee, supervisor and the wider system might intersect and position each person. How to have discussions about diversity in a safe and meaningful way, given the power imbalance and issue of evaluation that are present in a supervisor/trainee relationship, needs careful attention.

Use of self and self-reflexivity

I (SH) now try to share aspects of myself and how I position myself in relation to the GRAACCEESS early on in the supervisory relationship, to demonstrate that I value self-reflexive thinking in these areas. This has been more or less overt, perhaps influenced by how I position the trainee as interested in/keen and willing to engage with this exploration. Sharing cultural genograms can also be helpful, although careful discussion about the timing of doing this is needed, as is the more general issue of how work at the level of self-reflexivity/personal professional development fits with trainee evaluation.

Accept that mistakes will happen – work to recognise and learn from them

If people are making mistakes, it means they are at least trying something (Simon, 2010).

In attempting to explore my own evolving relationship to 'race' and racism, and to have conversations that address visible and invisible differences, I (SH) have made mistakes that have hurt others. I think this is probably not unusual. If my attempts are offered in the context of a trusting relationship where there is an established invitation to question and challenge, then mistakes are more likely to be tolerated and can create a platform for development for all involved.

Talk of visible and invisible differences

'Race' and diversity talk needs to happen even when there does not 'seem' to be difference. There is benefit in making explicit the links between visible and invisible differences, so that 'race' talk is firmly established in a context of talk about difference and connection. The concept of multiplexity (Akamatsu, 1998), considering how various and multiple marginalities affect people's lives can help to join and connect. For example, due to my own invisible differences, I (SH) may sometimes not feel myself to hold a position of power, but in my professional context I have to accept the powerful position that I inhabit. The sharing of ideas about invisible differences can therefore be a helpful way of demonstrating how risk taking by talking about more hidden issues can help with other conversations.

Conclusions

Tackling prejudice needs global as well as local responses. This paper has highlighted things that might help in the trainee-supervisor relationship. But action needs also to be taken at all levels of team, organisation, community and indeed society. Trainees need to develop ways of thinking and talking about how their selves affect and are affected by the work. Supervision during training can provide a secure base in which these kinds of risky conversations can happen. Both supervisors and trainees need to feel safe and brave enough to take risks to talk about both connections and differences in order to work to provide ethical, authentic and respectful services to their clients.

Although the British Psychological Society stipulates that awareness of social context and lived experience of the client is a 'core competency' (Toogood, 2010), we and others believe that further work and thought is necessary in order to put this principle into practice (Afwape, 2013, personal communication). Highlighting the importance of open conversations for trainees as part of the academic component of clinical training might embolden them, armed with theoretical frameworks and peers' experiences, to suggest relationships to the GRRAACCEESS be thought about in supervision in relation to themselves personally as well as in relation to the service user.

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Service evaluation of a parenting group for children with developmental disability and complex needs in a community setting

Bethan Manford & Miri Sizak-Cohen

A positive parenting group using developmentally appropriate interventions was facilitated within a specialist child and adolescent mental health service (CAMHS) for disabled children with behavioural concerns. Overall, based on parents responses, the group was experienced as helpful and meeting parents' expectations.

Building a village… 'It takes a whole village to raise one child'. (African proverb)

PARENTS OF CHILDREN with disabilities often experience greater stress and depression than those of typically developing children; parental stress and behavioural problems in children with developmental delay have a bi-directional relationship (Baker et al., 2003). Parenting programme participation can reduce parental distress, negative behaviours and dysfunctional parent-child interactions (Dyches et al., 2012; Marcynyszyn et al., 2011). Parenting groups provide a space where families can share their difficulties of having a child with special needs (Seligman & Darling, 2007) and increase positive feelings towards their child (McIntyre, 2008). Part of the journey of acceptance of a child with a disability is gaining insight and knowledge of the child's developmental stage and being mindful of the child's abilities and difficulties (Bartram, 2007). Whiting (2012) emphasised that sense-making determined how parents' experienced their child's disability and their relationship to help. The impact of culture in sense-making and finding meaning in the journey of parenting a child with disability, often related to personal and social perspectives (Whiting, 2012).

There is a lack of research on parenting groups and tailored programmes that are specifically designed for children with developmental disabilities. Parenting groups need to be redesigned to most efficiently meet the unique journey of parenting a child with a disability. Typical parenting groups do not take into account the gap between the child's chronological age and developmental stage. They also do not take into account the psychological journey that can sometimes include some feelings of bereavement and the unique attitudes and beliefs of parenting a child with a disability. McIntyre's (2008) study making minor modifications to Webster-Stratton's (2006) incredible years aimed to fill this gap.

Psychotherapeutic factors of group facilitation

Besides delivering a modified approach of the evidence-based programme by Webster-Stratton (2006) for children with disabilities, facilitators were mindful of therapeutic factors in group development. Facilitators worked with an understanding of group dynamics (Yalom, 1995) to provide a space where instillation of hope, altruism, cohesion and universality could be held. Psychological advice and strategies were provided for each family's needs, alongside containment for the emotional journeys which individuals brought, enabling a 'working group' model (Bion, 2001), supporting the group dynamics as a whole.

The group

A positive parenting group was facilitated by a clinical and assistant psychologist within the specialist CAMHS service. Children suitable needed to be aged 3–8 developmentally (not chronological age), with a permanent or enduring disability and learning disability. Children with autism spectrum disorder were excluded from the group as specialist groups were offered for them. A crèche facility and interpreter services were offered to all families to enable parents' attendance and engagement.

Method

The group was set up to run once a week for seven sessions; these were two hours in duration. One of the sessions involved video interactive guidance, where parents and their child play.

Parents were asked to complete a goal-based outcome (GBO; CORC, 2011) during their first session, choosing one area where they would like to see improvement in seven weeks. Both facilitators helped parents to define a suitable, achievable goal. Parents were asked to score their concern about their child's behaviour on a linear scale from 0 to 10 (10 being very happy and 0 being very concerned). This was conducted at baseline and immediately post group. The goals were reviewed immediately post intervention. They were also asked to complete an evaluation form at the end of the programme using a five point scale designed to measure what they found most helpful (0 = not at all helpful and 5 = very helpful) and whether their expectations were met by the group (0 = not at all met and 5 = all were met). The evaluation sheet also asked open questions, including: 'What was most helpful?', 'What were your expectations?', 'Further comments or suggestions?' and 'Was anything covered that was not understood?' (Law, 2012).

Participants

Sixteen families were referred to CAMHS for a parenting group intervention. Families were contacted prior to the group and the clinician made positive efforts to engage parents (trying to make a personal contact, giving them opportunities to establish a rapport and acquire additional information). Parents needed to attend one of the first two sessions in order to continue attending. Parents were reminded about the group via text and were contacted following sessions if they did not attend. Four families attended initially, but for various reasons could not commit to the full programme. Five families dropped out for factors including: not wanting a group intervention, moving to a different borough, work/study commitments, or additional appointments (e.g. operation). Seven parents attended for the duration, all of these were mothers, from a range of ethnic and cultural backgrounds (Puerto Rican, Arabic, black British, African and British), reflective of the diversity in Hackney, London. There were six different first languages and three religions within the group (Catholic, Christian, Jewish). At least one interpreter was present at every session.

Group aims

The group aims included: promoting understanding of children's behaviour within the context of developmental issues; promoting development of parent/child reciprocity; increasing positive relationships through play and praise; exploring thoughts and feelings; and sharing narratives and meanings of disability in the family and thinking about how these influence behaviour. The group also aimed to reduce feelings of isolation often experienced socially when parenting a child with disability. The group offered a range of effective, evaluated strategies for managing behaviour and parent/child interactions (Webster-Stratton, 2006).

Group content

Webster-Stratton's (2006) evidence-based incredible years' approach was used, with minor modifications for the needs of children with disabilities. This series utilised videotape modelling, roleplay and weekly homework activities. Some of the areas explored included: play and praise, understanding behaviours as communication, and parents attitudes and beliefs about parenting a child with a disability.

Group process

A crucial factor in creating a group with parents from different backgrounds was the challenge of finding a way for parents to understand and be understood. Facilitators wanted to create a space where parents could explore cultural beliefs and attitudes towards disability. One parent shared that in her country a child with disability would be killed and another described how the family would be ostracised from the community.

It was important to create a space where parents could develop trust and not feel judged. One parent was homeless and fell asleep intermittently during sessions whilst her baby was in the crèche. The group allowed her to sleep, accommodating her extreme tiredness and commitment to her child.

One parent was homeless and fell asleep intermittently.

The facilitators aimed to foster hope and realistic expectations of their children. The group needed to enable parents to hold in mind the ability and disability of their children, helping them to reconnect with the loss and love in their parenting journey, from sharing the difficulties of the birth to premature deliveries, complex medical needs, genetic syndromes and life threatening illnesses, as well as learning difficulties. In the first session, parents were asked to share why they chose the given name of their child. 'Jack' was the name given to one boy named after 'the only doctor who came' when an extremely premature child was born at 23 weeks. 'Faith' was the name given to a premature child (32 weeks) who was struggling to survive and experienced severe developmental delay and other medical complications.

The group aimed to support parents in accepting and parenting a child who may be very different from their expectations; a child who may be 'far from the tree' (Solomon, 2013). Parents were assisted in finding a common ground of the unique human experience of parenting a child with a disability; sharing the pain and bereavement of a 'per-

Table 1: Parents' goals, pre and post group intervention measures

Goal focus	Pre group score	Post group score
'To stop spitting and swearing at others'	2	5
'To accept sharing with siblings'	3	9
'To stop saying no about everything, especially the toilet as she never asks to go'	1	8
'To build positive communication skills with my daughter'	4	6
'To work on concerns about my son's behaviours, particularly transitioning between school and home'	3	5
'To gain the ability to deal with my son always wanting his own way and to handle his aggressive behaviour when I say no'	5	9
'To reduce his challenging behaviours'	1	–

fect' healthy child (Bruce et al., 2004). Alongside this, parents were encouraged to strengthen the tenacity, persistence and courageous dedication required in parenting a child with a disability.

Part of the group process was a break mid-session, giving an important opportunity for parents to connect in an informal way, sharing advice and empowering each over tea and coffee. Facilitators viewed this as a way to take care of the parents in both a practical and symbolic way.

The group offered a booster session after three months, where parents from previous groups could also attend, giving an opportunity to expand the village by bringing more parents together. This follow up enabled parents to explore strategy maintenance, progress, further problems, and outcome stability. Feedback given in the booster about the group was as follows:

> *'The group was the only place I felt I could talk honestly about my difficulties parenting my daughter.'* (Mother A)
>
> *'The group was the only place that I received advice and practical solutions that I can apply which help my daughter with her difficulties; also I gained a better understanding of my child.'* (Mother B)

IAPT measures were given again.

Results

Parents' goals, and pre and post group intervention measures are shown in Table 1. Results indicated that parents' ratings of their level of achievement of their goals had increased. Parents also rated the group as being helpful and meeting their expectations. One post measure score is missing as the family were not contactable.

The results for goal-based measures all show a positive increment. The mean at Time 1 was 2.6, which increased to 7 at Time 2. This shows a total mean increase of 4.4 in relation to goal achievement. Due to the small sample size, we need to bear in mind the limitation of the data, specifically in relation to its generalisability.

Expectations of the group

Open-ended questions in the group evaluation showed us that parents were hoping to: receive help to manage behaviours, learn how best to deal with behaviour using specific strategies and learn of knowledge that would be useful for the family as a whole. Some parents wanted to gain general support and reassurance.

Evaluations of the group

One parent did not complete the evaluation form. Two parents rated 3/5 for expectations being met, three parents rated 4/5 and one rated 5/5.

How helpful you found the sessions

Ratings were scores out of 5 (1 being not helpful at all and 5 being very helpful). One parent rated the group 2/5 and another parent 3/5 for helpfulness. Whilst two parents rated 4/5 and two rated 5/5 in helpfulness.

Qualitative data showed that parents found the following most helpful about the group: having the freedom to ask questions, specific strategies for consequences of behaviour, thinking about positive parenting alongside difficulties, being in a group where we can always get something from each other, being able to deal with my daughter, and the practical video interactive guidance session.

Discussion

Results suggest that advice furthered parental understanding and benefited families in coping with difficulties associated with their children's disability. Results showed that the group intervention was experienced as helpful and met the expectations of parents with lasting effects over at least three months. Parents' feedback and the facilitators' views were that the experience of being in the group was helpful for the following themes:

Building a sense of the village in East London

Two experienced clinicians facilitated the group, hoping to foster the notion of building a community around children with disability. The facilitators ensured they held parents in mind and provided a place where they could feel safe and empowered, and develop bonds with parents from various ethnic/social/religious backgrounds and with different languages. Parents were supported to find common ground and help each other in their understanding and in being understood in the unique journey of parenting a child with disability.

Witness to their lives

Balancing the content and process was a constant dilemma. Parents brought painful and difficult life circumstances (e.g. poverty, homelessness, social isolation, loss) which were given space and witnessed. Two parents were made homeless during the group and they were parenting alone without support. The group gave the parents space to share their anxieties of being homeless; having to negotiate systems and raise their children in complex circumstances. One of the parents was sleeping with different friends in the living room and had spent one night with her two children at a bus stop. She slept through parts of a group and the group could allow her space to rest and recharge whilst containing her distress. One of her children needed a heart operation, which was postponed due to the absence of a suitable home to recover.

…having to negotiate systems and raise their children in complex circumstances…

Fostering hope

Parents felt they had a better understanding of their child and their behaviours. They were able to meet parent peers in similar situations and be given tailored strategies for their children. By making progress in their devised goals and managing their children's emotional and behavioural difficulties, parents felt more positive and hopeful for their children.

Engagement

Clinicians were knowledgeable of factors that can affect engagement with families with disabled children in Hackney (e.g. numerous appointments, socio-economic difficulties, cultural/religious beliefs), and accommodated for these. Therefore, generalisability could be an issue as additional variables may affect the results, apart from the evidence-based programme (e.g. practitioner skills required for developing and maintaining therapeutic relationships in group facilitation).

An explanation for lower scores of rated helpfulness or expectations of the group may be that some families stated preferring individual work and were ambivalent about attending group interventions. This may have cultural implications, particularly for some communities who prefer individual interventions to avoid potential stigma in their community.

Limitations

Initially, there were 16 referrals made for the parenting group. As stated earlier, some families had moved out of borough and were unable to attend or had dual appointments.

Also, with the small sample size in this study, there were limitations to validity, power, effect size and generalisability. Future research could use a larger sample size (i.e. evaluation of many groups' data), using a more rigorous methodology to evaluate the group effects. Additional standardised outcome measures for learning disability could be used such as the Sheffield Learning Disability Outcome Measure (SPlD). This was used to assess changes in the way carers gain confidence in understanding and managing the child's behaviours, and can reflect change in behaviours of children with a disability.

In future studies parents could be interviewed about their experiences of, and successes and challenges of the tailored groups in order to gather a richer qualitative account of their experiences and changes in their parent-child interactions (McIntyre, 2008). This was an informal service evaluation; therefore, no rigorous data analysis was performed and results may not be generalisable. Parents were referred to the group by other professionals within the children's services and may have further input from professionals in the future. This may have a positive bias effect on results, with parents trying to maintain a good relationship with professionals in the service, thus reporting satisfaction with services provided.

Recommendations

It would be helpful to review the referral process and look further into which families gain access or engage with parenting programmes, and to explore what some of the barriers to engagement were.

Conclusion

In summary, the evaluation shows that the positive parenting group was well received by parents. The evaluation suggests that the parenting group for children with special needs increased parents understanding of their child's disability, helped to manage behaviour and aid understanding of communication. It could also connect parents with positive feelings about their child using play and praise strategies. Parents showed increased confidence and coping skills through adoption of advice and support of developmentally appropriate play, praise, limit setting and behaviour strategies.

There is a limited research body regarding parenting groups of children with disabilities. Further research looking at the impact of parent interventions for children with developmental disabilities would be beneficial for the knowledge base.

In considering the support and care needed from a village community to raise a typically developing child, the group helped parents to consider the importance of creating a broader support network to raise a child with a disability, and to learn from others in similar situations to themselves.

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The complex nature of complexity: What makes a case complex?

Sarah Oliver, Meena Seda, Jessie Earle & Lisa Shanahan

We conducted a qualitative study to examine clinicians' understanding of clinical complexity. The results indicated a variety of complexity factors and highlighted the abstract nature of the construct. Furthermore, emphasis was placed on clinicians' role in assessing and managing complexity.

COMPLEXITY is a term regularly used in mental health services. The introduction of pilot projects, such as Child and Young People's Improving Access to Psychological Therapies (CYP-IAPT) and Payment by Results (PbR), have emphasised the need to assess and capture certain 'complex elements' at first appointment. For example, the child and adolescent mental health services (CAMHS) PbR project currently proposes that future care clusters, on which payment for CAMHS will be based, will categorise differing levels of severity and complexity of need and these will be used to determine the level of intervention required (Department of Health, 2012). Recently within our service, we have been challenged about labelling cases as 'complex' and asked to explain in what way this is the case.

> We have been challenged about labelling cases as 'complex'.

Complexity is a difficult concept to define and measure, as there are a number of factors that can interact and influence the complexity of our clinical work. Tarrier et al. (1999) defined complex cases as those 'which do not fit comfortably into simple case conceptualisations or diagnostic categories' (p.xiii) and his book describes the importance of assessment and formulation in helping us to work with complexity. In addition, Bonavita and Simone (2008) recognised that complex cases encompass 'multiple levels', and Subotsky (2003) noted the 'conflicting obligations' in child services also impact on complexity due to conflicts such as 'confidentiality versus safety', 'diagnosis – entitlement or stigma' and 'the child's interests versus the parent's' (p239).

There have been several attempts to measure complexity. Most recently, the 'current view' tool was developed in consultation with experts in the CYP-IAPT programme. This was designed to capture the type and severity of problem(s), in addition to complexity and contextual factors, that may be seen to influence clinical work and outcomes. This tool was later revised in January 2013, following a consultation with clinicians participating in the programme, and further factors (e.g. engagement) were added. Whilst this measure is a comprehensive tool and captures items that were previously part of the Health of the Nation Outcome Scale Child and Adolescent Mental Health (HoNOSCA) developed by Gowers et al. (1999) & Paddington Complexity Scale (PCS; Yates et al., 1999), there is an acknowledgement that it is not exhaustive.

Given the absence of a commonly agreed definition of complexity, it is not surprising that studies examining the nature of complex cases have been scarce. However, in a conference aimed at discussing ways to work with complexity in adult services, Davies outlined his unpublished thesis (Davies, 2001), which indicated that the complexity of a case is not solely based on patient-based factors (i.e. the nature of the presenting problem). There are also clinician and service-based factors, such as time and resource capacity, and therapeutic relationship-based factors, such as the quality of clinician-patient relationships, engagement and communication, that are equally important.

Table 1: A summary of themes

1. **Referral Factors** (a) Individual factors (co-morbidity, cognitive difficulties, motivation, engagement, etc.) (b) Family factors (family composition, parental mental health, engagement) (c) Contextual factors (housing, financial difficulties, social deprivation) (d) Cultural understanding (e) Historical events
2. **Working Partnerships** (e.g. multidisciplinary working, interagency working and family networks)
3. **Organisational and Service Factors** (a) Clinician factors (e.g. knowledge and training) (b) Team support (e.g. peer supervision and shared responsibility) (c) External pressures (e.g. waiting lists)
4. **Complexity of complexity** (a) Layers (e.g. multiple issues) (b) Ambiguity (e.g. 'puzzle') (c) Intuition ('unease')
5. **Outcomes of complexity** (a) Consequences (e.g. social implications) (b) Solutions (e.g. co-located services and consultation)

To our knowledge, there has been little research examining the nature of complexity in Tier 3 CAMHS. This study aimed to explore clinicians' understanding of what makes a case complex.

Method

Clinicians from three CAMHS boroughs were invited to take part in a two hour focus group to discuss the nature of complexity. The final sample included eight clinicians: a family therapist, two psychiatrists, two psychotherapists, two psychologists, and a specialist mental health nurse. The cohort represented a range of CAMHS teams, including: generic; looked after children; adolescent outreach; paediatric; and learning disability teams.

A qualitative design was used to explore clinicians' understanding of complexity. Data was gathered through focus groups. A thematic analysis was conducted as outlined by Braun & Clark (2006). Two independent researchers examined the transcripts for initial codes and then discussed the overarching themes that emerged.

Results

The analysis revealed the following five overarching themes as presented in Table 1…

Referral factors

Clinicians agreed that many individual factors (e.g. comorbidity) could add to perceived complexity of a case. Family and contextual factors were considered to be equally as important as individual factors. For example, it was recognised that the child or young person's mental health could not be understood without putting it into context of the family system. Motivation and engagement of children and their families was required to encourage young people to access services and improve the therapeutic process. Clinicians reported that contextual factors (e.g. housing, socioeconomic deprivation and immigration status) could be especially difficult to manage as they were often beyond the therapists' control, yet could be influencing the case complexity significantly. The group agreed that culture would not necessarily lead to complexity, but the relationship a young person had to their culture, and how this related to their families' belief and their belief in the role of services, could lead to an increase in complexity.

Working partnerships

Children and young people were recognised as part of a larger system of families, peers and external agencies and could not be considered in isolation. The relationships between these various agencies were thought to add a level of complexity, particularly when parts of the network held different views. Clinicians described how differing views could lead to conflict, lack of a 'shared goal', and ultimately challenges in how the work proceeds. Additionally, bringing the systems together may add pressures of time, efforts and co-ordination.

How the family relates to and works with the larger system was also considered to impact upon complexity. It was thought that families could face challenges whilst navigating between the agencies and trying to understand their various roles. Clinicians acknowledged that clients and families with multiple needs often require ongoing support and advice from a number of services who may have varying remits. Sharing information between services was also noted to be difficult for clients and clinicians. This can be frustrating and confusing for both parties as individuals are 'not quite sure how services link together, or whether they do; services often don't.' (Participant 2).

Subsequently, clients and their families may feel disempowered and dissatisfied.

> *Parents then are left with kind of huge feelings of anxiety, kind of hopelessness, not feeling you in charge of what, how to be helpful to their child.* (Participant 2)

Given that these working partnerships can contribute to complexity, it will be important to consider the ways in which services work together and 'don't add to the complexity' (Participant 6).

Organisational and service factors

Thought was given to how clinicians' own personalities and interactional styles may tend to gravitate them towards more complex cases. Furthermore, debate arose around the need for clinicians to be experienced in order to successfully 'hold in mind information' (Participant 2) and 'contain anxiety and risk' (Participant 3) which may surround more complex cases, whilst they also acknowledged that newly qualified staff may bring new and innovative ideas to the workforce too.

There was a consensus that multidisciplinary work and peer supervision was helpful in managing complex cases, allowing responsibility to be shared, and thus easing the burden of child protection risks and decisions. Clinicians noted how external pressures such as time constraints, waiting lists and more structured care pathways (e.g. limited assessment/treatment sessions) could impede this team working and thinking space. This, in turn, limited the clinicians' ability to manage complexity, leaving them feeling isolated.

Whilst there was discussion around '[ignoring] some of the complexity so that it feels workable' (Participant 5) within service protocol restrictions (e.g. focusing on treatment goals), participants recognised how this could prevent clients' experiences and difficulties from being 'worked through' and 'processed enough for a family' (Participant 2). As a result, clinicians can be left feeling discomforted, proposing potentially inadequate plans when they have been unable to grasp the nuances of the case sufficiently. Clinicians worried that ignoring the complexities of a case may consequently lead to re-referral.

Complexity of complexity

Clinicians had a strong sense that overall complexity was 'highly complex' and somewhat inexplicable. Whilst clinicians felt that the presence of 'multiple layers' (Participant 4) which 'inter-relate' (Participant 2) indicated higher levels of complexity, there was recognition that this was not always the case. Case examples were given which may on the surface appear complex, but transpired to be more straightforward, and vice versa. Thus, clinicians highlighted the importance of using their own intuition and professional judgement in recognising and identifying complexity.

This intangible feeling of dealing with complexity could not be adequately labelled; it was more of 'a feeling', and yet was considered to be one of the most important factors in determining if a case was complex. They described this factor as giving a 'kind of stress' (Participant 5) or a feeling of unease, when 'things didn't seem to… fit' (Participant 2) or professionals 'can't quite get to grips [with the case]' (Participant 4). This left clinicians with a need to unpick the case further through means of assessment, to 'tease out' (Participant 6) factors and develop a coherent formulation. Consequently, thought was given to the ability to measure complexity, as it 'isn't a tick box exercise' (Participant 6), but more of a continuum that must take into consideration the multitude of influencing factors.

Outcomes of complexity

Throughout the conversation clinicians were aware of the importance of communicating the need to work with complexity. This has the potential to help reduce strains on other services such as youth justice, education and social care. The focus group progressed towards discussing solutions to manage complexity. Awareness was raised that a number of complex cases are held in Tier 1 due to challenges with engagement or access to services. Consequently, consultation between services and close partnership working was emphasised.

Discussion

The themes that arose from this focus group highlighted the multitude of factors that can contribute to clinical complexity, and these echo those factors highlighted by Davies (2001). In addition to the themes apparent in adult services, the added complexity of working with large complex networks was emphasised in this study due to the conflicting demands of each party (Subotsky, 2003). Furthermore, this study highlighted the complex nature of complexity and although multiple factors can influence cases, there was an understanding that practitioners' clinical judgement and expertise was necessary to assess complexity. Finally, in addition to identifying the types of complexity, this study identified consequences of working with complexity and emphasised the importance of supporting clinicians to enable them to tolerate the stress and uncertainty that complexity brings. It stressed the need to be holistic when working with young people and families in order to lessen the impact on other services and avoid re-referral and multiple episodes of care.

…supporting clinicians to enable them to tolerate the stress and uncertainty that complexity brings…

To our knowledge, no study has examined case complexity in a CAMHS setting. The themes identified in this study go beyond existing research from recognition of quantifiable factors to thinking about how, essentially, a number of elements and processes can interrelate on multiple levels to add to complexity of working with children, young people and their families. The extent to which these dynamics impact on a clinical complexity was not considered to be definitive. In addition, this study emphasises the challenges faced in identifying and defining complexity, given that frequently the 'unknown' adds to clinical complexity. Therefore, in light of this, complexity appears to be difficult to quantify and requires clinicians' expertise.

These findings have implications for measuring complexity. The current tools (e.g. the CYP-IAPT 'current view' form and the PCS) are successful in capturing a range of complexity factors but may be too simplistic in nature. Their 'tick box' nature perhaps might not allow for the variability and interplay of complexity factors inherent in cases, nor assess the more abstract components identified in this study. It may be worthwhile considering the use of continuums and scales which also incorporate clinician's judgement. In order to assess levels of complexity and develop coherent formulations, clinicians need the opportunity to conduct detailed assessments where necessary, and time may need to be given accordingly when transforming services.

Consideration should also be given to primary services, which often manage complex cases due to factors such as changing service criteria, mental health stigma, and accessing specialist mental health services. Therefore, determining effective and efficient means to work alongside other organisations to help manage complexity is important. This study shows that strengthening working partnerships and offering consultations is necessary to ensure families with complex problems receive the support they need. In addition, multidisciplinary working, supervision and peer support are seen as essential to enable clinicians to manage complexity within their caseload. It is important that services protect this space in a climate of service pressure and cuts.

This study invited a range of teams and professions to discuss their understanding of what makes cases complex. Although there was some debate around particular settings leading to greater complexity, staff were generally in agreement about the matters they discussed. In addition, the demographics of each borough varied significantly, which ensured factors discussed were not limited to factors associated with deprivation.

Thematic analysis allowed themes to be data driven, and inter-rater reliability was enhanced via analysis being conducted by two independent clinicians. It was noted that this focus group was facilitated as part of a request from commissioners, with the aim of assessing complexity in clinicians' caseloads. This might have influenced clinicians' contributions, through their desire to communicate a particular message to commissioners about the complexity of their work.

Further research could be conducted to determine the impact complexity has on the process of assessment and formulation, as well as length of treatment and treatment outcomes. In addition, it would be worthwhile exploring whether there are specific factors which will always lead to complexity and how measures could be developed to help services capture, understand and manage complexity.

This study stresses the complex nature of complexity. It recognises that complexity is a challenging concept to define and could be better understood when contrasted with cases that fit into simple care-pathways. The clinician's role in assessment of complex cases is essential and their views and opinions should be incorporated into complexity measures. In addition, it highlights the challenges that we face to ensure we work effectively with complex cases. Inter-agency relationships and team support are necessary to minimise the impact of complexity on services.

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Keep NICE and carry on? Reflections on evidence-based practice

Laura Tinkl & Syd Hiskey

This paper considers the term evidence-based practice by way of its relationship to empirically supported therapies and NICE guidance, before critiquing the randomised control trial methodology. We feel psychologists need to engage in such debates to inform those who commission services.

WE HAVE NOTICED that the phrase 'evidence-based practice' often crops up, at times with little thought, during discussions about the treatments we and other psychological therapists offer. Here we attempt to scratch the surface of this popular term and consider its relationship to empirically supported therapies and National Institute for Health and Care Excellence (NICE) guidance. As we'll see, it is possible to critique the highly (over?) valued randomised control trial methodology upon which many claims for evidence-based practice status are made, which may be especially important to bear in mind during conversations with those who commission services.

The foundations of empirically-supported therapies

Evidence-based practice has been defined as an 'integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences' (American Psychiatric Association, 2006, p.271). It requires professionals to meet the individual needs of service users by complementing clinical judgement with reference to the best available evidence regarding the efficacy and effectiveness of possible interventions. A strong movement towards evidence-based practice has been accompanied by a mandate to identify empirically-supported therapies for different health conditions (Chambless & Ollendick, 2000). Empirically-supported therapies are defined by the standards outlined by the US Food and Drug Administration agency as having demonstrated superiority relative to appropriate controls in two or more randomised controlled trials (RCTs) by two or more research groups. The specific mandate to identify psychological empirically-supported therapies was advanced by the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures in 1995. This was established to evidence the efficacy and cost-effectiveness of psychological therapies for discrete *Diagnostic and Statistical Manual for Mental Disorders* (see DSM-5, APA, 2013) categories, relative to cheaper and more readily available pharmacological interventions.

…the best available evidence regarding the efficacy and effectiveness…

The development and implementation of NICE guidance

NICE was established in April 1999 as a Special Health Authority for England and Wales to increase public awareness and reduce local variation in the care afforded to service users. It subsequently became responsible for the provision of evidence-based guidance for the most efficacious, safe and cost-effective interventions for specific health conditions. NICE guidance is developed in accordance with reviews of clinical and economic evidence conducted by independent guideline development groups, which in turn rely on a hierarchy of evidence that prioritises RCT methodology. Accordingly, empirically-supported therapies are routinely recommended over non-empirically-supported therapies in NICE guidance.

Since the establishment of NICE, strategic guidance from the Department of Health has specified that 'core' and 'developmental-standards' for NHS Trusts should conform to nationally-agreed best practice, particularly as defined in NICE guidance. This has led to the establishment of review bodies to monitor Trust compliance with NICE, which offer a number of incentives for Trusts to conform to NICE guidance. This includes the coveted status of Foundation Trust, with gives Trusts the autonomy to manage the delivery of local services and to secure three-year (as opposed to annual) funding contracts. Given the financial onus upon Trusts to conform to NICE guidance, therefore, we might question whether adhering to this is truly in the spirit of evidence-based practice.

A critical account of RCT (empirically-supported therapies) methodology

The strength of RCTs lies in their attempt to control differences and ensure treatment outcomes are less a by-product of chance or systematic bias. This is achieved by creating conditions which control for, or exclude, the influence of possible confounds. This does, however, require certain assumptions to be made about the nature of mental illness and its treatment. We therefore provide a critical account of some of these assumptions, which underpin the debate regarding the clinical validity of NICE guidelines.

Participants

RCTs select participants on the basis of discrete DSM based diagnoses. The advantages of this are that the DSM system is widely used in clinical practice, thereby allowing comparisons with pharmacological trials and between psychological therapies. The application of stringent exclusion criteria also removes the need for large participant numbers to observe an intended treatment effect (Westen et al., 2004). Nonetheless, the real-world applicability of such an approach is questionable given the high incidence of co-morbid DSM Axis-I disorders (estimated 50–90 per cent; Zimmerman et al., 2000) that 33–50 per cent of patients present with sub-threshold symptoms for a discrete diagnosis (e.g. Messer, 2001), and the enormous variability within diagnostic categories. Indeed, DSM categories used in this way for research purposes may blur the presentations of many patients.

Psychological processes

While there is evidence to suggest that empirically-supported therapies are clinically useful for psychological difficulties which relate a specific stimulus and a particular cognitive, affective and/or behavioural response (Westen et al., 2004), there is much less evidence to support the clinical validity of empirically-supported therapies as applied to the more complex symptom profiles routinely seen in secondary care services. These include generalised affective states, which may be caused and/or maintained by underlying and enduring personality traits (e.g. Westen & Bradley, 2005). Indeed, a core assumption of RCT methodology is that DSM Axis-I disorders can be treated independently of potentially change resistant personality factors. This is a clear limitation given that Axis-I disorders often function and respond differently to treatment in the presence of co-morbid Axis-II (personality) disorders (e.g. Wixham et al., 2007). Moreover, greater co-morbidity often results in criteria for an Axis-II disorder being met (e.g. Newham et al., 1998).

Treatments

To minimise differences within groups, RCTs routinely reduce psychological therapies to brief (6–16 sessions) treatment manuals to make them directly comparable with pharmacological trials. While there is evidence that brief therapies can have impressive effects (e.g. Roth & Fonagy, 2005), such constraints can at times prevent longer-term treatments from being examined. This is despite previous evidence from naturalistic studies which suggests 1–2 years may constitute optimal treatment length (e.g. Kopta et al., 1994) in some cases and that individuals receiving brief psychological therapy for a range of Axis-I disorders often seek further treatment within two years (e.g. Mueller et al., 1999).

The pragmatic reduction of therapies to prescriptive manuals may also be problematic as it circumscribes treatment, potentially at the expense of clinical acumen. It also assumes that the active ingredients of treatments are purely technical. The unique characteristics of service users and therapists are treated as random and therefore inconsequential. Such assumptions are, however, challenged by findings that technique accounts for a small degree of outcome and that non-specific process of therapy factors account for more, as well as being the best predictors of change (Norcross & Lambert, 2006). Indeed, a positive therapeutic-alliance is associated with the most gains (Castonguay et al., 2006).

Manualised treatments also assume that psychopathology is additive and can therefore be treated by single or sequential episodes of therapy. While this may be so for some presentations, such as simple phobias (e.g. Borkovec et al., 1995), it does not account for disorders which share common disposition or maintenance factors. Neither does it account for emergent symptomatology as a function of enduring personality patterns.

Issues of reporting

Further criticisms include researcher, funding and publishing biases. This includes therapist enthusiasm for particular treatments being offset against control conditions such as treatment-as-usual, which are expected to fail (Westen & Bradley, 2005). There is also concern that desired therapeutic outcomes in psychoanalytic and systemic (e.g. family) models, such as changes in personality structure and relationships, do not lend themselves as easily to RCTs as more readily-measurable changes in cognitions and behaviour (Roy-Chowdhury, 2010). This is likely to have contributed to the over-representation of cognitive behavioural therapy (CBT) in the evidence-supported therapy literature and NICE guidance.

Finally, there are concerns regarding the clinical validity of reported statistics in the current literature, which can be manipulated to reflect desired change. This includes poor reporting regarding analyses of those the research originally intended to treat (but who may have dropped out of the study for a number of reasons) and information regarding clinically meaningful yet harder to measure changes over time. For instance, there is concern regarding the usefulness of reporting the overall size of a treatment effect given that a moderate change can relate to both a moderate reduction in symptoms for a large number of participants and a large symptom reduction for a small number (Westen & Bradley, 2005).

A summary of RCTs

While RCTs are often cited as the gold standard in research trials, we propose that the assumptions upon which they are based do not translate smoothly into clinical practice and may have resulted in a false dichotomy, whereby therapies which have not been (or cannot be) tested with such scientific rigour have been rendered ‘unsupported’. Furthermore, we suggest that there has been a growing synonymy between empirically-supported therapies and evidence-based practice, with the introduction of NICE guidelines. This has resulted in strict adherence to an initially pragmatic solution to restricting differences within groups during research trials, yet has evolved into an (unjustified) safeguard against poor clinical practice (Goldfried & Eubanks-Carter, 2004).

Implications

The above has clear implications for clinical researchers who must be encouraged to provide commissioners, providers and consumers of psychological therapies with fuller descriptions of their underlying methodological assumptions and outcome statistics to avoid misleading conclusions. Further, given the compelling evidence regarding the significance of therapy process factors, we suggest that there is also a need for more research to identify how, as opposed to if, therapies work. In the spirit of evidence-based practice this would support professionals to provide highly tailored, yet research informed, treatments and not lose sight of the ‘individual’ in individual therapy.

Qualitative research methods may be important in achieving this because of their capacity to remain closer to the real-life experiences of therapists and patients, thereby likely complementing our current reliance on quantitative-approaches (which tend to lose clinical-validity in their quest to generalise across diverse populations). In a similar vein we propose that, true to evidence-based practice, there seems an increasing need to shift the current emphasis on identifying therapeutic packages (manuals) towards identifying empirically supported techniques with demonstrated clinical effectiveness (i.e. real world application). This is because, at present, we can only guess the active components of a comprehensive treatment manual (Hagemoser, 2009).

Conclusion

As providers of a wide range of psychological approaches, the significance of this debate speaks to the future of clinical psychologists as a professional group. This is because if we fail to comply with NICE guidance, we risk appearing outside of the emerging orthodoxy, at a time when demonstrating the relative benefit of talking therapies alongside cheap and accessible pharmacological interventions (e.g. Baker et al., 2009) and competitive tendering within the field seems as important as ever. Given that healthcare decisions are being increasingly driven by political and economic agendas we must ensure that we do not reduce ourselves to therapy technicians, blindly administrating manualised empirically-supported therapies evidenced on assumptions which may not reflect clinical reality.

That said, we do not suggest a bleak future for the creative, responsive and person-centred practitioner. Rather, we propose a reasonable position for us to adopt would be to continue to demonstrate NICE awareness, but complement this with evidence of outstanding clinical need. Ultimately, however, we need to make significant progress in narrowing the current gap between researchers and therapists, which will enable us to remain in keeping with notions of both practice-based evidence and evidence-based practice. This will likely require active support from organisations such as the British Psychological Society, by way of ensuring that clinical research excellence becomes lauded and rewarded by NHS Trusts as much as managerial skills seem to be.

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The British
Psychological Society

Division of
Clinical Psychology
Faculty of Psychosis
& Complex Mental Health

Community Mental Health Team Network & Assertive Outreach Network – Joint Event

Engaging People Who Are Hard-to-Reach

BPS London Offices, 30 Tabernacle Street, London EC2A 4UE

Monday 8 June 2015

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The morning will host presentations from experienced speakers on how their services have used resources in varying ways to meet the needs of such individuals. The afternoon will host skills development workshops, including 'Home visiting as a psychologist', 'Ethics and boundaries' and two workshops on 'First-hand accounts of sitting outside services'. These will be delivered by service users and carers, whose voices we aim to privilege throughout the day.

Speakers

'Shared care' as model for providing a comprehensive CMHT service
Ben Frayne, Clinical Psychologist Southern Health NHS Foundation Trust

Investing in CMHTs to improve outcomes
Stephen Goggins, Clinical Psychologist, South London & Maudsley NHS Foundation Trust

Reaching people via recovery colleges
Peer Trainers and Sara Meddings, Clinical Psychologist, Sussex Partnership Trust

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A trainee's reflections on seeking and managing informed consent in therapy

Hannah Wilson

This article considers some of the complexities in striving for informed consent, as experienced by a trainee clinical psychologist. This includes reflections from several clinical examples, including the potential impact of the consent process.

THE British Psychological Society define informed consent as, '…the client's right to choose whether to receive psychological services and to make this choice on the basis of the best information available' (BPS, 1995, p.16). When I first began clinical training, I largely viewed informed consent as an ethical 'tick-box exercise'. I agreed it was important for clients to consent to participating in therapy, but had not engaged with the importance of the discussion itself or the many challenges in seeking informed consent. As I have progressed through training, various experiences have caused me to reflect on the range of difficulties in seeking informed consent from adults deemed to have capacity to make decisions.

Informed consent

The Health and Care Professions Council's (HCPC) *Standards of Conduct, Performance and Ethics* state that, 'you must get informed consent to give treatment (except in an emergency)' (2008, p.3). This is echoed in the British Psychological Society's *Generic Professional Practice Guidelines* (2008). Guidelines for clinical psychologists were first published in 1974 (Goddard, Murray & Simpson, 2008), but the issue of informed consent has been cited as arising from the aftermath of the Nuremberg Code, post-World War II (Hayes, 2003). Although the reasons for informed consent are many, they can be broadly grouped as protecting or empowering the autonomy of the client to make a free and fully informed choice (Corrigan, 2003). Despite the importance of informed consent being highlighted throughout my career, its application to therapy was not something I had fully considered.

Various publications consider how informed consent applies to psychological therapy. Bray, Shepherd and Rays (1985) state that, 'consent, to be effective, must stem from a knowledgeable decision based on adequate information about the therapy, the available alternatives, and the collateral risks' (pp.53). More recently, Follette, Davis and Kemmelmeier (2003) discuss some of the aspects which should be addressed with regards to informed consent: therapist credentials; confidentiality, and its limits; the process of goal-setting; the assessment process; and the proposed treatment, including available alternatives. These issues begin to highlight the complexities of applying the notion of informed consent to therapy, as I have experienced during my clinical work.

Informed consent in my clinical practice

Throughout my first placement, I endeavoured to comply with HCPC and BPS requirements by addressing informed consent with clients. I outlined the process of therapy, the limits of confidentiality, and my own position as a trainee, including the role of supervision. This was concluded by asking, 'are you happy to continue?' I had no expectation of a negative response, and gave little information on what to expect from therapy. On reflection, this was partly due to my own uncertainty of what therapy would involve, not having delivered it before. One client responded, 'I don't have much choice, do I?' We discussed his choices, and I emphasised that continuing was entirely his decision. His remark troubled me, so I voiced my concerns within supervision.

Reflecting on the situation with my supervisor, I realised the process of informed consent could be empowering for clients. Especially for individuals who feel powerless, encouraging a sense of agency could play an important therapeutic role. Hoener, Stiles, Luka and Gordon (2012) found that clients experienced aspects of agency as key to their progress in therapy, including being informed. Participants valued feeling 'active, involved, and responsible for themselves' (p.79). My current stance at that time did not invite a collaborative discussion with clients, and consequently they played a passive role within the consent process.

Subsequently, I have striven to facilitate conversations with clients regarding the therapy process, what it might entail and their feelings regarding it. I am conscious to advise them of the 'risks'; that some aspects of therapy may be distressing and will not always feel easy. By addressing the elements suggested by Follette, Davis and Kemmelmeier (2003), I have found clients are more forthcoming with their fears or uncertainties about therapy, and we are able to address those together. In doing so, clients' autonomy is respected and their sense of ownership over decisions within therapy may be enhanced (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). However, my appraisal of 'informed consent' continued to evolve during my next placement, particularly with one client whom I saw throughout.

Working with Susie

When Susie (pseudonym) and I first met, we discussed what therapy may entail and she consented to continuing. After several sessions working together on her intrusive thoughts and compulsions, Susie told me she felt we were making progress. She began to speak about a voice she heard, which belonged to 'Susanne', who she felt was both part of, and separate to, her own identity.

In our fifth session, Susie presented as highly anxious and agitated. She told me she was hearing Susanne, who wanted to 'take control'. She began staring at the table, then there was a palpable shift within the room, and Susie's entire demeanour changed. She told me I was now speaking to Susanne, and then waited expectantly.

I had recently attended a training event regarding dissociation, and dissociative identity disorder. The *Diagnostic and Statistical Manual of Mental Disorders* (4th edn.; American Psychiatric Association, 2000) criteria for dissociative identity disorder include, 'the presence of two or more distinct identities or personality states' (p.529), often referred to as an alternate identity or alter (International Society for the Study of Trauma and Dissociation (ISSTD), 2011). Certainly, it felt as though there were a new personality within the room. I followed the training event's guidance, which recommended opening a dialogue with 'Susanne'.

We spoke for 10 minutes and when Susie 'returned' she was understandably shaken and confused. Amongst the many questions in my mind, a prominent one was what to tell her about Susanne. I had not asked Susanne whether I could share our discussions with Susie, but felt that not doing so would distress Susie further. The HCPC state that, 'you must act in the best interests of service users' (2008, p.3). I was conscious that both Susie and Susanne were potentially 'service users' and that their best interests may not always overlap. I decided Susie had been my primary client, and it would be in her best interests to disclose some of what had occurred with Susanne. I shared a brief overview of our conversation, but chose not to share my impression of Susanne's character, as I was conscious that this may affect Susie's own feelings towards her. Susie said she now felt calmer, as for her it was an alarming memory gap.

I explained a little about dissociation to Susie, and she related experiences both during and previous to the session conforming to much of the description. I answered her questions as fully as I was able. The HCPC dictate that clinical psychologists must work 'within the limits of your knowledge, skills and experience' (2008, p.3). Mindful that I was at the edge of my knowledge, we agreed that I would discuss our next steps in supervision.

When discussing Susie with my supervisor, I found that 'consent' consumed much of our conversation. Assuming that Susanne was a separate alter, I had several questions: Did

I seek her consent before continuing therapy? If Susanne didn't consent, could I continue seeing Susie for therapy? Did I need consent from each alter to share information with the other? These queries are echoed by Barlow (2007), considering research with individuals who experience dissociation, including if one identity withdraws consent, whilst another wishes to continue. Barlow does not offer a definitive response to these, but acknowledges the complex nuances of the consent process with these individuals, and recommends creating a plan with the client at the start of any interactions.

Due to our collective lack of confidence in how to proceed, my supervisor and I sought consultation from a local psychologist with extensive experience of working with individuals who experienced dissociation. The consultation validated my uncertainties, as there is a lack of professional guidance regarding this aspect of therapy for clients who experience dissociation. O'Neill (1998) interviewed several therapists who presented differing views on consent and sharing information between alters: one considered it unethical to 'hide information from people' (p.131), whilst another afforded each alter full confidentiality. The psychologist I consulted with advocated seeking consent to therapy from each alter, where possible, but to treat 'the host', Susie, as the primary decision-maker. He recommended seeking consent from each alter to share information with the other, as the ultimate aim of therapy for dissociation is integrated functioning of the different alters (ISSTD, 2011).

Although Susie previously consented to 'therapy', I considered it important to revisit this. Our previous session had taken an unexpected turn, and the trajectory of our future work had potentially shifted. Whilst Susie's hopes and goals for therapy initially considered her intrusive thoughts and compulsive behaviours, these may now include managing Susanne's presence. Susie may also be reluctant to continue therapy, if she connected our sessions with distressing experiences. In order to maintain informed consent, I planned to review the process with Susie. Considering that events within the previous session had left Susie feeling powerless, I also hoped she would regain some sense of control, by involving her in collaborative decisions.

At our next session, Susie and I discussed what our future work might involve. Susie wanted to explore the purpose and function of Susanne, and how to manage this development. The ISSTD (2011) advocate a three-phased approach to working with individuals who experience dissociative identities: establishing safety and stabilisation, working through traumatic memories, and identity integration. Treatment was described as lengthy, and the therapeutic alliance was fundamental to its progression.

With my placement soon ending, I did not feel it would be in Susie's – or Susanne's – best interests to undertake work which we could not complete. I relayed the above to Susie, and together we considered our options. These included terminating therapy, or pausing until another therapist was available. She opted to continue therapy, aware of my upcoming departure, and we agreed to work on distress tolerance and grounding as part of phase one. She agreed to continue therapy with my supervisor after my placement finished. She also agreed for information to be shared with Susanne, unless she specified otherwise.

My experiences with Susie caused me to reflect on 'informed consent' in a variety of ways, but particularly lead me to see it as a process, rather than a discrete event, within therapy.

Consent as a process

After working with Susie and with subsequent clients, my understanding of informed consent continued to develop. Through these experiences, I understood that the HCPC requirement to 'get informed consent' was more complex than three words may imply. As Beahrs and Gutheil (2001) describe, 'neither party knows at the outset in what directions the therapy might evolve, what information or understanding may unexpectedly emerge, what roadblocks the therapy will need to surmount, or what the final outcome will be' (p.6).

It is undoubtedly important to have initial conversations with clients regarding therapy, including therapist credentials, confidentiality, options and the therapy process before seeking their consent to continue. However, as Beahrs and Gutheil express, many of these aspects can only be tentatively addressed at the outset. There are multiple unknowns with regards to therapy, and consequently, informed consent should be seen as an on-going process (Follette, Davis & Kemmelmeier, 2003; Pope & Vasquez, 1991). As components of the consent process change, such as the treatment trajectory, the consent itself should also be revisited before therapy moves in a new direction (O'Neil, 1998). Even where therapy proceeds as anticipated, clients' distress or state of mind may affect their ability to retain the information discussed in the first session; therefore, reviewing aspects of consent could still be of benefit. This also ensures that both therapist and client are working with the same hopes and expectations for therapy, which may be important in the therapeutic alliance.

Conclusion

Informed consent is an essential part of professional practice for clinical psychologists and has the potential to impact greatly on the course of therapy. There are many complexities in striving to attain informed consent, and it may serve a number of functions within therapy. Ultimately, clinical psychologists should endeavour to ensure that their clients possess adequate knowledge and information to allow them to give fully informed consent, which is unlikely to be achieved in only one discussion in the first session. In addition to meeting professional guidelines, reviewing and revisiting the factors within consent may have added benefits within therapy. This may include nurturing the therapeutic alliance, and providing clients with a greater sense of agency and control. Future research or guidelines regarding informed consent in complex areas such as dissociation would be of great value for both clients and therapists.

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Clinical Psychology News

Award winners in clinical psychology

Pre-Qualification Group Award winners Tania Bosqui (left) and Eleanor Hambly

ONE OF THE MOST rewarding parts of the role of being Membership Services Unit Director is to promote the excellent work which is done by DCP members. Both the DCP and the BPS have a number of awards for which members can be nominated, and all BPS member networks can put forward names for national awards in the Queen's Birthday and New Year's Honours lists. I am sure you can think of people at every stage in their career as psychologists who stand out and who have gone the extra mile in terms of their work with clients, their professional expertise, their training of others, or their research and publications. If so, we would like to hear about them. We would also like to hear your ideas for new awards. Please get in touch at the address at the end of this article to discuss possible nominations as the process begins *now*.

The DCP awards committee meets in July to consider nominations for the May Davidson Award and the Monte Shapiro Award. These are presented at the DCP Annual Conference in December. Other awards are presented by the DCP's Pre-Qualification Group, the Faculty for the Psychology of Older People (the Una Holden Award, presented at the FPOP conference in June) and the Faculty of HIV and Sexual Health (the Oliver Davidson Award, given for a recently qualified clinical psychologist for the advancement of research and clinical services in that field). The details of the award criteria are available on the DCP website (tinyurl.com/dcpawards).

This year, it was my great privilege to present the Pre-Qualification Group Award and the Monte Shapiro Award at the DCP Annual Conference in Glasgow, and Richard Pemberton, DCP Chair, presented the May Davidson Award. The Pre-Qualification Group Award was given jointly to Tania Bosqui and Eleanor Hambly.

Tania began her career in community mental health and gained experience in a humanitarian NGO in south India and an IAPT service in Birmingham, completing an MSc in Poverty Reduction and Development

Management at the University of Birmingham and the Doctorate in Clinical Psychology at Queen's University Belfast. Her final elective placement was with the Psychosocial Department of the Palestinian Red Crescent Society in the occupied territories. Since graduation, Tania has worked clinically for an adult mental health service in Northern Ireland, for the British Red Cross Psychosocial Team, and as a researcher at Queen's University Belfast for the Centre for Child Care Research and the Centre for Public Health.

In her acceptance speech Tania talked about her clinical doctoral training experience in Northern Ireland, the development of her understanding of psychological trauma in the context of ongoing political and community unrest and the application of this to psychosocial activities in the occupied Palestinian territories. This included the use of the international model of psychosocial interventions in emergency settings and learning about the role of clinical psychology in implementing this model. She then discussed the importance of developing an evidence base to inform the interventions and she described her professional hopes for the future.

Eleanor Hambly graduated in psychology in 2012 from Reading University. At university she also worked at the Institute of Psychology as a Research Assistant and then with Kent and Medway NHS Psychological services. Volunteering with Student Minds (the UK's student mental health charity) at Reading, she became a trustee in 2013. Following graduation she worked with Brighton and Hove Eating Disorder Service and then worked as an Assistant Psychologist in Berkshire Child and Adolescent Mental Health service (CAMHs). Her acceptance speech described the 'University Challenge' *Report on Integrating Care for Eating Disorders at Home and at University.*

This investigated the care university students with eating disorders received from the NHS. Eleanor discussed the implications of the lack of integration, personalisation and effective care provided for university students with eating disorders, as well as the recommendations from the report. The difficulties faced by students obtaining care from different doctors when moving between home and university showed how many students' recovery was put at risk. Following publication of the report she met with Norman Lamb (Minister for Care and Support) and became involved with clinical commissioning groups to implement the recommendations from the report. She started her clinical psychology training in September 2014 at the University of Surrey.

The mid-career May Davidson Award was this year given to Stephen Weatherhead, Lancaster University and Lancashire Care NHS Trust. After qualifying from the Lancaster DClinPsy programme in 2008, Stephen went on to specialise in brain injury, primarily in outpatient and community settings. He has practised both in the NHS and the independent sector and was a co-founder of Neuro Family Matters, which was set up in 2010. Later that year, Stephen took a role with the Lancaster DClinPsy programme as a research lecturer and clinical tutor. In the six years since Stephen has been qualified he has co-edited three books: *The Pocket Guide to*

May Davidson Award winner Stephen Weatherhead

Therapy, *Narrative Approaches to Neurological Conditions* and *Practical Neuropsychological Rehabilitation in Acquired Brain Injury: A Guide for working clinicians.* In December 2013 Stephen became editor of *Clinical Psychology Forum* and in July 2014 became Director of the Division's Professional Standards Unit.

His acceptance speech was entitled 'Three little birds: Narratives, clinical psychology training, communities'. He described the opportunities he saw that were offered by the profession which enable us all to develop a whole range of interests and diverse experiences within a single career. His lecture explored the role of narratives in research, therapeutic and neuropsychological settings. He commented on how narrative approaches have gained renewed momentum in recent years. For example, in brain injury settings creating a space for stories to emerge and change is as important as understanding the functional neuroanatomy and cognitive profile of the injury itself. Similarly, in research settings there is an increased appreciation of the importance of rich narratives in informing academic, clinical and political contexts. Stephen talked of how others had supported him to develop his interests and he in turn had been able to nurture the interests of others, particularly as part of the training community. Examples included the co-development of innovative clinical psychology placements, including a recent placement in Malawi, and empirical research into religion, culture and a range of areas where clinical psychology can interact with other disciplines and other ways of thinking. His take home message was that finding the space for overlap, sharing knowledge and experiences, and learning together is hugely rewarding for individuals and society. He concluded with a discussion of social media communities such as Twitter, and how they have enabled the development of new opportunities for clinical psychology.

Monte Shapiro Award winner Barbara Wilson

The Monte Shapiro Award is presented to someone later in their career. Barbara Wilson is a clinical neuropsychologist who has worked in brain injury rehabilitation for over 35 years. She has an OBE for services to rehabilitation (1998) and two lifetime achievement awards, one from the British Psychological Society and one from the International Neuropsychological Society. She received the Ramon Y Cajal Award from the International Neuropsychiatric Association (2011), and the 'Distinguished Lifetime Contribution to Neuropsychology Award' from the National Academy of Neuropsychology (2013). She has published 22 books, over 270 journal articles and book chapters, and eight neuropsychological tests. She founded and is editor of the journal *Neuropsychological Rehabilitatio n.* In 1996 she founded the Oliver Zangwill Centre for Neuropsychological Rehabilitation and has a rehabilitation centre in Quito, Ecuador named after her. She is currently president of the Encephalitis Society and on the management committee of the World Federation of Neuro Rehabilitation. The Division of Neuropsychology has a Barbara A. Wilson Prize for distinguished contributions to neuropsychology named after her. She is a Fellow of The British Psychological Society, the Academy of Medical Sciences and the Academy of Social Sciences. She is honorary professor at the University of Hong Kong, the University of Sydney and the University of East Anglia and has honorary degrees

Professional Practice Board Lifetime Achievement Award winner Professor Neil Frude

from the University of East Anglia and the University of Cordoba, Argentina.

Barbara talked about 'The past present and future of neuropsychological rehabilitation'. She described the earliest known description of the treatment of brain injury on an Egyptian papyrus of 2500–3000 years ago, discovered by Edwin Smith in Luxor in 1862. Moving forward to modern rehabilitation, which began during World War I, she acknowledged the many contributions of others, including Goldstein, Luria, Zangwill, Ben-Yishay, Diller and Prigatano. Current neuropsychological rehabilitation is concerned with the amelioration of cognitive, emotional, psychosocial and behavioural deficits caused by an insult to the brain. She emphasised that rehabilitation is *not* synonymous with recovery or treatment, but a two-way interactive process whereby people who are disabled by injury or disease work together with professional staff, relatives and members of the wider community to achieve their optimum physical, psychological, social and vocational well-being. She concluded by emphasising, as she had demonstrated so inspiringly throughout her career, that in good clinical practice, we as psychologists need to focus on real life problems and develop a broad theoretical base.

Another lifetime achievement award, this time awarded by the Society's Professional Practice Board was given to Professor Neil Frude, head of the South Wales Doctoral Programme in Clinical Psychology. This award is made each year to recognise someone who has made an unusually significant contribution in a career as an applied psychologist. In 2003 Professor Frude developed the Book Prescription Scheme, under which GPs recommend books from a shortlist of self-help books ratified by psychologists to their patients. It has developed from a local initiative to a national, government-funded scheme in Wales. Similar schemes have been set up in other countries, including Denmark and New Zealand. In 2013, a national books on prescription scheme for England was launched by the Reading Agency. An extension of this, Books on Prescription for people living with dementia and their carers, was launched on 26 January, also by Norman Lamb. A further roll-out of books for children and young people will follow shortly and the main list will be revised.

Earlier in his career Professor Frude researched the family and the effects of physical abuse on children. More recently he has taught in universities and on clinical psychology training courses and is a Fellow of the British Psychological Society. In 2004, he appeared as a stand-up comedian for 16 nights at the Edinburgh Fringe in his one-man show.

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Book Review

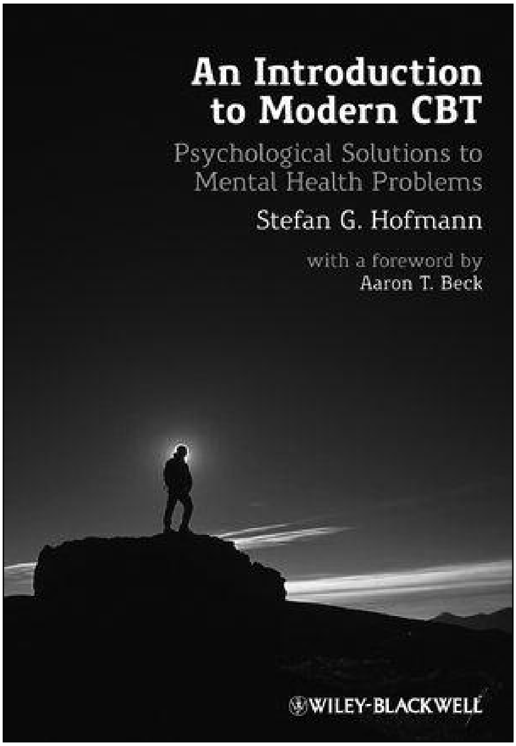
An Introduction to Modern CBT: Psychological solutions to mental health problems

Stefan G. Hofmann

(foreword by Aaron T. Beck)

John Wiley & Sons Ltd, 2012, 236pp.

Reviewed by Marie Sara Louis



AN INTRODUCTION TO MODERN CBT offers a general overview of Cognitive Behavioural Therapy (CBT) today; its techniques, its applications and its effectiveness. This book aims to show how such a simple psychological tool can be used to help with a multitude of psychological problems.

The book starts with a thorough introduction to the origin of CBT, which gives the reader an in-depth look into how CBT was developed. The book then moves on to describe how CBT has progressed into one of the most widely used techniques in a therapist's arsenal. The author states that the concept of CBT is almost a common sense notion and that various philosophers have extoled the benefit of thinking 'positively'. However, this only serves to enhance the broad message that this remarkably simple technique has so many applications. By the end of the first chapter, the reader will already have a good basic understanding of this technique which makes the chapters that follow much more accessible.

The latter chapters consist of all manner of psychological disorders that can be treated by 'modern CBT'. These range from chronic pain and alcohol abuse to sexual problems and phobias. The format for these chapters follows the same basic structure: a case study is introduced, a model is formed and solutions are created to help individuals. The constant relating back to case studies gives the reader a worked example to follow that illustrates how the process of CBT works. This also gives an insight into how a therapist formulates a solution.

Unfortunately, the one let down of the book is its lack of acknowledgment of CBT's limitations. Whilst the book does describe modern techniques of CBT, and expands on current development, CBT's limitations are never acknowledged and this is highlighted by the choice of case studies. All the case studies selected by the author involve individuals who have strong emotional support and financial security. It is almost a practicality issue: How can CBT help someone with no support, money or time to partake in the therapist's advice?

To conclude, this book is an excellent overview of CBT as it is used in modern society. However, it does not address limitations or suggest future directions to increase practicality. Nevertheless, if you require a book to further your knowledge of CBT, whether you are a health professional, a student or merely interested in the subject look no further.

DCP Update

Stephen Weatherhead

THIS MONTH, in place of his regular Chair's column, Richard Pemberton has asked that I write an update on the ongoing inclusivity work. I think this shows the importance being given to this initiative. We are working hard to make sure this is a meaningful process with positive, strong outcomes. In doing so, we have been working hard to engage people who could help us in this process. This consultation has taken a range of forms, including e-mail and written communication with DCP members and wider networks within the Society, and the discussion forum, as well as less conventional approaches such as a Skype session with the third year trainee clinical psychologists on the Plymouth programme, and of course the open forums to which all DCP members were alerted.

Some great information and ideas have come from this work, all of which will be considered as we work towards the launch of a strategy and policy at a CPD event in Autumn 2015. As an example, here are the key learning points that came directly from the open forums in Manchester and London:

- We need an inclusivity lead and clear drives to embed equality and diversity throughout DCP networks.
- We need to create discussion boards and 'safe spaces' to discuss difficult topics.
- We need to focus on specific named groups as well as others less easily defined but equally important.
- We need to thoroughly proofread to ensure language is sensitive throughout.
- We need to make sure we create mechanisms to take a political stance and advocate for the marginalised.
- We need a clear leadership strategy in this area.
- Bottom-up learning mechanisms are paramount.
- We need to ensure inclusive criteria for selecting to leadership positions.
- Mistakes will happen and we can support each other through them.
- We must include a mentoring system.
- We must focus on specific groups as well as general inclusivity.
- There must be space to challenge prejudice, so the strategy must be strong and not too woolly.
- Increased statistical data collection is required on professional demographics throughout the career span.
- We need to gather feedback from service users about inclusive practice in clinical psychology
- We must attempt to influence the profession to offer job roles outside traditional nine to five patterns.
- We need a social inequalities research strategy built with the communities.
- We need research to be co-produced and funding issues to be addressed and resolved without increasing power differentials.
- Research needs to be transparent, tracked and disseminated well.
- We need to disseminate this report widely.
- We need to make space for people to contribute to the strategy.
- The discussion pages may well be one place to enable people to connect and share ideas, but this must be made public in order to be of most use.
- There is a danger with inclusion that you drive racism, sexism, etc. underground. We need to have the subjective narrative to allow for open discussions and bear witness to the pain.

We will now be working to include this and all the other pieces of feedback and ideas into the inclusivity strategy, with further consultation over the summer period. There is a small group of us doing the direct work associated with this: Stephen Weatherhead, Guilaine Kinouani, Anna Daiches, Zenobia Nadirshaw and Yvonne Stewart-Williams.

However, we have a large reference group developing, which is growing daily. If you would like to join the reference group and receive regular updates, please contact me via the e-mail address at the end of this article. You can then keep involved and make comments on any updates as we are developing the work further.

In addition to the working group and the reference group, we would like to give special thanks to:

- The third year trainees and Annie Mitchell from the Plymouth Programme.
- All attendees from the open forums and the facilitators: Anna Duxbury, Rachael Ellis, Rachael Faulkner, Jen Kilyon, Guilaine Kinouani, Jay McNeil, Donna Reeve and Yvonne Stewart-Williams.

The next steps are for a final draft of the strategy and policy to be produced, reviewed, ratified and launched in Autumn. However, this will not be the end of the work. Inclusivity is never 'done'; we must always strive forward with this work. The DCP executive will be putting efforts into doing so, but it will be imperative that everyone connected with the DCP become part of this process. We need this work to be integral to everything we do.

Ste

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DCP CPD workshops 2015

EVENT	DATE
Parenting Across Cultures Dr Iyabo Fatimilehin CPsychol AFBPsS, Amira Hassan CPsychol & Dr Aneela Pilkington *Faculty for Children, Young People and their Families* *www.bps.org.uk/2015cpd047*	1 June
Peer Group Supervision: A structured model for facilitation of community working and professional development Professor Jacqueline Akhurst CPsychol ABPSsS *www.bps.org.uk/2015cpd052*	15 June
Cognitive Assessment of Children and Young People (Part 1) Dr Liam Dorris CPsychol ABPSsS and Dr Kerstin Verity CPsychol ABPSsS *Faculty for Children, Young People and their Families* *www.bps.org.uk/2015cpd092*	18 June

www.bps.org.uk/findcpd

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