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Editorial

Stephen Weatherhead

THERE ARE pivotal points in time for any organisation, and I feel like we're experiencing one in the BPS/DCP at the moment. As you'd expect, this is somewhat reflected in the pages of our member publication (aka CPF/aka 'the magazine'/aka 'Forum'/aka 'What's that?'). If you've followed Richard Pemberton's 'Notes from the Chair' over the last couple of years you'll have seen discussions of finance, politics and all sorts of other things I'm told it's impolite to discuss! However, we must discuss these issues, and it is really important to get to grips with them if we are to maintain our standing as a profession. We must also engage well with what Richard describes as three 'transformational themes': diagnosis, inclusivity and experts by experience. If we are honest with ourselves, there have been times when we have got it seriously wrong on these issues, but if we get them right, we can really make a difference to individuals and to society.

Celia Smith's article on 'progress and prospects' in relation to black and minority ethnic representation in our profession presents some important reading (as an ethics column should) and I am pleased to be able to include a commentary on the article, from some leading figures in the clinical psychology training community. When I read it, I was reminded of some reading I'd been doing on 'sus' laws in policing.

In case you need a reminder, 'sus' laws are the rights police hold to question people of suspicion, without any actual evidence. They are essentially profiling and are commonly referred to as 'stop and search' strategies. In the UK, the policies, which date back to the early nineteenth century, came under fierce scrutiny in the 1970s and 80s (they are often implicated as the cause of 'the race riots'), and re-emerged in 2007. In 2010 the Equality and Human Rights Commission published 'Stop and think: A critical review of the use of the stop and search powers in England and Wales'. The review said: 'The figures are stark: if you are a black person, you are at least six times as likely to be stopped and searched by the police in England and Wales as a white person. If you are Asian, you are around twice as likely to be stopped and searched as a white person.'

And: 'Despite years of debate and several initiatives aimed at tackling the problem, these ratios have stayed stubbornly high.' (Equality and Human Rights Commission, 2010, p.5).

When taking Celia's article and the commentary on it together, I wonder whether the second quote could be reasonably applied to our profession too? Some good stuff is going on, but we can and must do more. Not just in relation to ethnicity either, but all marginalised individuals and groups.

The main articles in this issue are also of great interest and further illuminate the developing narratives in our profession. Hunter (1991) said: 'Clinicians, whatever their theoretical orientation and practical commitments, spend their days working with people's stories'. We see this displayed wonderfully in both Hilary Garroway's article on 'An holistic approach to CBT', in which she offers one way 'to integrate a person's faith into therapy'. The images and formulations in this article are a great resource too.

Sarah Whittaker-Howe explores 'the story-telling movement' as a great, subtle, yet powerful intervention to support people after they have experienced the trauma of war. Another very different yet equally powerful article is the one about the on-call neuropsychology service. I view this as another example of how the terrain of our profession is shifting, making us more available to our colleagues and, most importantly, the people who need our services.

I'd like to finish by returning to where I began this editorial: talking of the pivotal time our profession is experiencing. Jamie Hacker Hughes sends a goodbye message at the end of this month's CPF as he completes his term of office as the Society's President. I am sure many of you will agree that he has made a huge difference in facilitating the Society becoming a more visible and vocal presence. I have personally witnessed how courageously he has worked on this, and I hope we can continue to show our faces a bit more in public, under our new President, Peter Kinderman. Our society needs us to.

Jamie leaves quite a space to fill, but, hey, if anyone can match Professor Hacker Hughes on the vociferousness front, Professor Kinderman can!

Ste

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References

Equality and Human Rights Commission (2010). *Stop and think: A critical review of the use of the stop and search powers in England and Wales.* Manchester: Author.

Hunter, K.M. (1991). *Doctor's stories: The narrative structure of medical knowledge.* Princeton, CA: Princeton University Press.

Ethics Column

Increasing the number of black and minority ethnic clinical psychologists: Progress and prospects

Celia Grace Smith

THIS ARTICLE was originally commissioned for a presentation at the Minorities in Clinical Psychology Training Annual Conference in 2014 and has since been updated with the latest data. This article is not intended as a systematic review. It represents one view within the broader debate surrounding minority representation in the profession of clinical psychology. The debate is both complex and contentious. In recent years especially, substantive efforts have been made by sections of the profession to diversify representation. Yet the quantitative data shows enduring gaps in representation, suggesting there is further work to be done.

I wish to acknowledge the decades of focused research in this area from (amongst others) Katrina Scior and Graham Turpin, who have provided helpful guidance in this discussion. I also thank Richard Pemberton, Stephen Weatherhead, Tony Wainwright and Jamie Hacker Hughes, who have worked to increase progress in this area. Finally, I wish to credit Snehal Shah, whose recent research amplifies the voices of trainee clinical psychologists from black and minority ethnic (BME) groups from a contemporary viewpoint.

Where I have omitted relevant research, innovations or contributions to the debate, I apologise. This article must be read in the context of other research. It would also benefit from follow-up responses. It is my hope that this article – though partial – serves the purpose of furthering the debate on the subject. A more open debate will aid further tangible progress, which is our common aim.

Introduction

'Ethics is related to the control of power', says the British Psychological Society's *Code of Ethics and Conduct* (2009). This article addresses this aspect in the context of the underrepresentation of BME groups within the profession of clinical psychology. It looks at: demographic data on people receiving mental health care; the acceptance rate of people from BME communities applying and training to be clinical psychologists; the latest initiatives addressing underrepresentation; and recommendations aiming to expand BME representation in the field.

The article is concerned primarily with ethnicity. The intention is not to deny the importance of other types of discrimination in the profession, nor to disregard the significance of intersectionality, in which the interplay of ethnicity and other protected characteristics result in multiple disadvantages. Whilst not in scope of this article, research into the experience of clinical psychologists with other protected characteristics (e.g. gender, sexual orientation) is necessary, particularly research that takes an intersectional approach.

The Commission for Racial Equality takes the term 'ethnic minority' to refer to people who, when it comes to ethnic monitoring categories, would tick a category that isn't 'white'. It therefore includes dual heritage ethnic minorities but excludes white ethnic minorities. According to the same monitoring categories, I will use the term 'black' to refer to people who self-identify as 'black or black British'. This includes people of Caribbean and African origin.

Table 1: Median length of stay of people admitted to mental health wards by ethnic profile

Ethnic group	Men	Women
White British	161	71
White Irish	218	114
Other white	238	113
White and black Caribbean	275	191
White and black African	182	92
White and Asian	226	78
Other mixed	173	112
Indian	172	70
Pakistani	153	56
Bangladeshi	134	55
Other Asian	167	61
Black Caribbean	345	122
Black African	141	66
Other Black	248	58
Chinese	135	51
Other	131	76
Total	**174**	**75**

The term 'BME' used as an adjective can be problematic and othering. Where this usage appears below (for example 'BME psychologist' or 'BME trainee'), I intend this as a succinct denotation of individuals who come from black or minority ethnic backgrounds.

Mental illness and ethnicity

Clinical psychologists care for many people from ethnic minorities. The latest census material shows that 23 per cent of people known to mental health services are from BME groups. These are just the individuals that are known to services (CQC, 2011). This does not account for the numbers of undiagnosed, untreated or disengaged individuals who are not captured within the NHS data.

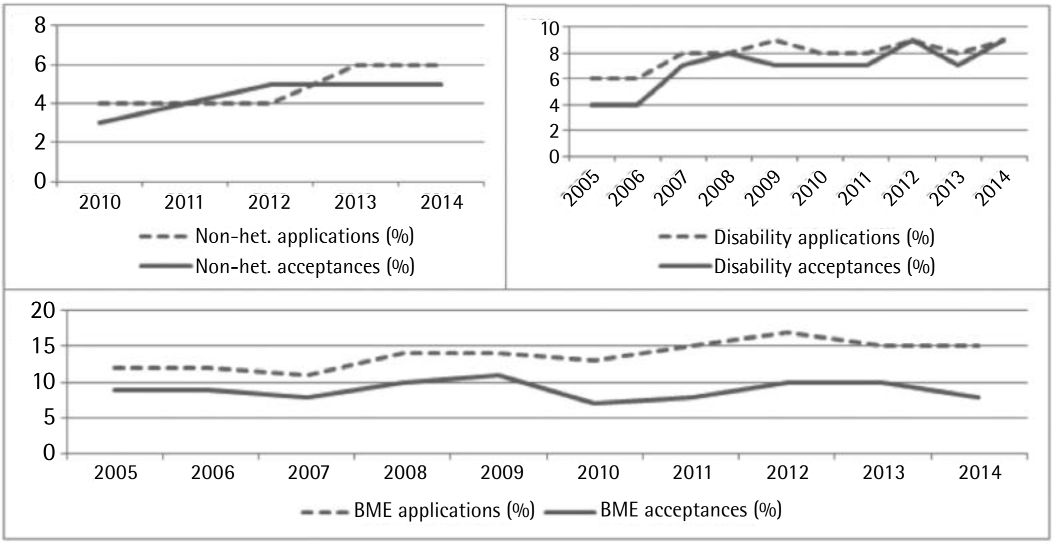
The connection between ethnicity and people receiving a diagnosis of mental illness is highlighted by the latest census data. This data shows that people from BME groups have higher rates of being detained under the Mental Health Act (1983) and longer lengths of stay than people who are white. We know that 49 per cent of all people on mental health wards are detained under the Mental Health Act on admission to hospital. These detention rates are 6 per cent lower than average among white British individuals, and between 19 per cent and 32 per cent higher than average among people who are black Caribbean, black African, 'other black' or those who have dual heritage. Length of stay is also longest for patients who have black African or black Caribbean heritage (CQC,2011; see Table 1).

The link between people receiving a diagnosis of mental illness and ethnicity is contentious. The correlation can be misused to heighten prejudices against people from ethnic minorities. Subtle acts of racism in clinical settings indicate the way in which the link between ethnicity and mental health is abused. An example of this behaviour includes diagnosing a black client with bor-

Table 2: Equal opportunities data for Leeds Clearing House (Clinical psychology: Applicants and acceptances)

Year	Minority group	Applicants (N)	Acceptances (N)	Applicants (%)	Acceptances (%)
2014	BME	582	50	15	8
	Disability	316	52	9	9
	Non-heterosexual orientation	214	32	6	5
2013	BME	548	69	15	10
	Disability	301	38	8	7
	Non-heterosexual orientation	192	29	6	5
2012	BME	630	56	17	10
	Disability	317	52	9	9
	Non-heterosexual orientation	165	29	4	5
2011	BME	530	45	15	8
	Disability	261	40	8	7
	Non-heterosexual orientation	143	23	4	4
2010	BME	394	46	13	7
	Disability	238	51	8	7
	Non-heterosexual orientation	104	20	4	3
2009	BME	322	68	14	11
	Disability	196	43	9	7
	Non-heterosexual orientation	N/A	N/A	N/A	N/A
2008	BME	307	57	14	10
	Disability	179	44	8	8
	Non-heterosexual orientation	N/A	N/A	N/A	N/A
2007	BME	263	48	11	8
	Disability	172	38	8	7
	Non-heterosexual orientation	N/A	N/A	N/A	N/A
2006	BME	295	50	12	9
	Disability	141	24	6	4
	Non-heterosexual orientation	N/A	N/A	N/A	N/A
2005	BME	248	49	12	9
	Disability	126	24	6	4
	Non-heterosexual orientation	N/A	N/A	N/A	N/A

Figure 1: Graphs showing application/acceptance rate gap for BME candidates compared to people with other protected characteristics (i.e. people with disabilities and people with non-heteronormative orientations



derline personality disorder after being loud, emotional and confrontational with the therapist. This has been likened to the experience of being stopped by police officers while driving (e.g. 'driving while Black') (Shah, 2010).

Clinical psychologists versus other professions

We live in a multicultural country. The UK's population (estimated 63.7 million, ONS 2011a) and the NHS staff workforce (1.2 million people; HSCIC, 2016) are substantially diverse, with 1 in 8 from a BME community at a national level (11.7 per cent, ONS 2011b) and 1 in 6 from a BME community at an NHS workforce level (14 per cent). London tells a more pluralistic story, with 45 per cent of the population and 41 per cent of London's NHS staff coming from ethnic minorities (Kline, 2014).

It is well known that the medical professions attract and maintain people from a range of ethnicities. Some 60.2 per cent of specialty doctors in England are from ethnic minorities, as are 55.6 per cent of senior house officers and 33.9 per cent of consultant doctors (HSCIC, 2013a).

Non-medical workers are less diverse. Some professions represent BME groups reasonably well, such as pharmacists (22.6 per cent) and orthoptics (20.5 per cent) (HSCIC, 2013b). However, clinical psychology as a profession shows lower numbers. The latest NHS workforce census (2013) shows there are 9.6 per cent qualified clinical psychologists in England from ethnic minorities (HSCIC, 2013b), up only 2.4 per cent from the last count in 2004 (Shah, 2010).

Applicants to the clinical psychology doctorate

The data from Leeds' Clearing House for Postgraduate Courses in Clinical Psychology (the central hub for people seeking to become clinical psychologists) indicates that the profession's problem may lie in the application to be a clinical psychologist.

In 2014, 15 per cent of applicants were from BME groups, yet only 8 per cent were accepted onto the course (see Table 2). Whilst the application rate has grown incrementally over the last seven years from 12 to 17 per cent, the acceptance rate for clinical psychologists from BME backgrounds has remained largely low and static (hovering around the 7–11 per cent mark). This is in contrast to the other minority groupings, whose application and acceptance rates are roughly equal. For example, in the last nine years there has been an approximately equal application and acceptance rate for people who are disabled and non-heterosexual. The issue is not that BME individuals do not apply to become clinical psychologists, but that they do not get accepted. Figure 1 illustrates the application/acceptance rate gap for groups with different protected characteristics based on the dataset in Table 2. This data provides contemporary evidence for historic research focused specifically on the discrepancy between numbers applying and those succeeding to gain a place (Turpin & Coleman, 2010).

Problems facing BME individuals entering the clinical psychology profession

A number of studies have explored the factors that influence BME individuals' decisions about pursuing clinical psychology training. Detractors include the uncertain route into the profession, initial low pay, the community's perception that it is relatively low status compared with other professions (e.g. medicine) and its 'whiteness' (Shah, 2010). Attractors include interesting clinical work with career structure and future prospects of good pay, as well as making a social contribution and developing culturally relevant services (Goodbody, 2009).

Graham Turpin, a leading researcher in this area, has commented on further factors influencing the relatively low acceptance rate for BME candidates. Discrimination is one suggested factor (explored in detail below). Emphasis is also placed on the challenge of gaining relevant experience. In particular, assistant psychologist posts are viewed as a barrier. To gain an assistant psychologist post, graduates need to be able to tolerate one or several years in a poorly paid role where moving around the country is likely. Graduates who can afford to work as an intern or as less well paid assistants will also have an advantage. This privileged profile is contrasted with marginalised candidates, whose priority is more likely to be securing a well-paid job upon graduation (G. Turpin, personal communication, 26 January 2016).

Addressing the problem

In light of the data, a number of researchers have examined factors associated with application success (Phillips et al., 2004; Scior et al., 2007). There has also been research into selection procedures (Simpson et al., 2010). Notably, the research of Scior et al. (2007) constitutes one of the largest studies into the progress of BME applicants through selection. Key findings of this research indicate that a large proportion of applications from BME candidates are rejected early on in the process. This is because they are less likely to meet basic selection criteria than white candidates. The resulting action of this research is the pan-London Widening Access initiative, which has been active over the past decade. The initiative includes high-quality careers advice through an annual open event targeting BME graduates who may consider a career in clinical psychology, as well as a mentoring scheme targeting BME graduates. Katharine Alcock (University College London) has been principal in the development and growth of this work. Although the initiative began as a London-only scheme, over the past 12 months it has been disseminated across UK training courses. Resources have been made available to all parts of the country that might consider implementing a similar scheme (UCL, 2014).

Efforts have also been made in other centres across the country. Salomon's Centre for Applied Psychology has highlighted BME role models through online videos that present question-and-answer information to prospective candidates. However, such media has yet to be implemented across the country (Canterbury Christ Church University, 2015).

Experiences of discrimination

Whilst not explored in the context of the selection process, discrimination is a theme that has been raised in relation to the lack of diversity in the profession. BME candidates who have been successful in their applications have shed light on their experiences of discrimination within their training, whether covert or overt. Transcripts from BME individuals discussing their first placements explore themes of occupational stereotyping (Box 1), the failure of advocacy by senior psychologists (Box 2) and the lack of support available to trainees in addressing instances of racism (Box 3).

One of the major areas of covert racism is supervision. Research shows that, whilst discussions on ethnicity and culture are an essential component of competent supervision, these discussions occur infrequently. There

Box 1: Mistaken for a nurse (Shah, 2010)

'I've had experiences where I've sat down in a meeting and people haven't known who I am. I've had white people ask me questions like, 'Oh sorry, are you supposed to be here? Who are you? Or: 'Oh, I've not seen you before. Are you a student nurse?' Now, I, as a Caribbean person, can identify with the fact that there are a lot of African student nurses. But it's just a stereotype. This idea that I as a black person I must be a nurse – I couldn't possibly be anything else – is a manifestation of the beliefs that people have. When I tell people I'm a trainee clinical psychologist, they often almost fall off their chairs with disbelief and shock. I'm saying to people in these meetings, 'No actually, I'm a trainee clinical psychologist. And the case that we're meeting to talk about? I'm the person providing the therapy.' Their faces go bright red with embarrassment, because there's a preconscious awareness that what they've said has actually been very prejudicial.'

are reports of trainees working with supervisors who avoid discussing the impact of issues of ethnicity and culture on the treatment of service users by 'verbally suggesting that the trainee ignore these or criticising trainees who expressed interest in addressing these issues with clients' (Shah, 2010). There are further problems with trainees feeling as though they cannot broach the topic of ethnicity as a point of personal–professional development. Trainees feel inhibited from discussing elements of their personal ethnic identity and the impact this has on their clinical work.

One of the main problems with this type of supervision is that it pushes concerns over inequality 'inwards', where people negotiate these issues without support from other colleagues. The literature suggests internalised racial oppression is a problem, where individuals come to absorb the values and beliefs of the dominant culture and therefore come to believe some of the stereotypes of their own minority culture (Alleyne, 2004). Individuals may come to have lower expectations of, and aspirations for, themselves and those from their communities. This can affect the way individuals in the community see themselves. It may make them feel mistrustful or resentful of others in the community who deny that racism exists or who are seeking to behave or be 'white'. Such internalised racial oppression can lead to self-hate, low self-esteem and the disowning of one's ethnic heritage.

Parallels between ethnic minorities and internalised oppression can be made to trainees from other minority groups (e.g. trainees who identify as non-heterosexual or who have had a previous diagnosis of mental illness). Under these circumstances, trainees may seek to distance themselves from these cultures for fear of negative associations (Daiches & Anderson, 2012). This is in spite of the influence such communities may have had on their identity in the past, and despite the potential for enhanced therapeutic practice that can arise from belonging to more than one culture/community (Lim & Campayne, 2007).

A further issue for BME trainees is the assumption that western values, practices and norms are validated over and above those of non-dominant cultures. The literature suggests that the Eurocentric and individualist models of understanding psychological distress dominate. For BME clinical psychologists entering a predominately white profession, this can create dilemmas if one's personal values are at odds with those underlying the academic teaching of the course. There is a convincing argument that trainees are consequently exposed to the double-bind of either being alienated by the institutions if they reject these Eurocentric models, or

Box 2: The failure of advocacy from senior psychologists (Shah, 2010)

'[Once], this psychiatrist said in a meeting of about eleven people, that this client was dressing like a black drug dealer. I could not believe it. I wanted the ground to open up and swallow me. I was the only black person in the room. My manager was in the room at the time. I looked at her and she looked at me then looked down. I wasn't the senior psychologist. She was. I was so shocked and she carried on talking and I don't know what she said, because I couldn't focus. I couldn't listen to what she was saying.'

Box 3: lack of support for trainees dealing with racism (Shah, 2010)
'It's hard to think about what I can say in the situation, because you can't turn around and say to people (like I honestly might like to say), 'How f*****g racist is that?' I can't say that in a meeting, because then I look like the stereotypical aggressive black person. It's not an intellectual response that comes up immediately, it's an emotional response. Then I have to spend time working through that emotional response to bring myself back to an intellectual place where I can then challenge or express my views or opinions about the prejudice that's been expressed in a way that isn't going to be offensive to everybody. And in a way that it means that people are going to be able to hear it, which is very hard. I think it's something that training doesn't teach you.'

being alienated from their own experiences and communities if they accept them.

Recommendations for widening representation of BME groups in clinical psychology

1. Trainees have signalled a need to talk openly about BME issues in supervision (Shah et al., 2012; Rajan et al., 2008; Adetimole, 2005). This includes reflecting on their personal experiences as well as thinking about the backgrounds of the people they are treating. Key aspects of what makes BME trainees feel safe in supervision include feeling understood, not being dismissed and having a space for meaningful dialogue about ethnicity and culture. It is seen as helpful when supervisors take on the role of addressing white privilege, so that BME trainees do not feel responsible for confronting BME issues themselves (Hird et al., 2006). Placement supervisors should therefore receive training specifically on the importance of raising these issues in supervision. (Note that such training needs to be more than superficial, one-off 'cultural competence' seminars, but should be based on community engagement and numerous 'cultural encounters') (Turpin & Coleman, 2010).
2. Research suggests that aspiring BME psychologists at both undergraduate and postgraduate level would benefit from positive role modelling. The literature recognises that undergraduate psychology students are rarely exposed to BME role models from academic staff, and that undergraduate programmes might be able to compensate for this by providing 'greater exposure to the relatively greater number of successful BME professionals working within the NHS (Goodbody, 2009).
3. Greater structured advice, support and mentoring is needed for BME undergraduates. Research shows that BME students tend to be less well informed or enabled with regard to career entry and application to further training. More information about the questions asked at interview, the type of volunteering work appropriate and the routes for getting volunteer placements would be just a few places to start (Turpin & Coleman, 2010). Increasing the number of BME psychologists sitting on selection panels at the doctorate stage could also be constructive. Turpin has further suggested that the Committee on Training in Clinical Psychology could, as part of its accreditation criteria, require clinical courses to offer support and outreach to all local undergraduate programmes.
4. Further expansion of the Improving Access to Psychological Therapies programme. The programme helps to attract more psychology graduates into acquiring relevant experience through recruiting them onto a one-year training programme for psychological wellbeing practitioners. The provisional analysis of the ethnicity profile of the workforce and its trainees, particularly from London, is very promising, though we await the most recent data (Turpin & Coleman, 2010).
5. Little research has been undertaken into what other support BME clinical psychologists already find helpful, though 'minority peer support' has been

> identified as an informal method that should be considered. There are examples of qualified BME clinical psychologists creating such groupings, which aim to validate the cultural, preferred identities obscured in the profession (Goodbody, 2009). An example of this was the creation of the national black and Asian clinical psychology network in 2007 (Cape et al., 2008).

There are also examples of best practice regarding methods of improving racial and ethnic equality in other professions related to mental health. An example is the psychotherapeutic profession's use of 'Thinking Spaces'.

'Thinking Space' discussion forums, initiated by psychoanalytic psychotherapist Frank Lowe twelve years ago, are distinctive. Started as a means of exploring issues of race, ethnicity and culture, Lowe describes the way his monthly forums bring together thinkers and writers from a wide variety of disciplines, united by 'honesty, courage, loyalty and shared commitment to facing the uncomfortable truths that are expressed in the areas examined.' The forums constitute a 'container for thought' – a 'mental space' in which the participants can learn and develop. A book on the subject, *Thinking Space: Promoting Thinking About Race, Culture and Diversity in Psychotherapy and Beyond*, claims that the forums accomplish what consulting rooms cannot: 'When such huge issues are swirling around, it can be difficult to think in the consulting room. These are topics that are more easily evaded than engaged with. But in Thinking Spaces the engagement is undertaken.' (Lowe, 2013).

In the DCP, Stephen Weatherhead has been leading the profession's work on inclusivity, equality and diversity. The group have recently held a series of forums that represent Lowe's themes of engagement, learning and development.

From a research perspective, we await evaluative data on the efficacy of these initiatives. Examining outcomes will be a critical next step in progressing prospects for pre-qualified, trainee and qualified BME clinical psychologists.

Conclusion

A significant proportion of the population, the NHS workforce and the population of people with mental illness are from ethnic minorities. It is therefore crucial that 'cultural competence' is considered an essential component of the training and day-to-day work of clinical psychologists.

Cultural competence and the expansion of BME representation within clinical psychology will go hand-in-hand. Data from Leeds Clearing House shows us that the BME acceptance rate for the clinical psychology doctorate has remained largely low and static over the last decade, in spite of an increase in the BME application rate. The problem appears to lie in the pre-qualification stage of becoming a clinical psychologist.

Several researchers in the last decade have identified a number of challenges facing aspiring BME clinical psychologists. Based on their findings and further examples of best practice from the psychotherapy profession, it is possible to formulate specific recommendations, including changes in supervision, role modelling (undergraduate and postgraduate), mentoring (undergraduate), IAPT programmes, peer support networks and discursive forums ('Thinking Space'). In the future, recommendations for improvement will be enhanced by: (a) evaluative data of outreach initiatives; and (b) future sharing of best practice from other applied psychological professions – including, for instance, counselling psychology and education psychology.

Despite limited quantitative gains, diversity has long been on the agenda of the Group of Trainers in Clinical Psychology. At present, the profession has shown signs of doing more to attract members of BME communities into the profession, though there is evidently much more to be done. As well as reviewing the efficacy of outreach initiatives, directions for future research may involve asking how we can ensure that, once inside the profession, individuals feel valued and well supported.

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References

Adetimole, F., Afuape, T. & Vara, V. (2005). The impact of racism on the experience of training on a clinical psychology course: Reflections from three black trainees. *Clinical Psychology Forum, 48*, 11–15.

Alleyne, A. (2004). Black identity and workplace oppression. *Counselling and Psychotherapy Research, 4*(1), 4–8.

British Psychological Society (2009). *Code of ethics and conduct.* Leicester: Author.

Canterbury Christ Church University (2015, 3 July). *Clinical Psychology at Salomons: Why did you choose Salomons?* Canterbury: Canterbury Christ Church University. Retrieved from www.youtube.com/watch?v=BRV3mSRHbMs&index=22&list=PLvA-paRZoYvZM-9XUK2H5A0OMLLjr8eYct

Cape, J., Thompson , M., Roth, A., Scior, K., Heneage, C. & Du Plessis, P. (2008). Promoting diversity [Letter]. *The Psychologist, 21*(1), 72–73.

Care Quality Commission (2011). *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales.* London: Author.

Daiches, A. & Anderson, D. (2012). The experiences of training as a clinical psychologist with a minority sexual orientation. *Clinical Psychology Forum, 232*, 14–17.

Goodbody, L. (2009). *A critical analysis of the personal and professional development of majority and minority group clinical psychologists: Power, difference and identities.* Canterbury: Canterbury Christ Church University.

Health and Social Care Information Centre (2013a). *Hospital and community health services: Medical and dental staff by grade and ethnic group category (2013).* Retrieved from www.hscic.gov.uk/media/14121/NHS-Hospital–Community-Health-Service-HCHS-Medical-and-Dental-staff-by-grade-and-Ethnicity–September-2013/xls/AH122.xlsx

Health and Social Care Information Centre (2013b). *Hospital and community health services: Non-medical staff by grade and ethnic group category (2013).* Retrieved from www.hscic.gov.uk/catalogue/PUB13741/nhs-staf-2013-non-med-detl-tab.xlsx

Health and Social Care Information Centre (2016). *NHS workforce statistics, October 2015, provisional statistics.* Retrieved from www.hscic.gov.uk/catalogue/PUB19670/nhs-work-stat-oct-2015-pdf.pdf

Hird, J.S., Tao, K.W. & Gloria, A.M. (2006). Examining supervisors' multicultural competence in racially similar and different supervision dyads. *The Clinical Supervisor, 23*(2), 107–122.

Kline, R. (2014). *The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England.* London: Middlesex University.

Lim, R. & Campayne, P. (2007). *Different women, different places.* Christchurch: Katalytik.

Lowe, F. (2013). *Thinking space: Promoting thinking about race, culture and diversity in psychotherapy and beyond.* London: Karnac Books.

NHS Institute for Innovation and Improvement (n.d.). *Building capability, breaking through – Frequently asked questions.* Retrieved from www.institute.nhs.uk/building_capability/breaking_through/frequently_asked_questions.html

Office for National Statistics (2011a). *2011 Census: Population Estimates for the United Kingdom, 27 March 2011.* London: Author.

Office for National Statistics (2011b). Population estimates by ethnic group 2002–2009. Statistical Bulletin, 18 May. Retrieved from www.ons.gov.uk/ons/rel/peeg/population-estimates-by-ethnic-group–experimental-/current-estimates/population-density–change-and-concentration-in-great-britain.pdf

Phillips, A., Hatton, C. & Gray, I. (2004). Factors predicting the short-listing and selection of trainee clinical psychologists: A prospective national cohort study. *Clinical Psychology and Psychotherapy, 11*, 111–125.

Rajan, L. & Shaw, S.K. (2008). 'I can only speak for myself': Some voices from black and minority ethnic clinical psychology trainees. *Clinical Psychology Forum, 190*, 11–16.

Scior, K., Gray, J., Halsey, R. & Roth, A. (2007). Selection for clinical psychology training: Is there evidence of any bias towards applicants from ethnic minorities? *Clinical Psychology Forum, 175*, 7–11.

Shah, S. (2010). *The experience of being a trainee clinical psychologist from a black and minority ethnic group: A qualitative study.* Hatfield: University of Hertford.

Shah, Goodbody, Wood & Nolte (2012). The experience of being a trainee clinical psychologist from a black and minority ethnic group: A qualitative study. *Clinical Psychology Forum, 232*, 32–35.

Simpson, J., Hemmings, R., Daiches, R. & Amor, C. (2010). Shortlisting from the Clearing House application form: Is it fit for purpose? *Psychology Learning and Teaching, 9*, 32–36.

Turpin, G. & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning and Teaching, 9*(2), 17–27.

University College London (2014, Summer). *Doctorate in Clinical Psychology Course Newsletter.* Retrieved from www.ucl.ac.uk/dclinpsy/docs/coursenewsletters/summer2014

Commentary

Underrepresentation in the profession: What's been done and what are the priorities going forward? Commentary on Celia Grace Smith's Ethics Column

Katrina Scior, Mike Wang, Anthony D. Roth & Kat Alcock

CELIA SMITH rightly draws our attention to the continuing underrepresentation of individuals from black and minority ethnic (BME) backgrounds in the profession, and we are pleased to note recognition of the various efforts that have taken place to address this issue to date. As members of the training community we would like to further highlight ways in which the profession as a whole can move forward in a targeted, resource-efficient and effective manner, building upon existing initiatives.

Historically, the number of applications from BME backgrounds was low, but this is no longer the case across the UK as a whole – the latest figures show that they make up 15 per cent of applicants. As Smith notes, 'The issue is not that BME individuals do not apply, but that they do not get accepted.'

Our failure to increase the proportion of BME trainees accepted onto courses is concerning and we need to ask why that might be. Whilst we have no doubt that racism is present in applied psychology (as it is elsewhere in society), we believe the reasons are more complex.

As we showed in an earlier study (Scior et al., 2007), BME applicants are less likely than white applicants to meet basic selection criteria and are therefore more likely to be rejected early in the selection process. We have also shown that entry into the profession appears to be less affected by social and educational advantage than other more established professions such as medicine, law or journalism (Scior et al., 2015). So if we are getting the message out across the social spectrum that clinical psychology is a career to aspire to, and have succeeded in significantly increasing the number of applicants from BME backgrounds, why the continued underrepresentation even at training grade?

Mental health problems remain highly stigmatised in many BME communities and psychological interventions are either unfamiliar or viewed with great suspicion (Wynaden et al., 2005). This is particularly relevant in south Asian families, where career choices are often made not by the individual but by the family and community. Furthermore, 'you cannot be what you cannot see' – because there are relatively few BME psychologists, BME individuals who might consider psychology (possibly despite their parents' reservations) may decide that this profession is not for them. Accordingly, young people of the highest academic calibre from such communities are more likely to be directed towards and attracted to medicine, law, accountancy, pharmacy and engineering (Lightbody et al., 1997)

To address these issues, we believe our priorities should focus on: (i) ensuring that applicants from BME backgrounds stand an equal chance to white applicants of turning in a strong application, through good quality careers advice and targeted mentoring by qualified and trainee clinical psychologists; and (ii) doing more to ensure that clinical psychology is seen as an attractive and aspirational career choice by young people from BME backgrounds. As Celia Smith states, initiatives to this effect are already in place in some parts of the country. The six London and South East England courses (Institute of Psychiatry, Royal Holloway, Canterbury Christ Church University, University College London, University of East London, University of Surrey) have worked together since 2006 to give BME undergraduates access to good quality careers advice relating to clinical psychology (Cape et al., 2008). In addition, since 2011 the University College London course has run a large-scale mentoring scheme for BME psychology undergraduates and recent graduates on behalf of the London courses. The format and outcomes of this scheme will be reported in detail in a future issue of *Clinical Psychology Forum.* In short, it has been designed to provide potential applicants with supportive, welcoming and effective input from both trainee and qualified clinical psychologists, with the aim of increasing the acceptance rate of mentees. Over the past two years, 160 mentees have attended trainee-led workshops, facilitated by trainees from across the London courses and focusing on reflection as a skill. Additionally, mentees have each been paired with both a trainee and a qualified clinical psychologist. During this two-year period, the scheme was funded by the DCP, with a remit that included sharing the knowledge and resources developed with other courses nationally. To this end, we have given presentations at DCP and Group of Trainers in Clinical Psychology events (e.g. Alcock, 2014), and shared all resources with the DCP so that they can be accessed via the Inclusivity website (www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology). The University of Oxford doctorate programme has built on the London model, and ran its first widening access event in November 2015.

It is clear that to attract the brightest and best BME candidates we also need to reach young people while they are still at school, presenting clinical psychology as an aspirational career with a diverse and welcoming membership. In Leicester, we have been visiting local independent sector schools and sixth form colleges (which have predominantly south Asian students) to encourage them, their families and communities to consider clinical psychology as a worthwhile career option. In London, a coordinated initiative of trainee-delivered careers talks was piloted by University College London in 2015, in socially and ethnically diverse secondary schools and further education colleges. This scheme is now being rolled out across the London training courses.

We encourage colleagues elsewhere in the UK to join and build upon these efforts, and are happy to share all tried and tested resources with them.

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References

Alcock, K. (2014, November). *Widening access to clinical psychology: Promising strategies.* Presented at Group of Trainers in Clinical Psychology Annual Conference, Belfast.

Cape, J., Roth, A., Scior, K., Thompson, M., Heneage, C. & Du Plessis, P. (2008). Increasing diversity within clinical psychology: The London initiative. *Clinical Psychology Forum, 190,* 7–10.

Lightbody, P., Nicholson, S., Siann, G. & Walsh, D. (1997). A respectable job: Factors which influence young Asians' choice of career. *British Journal of Guidance & Counselling, 25,* 67–79.

Scior, K., Gray, J., Halsey, R. & Roth, A. (2007). Selection for clinical psychology training: Is there evidence of any bias towards applicants from ethnic minorities? *Clinical Psychology Forum, 175,* 7–11.

Scior, K., Williams, J. & King, J. (2015). Is access to clinical psychology training in the UK fair? The impact of educational history on application success. *Clinical Psychology Forum, 274,* 12–21.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z. & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14,* 88–95.

DCP CPD workshops

EVENT	VENUE	DATE
Diagnosis, formulation & the assessment of trauma Dr David Lane Cpsychol FBPsS & Angela Busuttil CPsychol AFBPsS	BPS London Office	4 April 2016
An introduction to the contribution of clinical psychologists as expert witnesses in the family courts: A practical guide Dr Jamie Craig CPsychol AFBPsS & Dr Miriam Silver *Faculty for Children, Young People and their Families*	BPS London Office	6 April 2016
Neuroscience and trauma therapy Dr Timothy Dunne CPsychol AFBPsS	The Met Hotel, Leeds	8 April 2016
Effective parenting for Muslim families in the modern world Kathleen Roche-Nagi	BPS London Office	14 April 2016
Cognitive assessments with children and young people in non-neuropsychology specialist settings (Day 1 of 2) Dr Katie Hunt CPsychol AFBPsS & Dr Sarah Helps *Faculty for Children, Young People and their Families*	BPS London Office	18 April 2016
The current state of child neurorehabilitation: innovations, evidence base and guide to best practice Dr Katie Byard CPsychol AFBPsS and Dr Peter Tucker CPsychol AFBPsS	BPS London Office	22 April 2016
Child sexual abuse across the lifespan: Impact and interventions Professor Thanos Karatzias CPsychol AFBPsS, Dr Sandra Ferguson CPsychol & Adam Mahoney CPsychol	BPS London Office	26 April 2016
Why is suicide a male gender issue and what can psychologists do about it? Martin Seager CPsychol AFBPsS & John Barry CPsychol AFBPsS	BPS London Office	28 April 2016
'When OCD says you are a monster': Treatment strategies for intrusive harm OCD, 'pure O' and complex OCD presentations Dr Heather Sequeira CPsychol AFBPsS	BPS London Office	3 May 2016
Personality changing in neurological conditions Dr Giles Yeates CPsychol AFBPsS & Dr Audrey Daisley CPsychol	BPS London Office	16 May 2016
Cognitive Analytic Therapy in a forensic setting Dr Palwinder Athwal CPsychol & Tammy Watcher DCP North West Branch	The Portland Hotel, Manchester	20 May 2016

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The impact of group cognitive behavioural therapy on anxiety and level of functioning in people with a diagnosis of chronic fatigue syndrome

Laura Brummer & Zoe McAndrews

Chronic fatigue syndrome can be accompanied by comorbid psychological difficulties. This audit evaluated the efficacy of a group cognitive behavioural therapy intervention in reducing functional impairment, anxiety and depression. Findings suggest small improvements in depression and functioning, and significant reductions in anxiety.

CHRONIC FATIGUE SYNDROME (CFS) is defined by the National Institute of Health and Care Excellence as a relatively common chronic illness with a complex range of disabling symptoms which can vary in severity across a person's life span (NICE, 2007). CFS remains a controversial diagnosis and debate around this continues. The role of psychological interventions in the treatment of CFS also remains controversial for those with the diagnosis as well health professionals.

Whilst not much is known about the aetiology of CFS, the condition has been shown to have a disabling impact for many sufferers (Cella et al., 2011) and the prognosis remains unclear (Joyce et al., 1997). Symptoms include fatigue, which feels overwhelming and unlike normal tiredness. Other symptoms that may coexist include, but are not limited to, memory and concentration difficulties, pain, sore throat, headaches, dizziness, and sensitivity to light and noise (Burgess & Chalder, 2005).

It is common for sufferers to have comorbid difficulties, including chronic pain (or fibromyalgia) (Aaron et al., 2000), depression and anxiety disorders (Henningsen et al., 2003). However, the interaction and causal relationship of these difficulties remains a topic of debate (Sharpe & Carson, 2001; Gillespie et al., 1999). For example, a high prevalence of generalised anxiety disorder (GAD) has been found in CFS patients (Fischler et al., 1997). Fischler et al. propose that, due to the early onset and chronicity of GAD, it may be a key vulnerability factor in the development of CFS. Equally, it could be understood that with increasing withdrawal from activity due to disabling nature of the condition there will be a causal increase in levels of anxiety when faced with activity (Chalder et al., 2015).

Due to the unpredictable nature of symptoms and comorbid difficulties associated with CFS, an unhelpful cycle of maintaining factors can develop. This is often referred to as the 'boom and bust cycle' (bursts of over-exertion and activity followed by excessive rest and inactivity, disturbed sleep pattern, symptom focusing and avoidance of activity) (White et al., 2011).

There has been growing research into effective treatment approaches to support sufferers to break these unhelpful maintenance cycles. Cognitive behavioural therapy (CBT) is an approach that has a considerable evidence base demonstrating its efficacy in treating depression, anxiety and a number of physical health conditions, such as chronic pain (Hofmann et al., 2013) by addressing these maintaining cycles. CBT has also been recommended as a treatment intervention for sufferers of CFS (NICE, 2007). CBT for CFS often focuses on helping the sufferer to understand the relationship between symptoms, thoughts, behaviours and emotions; changing unhelpful behaviour patterns to establish a stable level of activity and reappraise the thoughts and feelings that underlie these patterns (Surawy et al., 2005). CBT has been found to be more effective than pacing alone (The PACE trial; White et al., 2011).

Evidence for group CBT interventions is more limited, however, as much of the research has focused on CBT delivered on an individual basis (Malouff et al., 2007; Saxty & Hansen, 2005). O'Dowd et al. (2006) compared group CBT (which included a graded exercise component) with a support group and with standard medical care. CBT was shown to result in significant improvements in fatigue symptoms, as well as mood and physical fitness. In a meta-analysis, Malouff et al. found that group CBT was as effective as individual CBT, demonstrating similar effect sizes.

A tertiary NHS CFS service offered a group CBT intervention that incorporated graded exercise principles for adults diagnosed with mild to moderate CFS, in line with NICE recommendations (NICE, 2007). If suitable, after an initial assessment of needs, service users were offered the opportunity to attend a group. The service aimed to provide an evidence-based intervention in line with NICE recommendations, and in line with good practice the group was audited.

Method

Participants

All service users who attended a group CBT programme between December 2013 and February 2014 were included in the audit. Over this period 63 service users attended at least one session of the group intervention. Of these, 26 service users either did not complete treatment or did not return outcome measures in the final session and were excluded from the analysis. Of the remaining 37 participants 26 were female (70 per cent), and the age ranged from 18–65 years. All service users were referred to the specialist service by their GP and all had been given a formal diagnosis of CFS by an appropriately qualified medical professional. All participants attended at least two thirds of the group sessions.

Intervention

The group intervention covered educational information and techniques used as part of CBT treatment for CFS, as recommended by Burgess and Chalder (2004) in the PACE trial manual (White et al., 2011). This includes providing psychoeducation on sleep and fatigue management, challenging unhelpful thoughts, setting graded goals, relaxation techniques, and relapse management. The group was also updated to incorporate an introduction to mindfulness and third wave CBT principles, including acceptance and compassion focused approaches, based on emerging research (Surawy et al., 2005; Van Damme et al., 2006; Rimes & Wingrove, 2013). The group was delivered in two formats: six weekly sessions of two hours duration, or three weekly sessions of four-and-a-half hour workshop sessions. The groups were offered in line with service user preference. The clinicians delivering the programme comprised four assistant clinical psychologists, and a qualified clinical psychologist. The same session plans and group materials (work books and flipcharts) were used for each group, and the content was covered in the same order. Service constraints meant that it was not possible to gather follow-up data and so only pre and post group data were included in the analysis.

Outcome measures

The primary outcome measure was the Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002) which measures the subjective severity of the functional impairment of a problem on an individuals' ability to perform everyday activities, including work, home management, private and social leisure activities, and family and social interactions. The scale consists of a five-item self-report Likert scale ranging from 0 (not at all impaired) to 8 (very severely impaired). Scores are totalled and range from 0–40. Cronbach's alpha has been reported to be between 0.7–0.9 for the measure (Mundt et al., 2002). The WSAS has also been demonstrated as a reliable and valid assessment of disability in patients with CFS (Cella et al., 2011).

The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) is a measure for screening the presence and severity of anxiety and depression. The measure consists of two sub-scales for anxiety and depression, with a total of 14 items, each ranging from 0–4. Scores of 7 or below are considered to be non-clinical, whilst the clinical range includes scores of 8–10 (mild), 11–14 (moderate), and 15–21 (severe). It has been proposed to have good reliability and validity at measuring severity and caseness across a range of populations (Bjelland et al., 2002).

Outcome measures were collected from service users at the first session of the group and repeated at the end of the final group session. Service users used diaries to record levels of fatigue; these were not routinely collected and are therefore not included in the audit.

Statistical analysis

Outcome data were entered into encrypted Microsoft Excel spreadsheets, and descriptive and inferential statistics were analysed using SPSS. Preliminary analysis explored distributions of means, in order to determine whether parametric assumptions were met. As parametric assumptions were not met, the Wilcoxon Signed Ranks test was used. Cohen's d (1992, as cited in Field, 2005) was used to calculate effect sizes, using the proposed benchmarks for small (0–.29), medium (.30–.79), and large (.80) effect sizes. Reliable change was also assessed using the Reliable Change Index (Jacobson & Truax, 1991). The number of participants who demonstrated reliable change, and whether these participants deteriorated or improved following the intervention was determined.

Results

Descriptive statistics

Descriptive statistics show that there was a small reduction in scores for functional impairment, anxiety and depression across both group and workshop interventions when comparing pre- and post-intervention means (Table 1).

Inferential statistics

Normality assumptions were assessed through statistics for skewness and kurtosis, as well as observing histograms, which indicated that data were not normally distributed, and so non-parametric testing was appropriate.

Effect of group intervention on functional impairment

A Wilcoxon's Signed Rank Test showed that the small improvements made in functioning were not significant (Z = –1.23, p = .11, r = –.14). Reliable change analysis indicated that 37 per cent of participants showed reliable improvement after completion of the treatment.

Effect of group intervention on anxiety and depression

A Wilcoxon signed-rank test showed that levels of anxiety significantly decreased following treatment (Z = –2.34, p < .01, r = –.27). Reliable change analysis indicated that 14 per cent of participants showed reliable improvement after completion of the treatment.

A Wilcoxon signed-rank test showed that the small improvements made in depression were not significant (Z = –1.11, p = .22, r = –.13). Reliable change analysis indicated that 17 per cent of participants showed reliable improvement after completion of the treatment.

Discussion

The audit aimed to evaluate the efficacy of a group CBT intervention in reducing the severity of functional impairment, anxiety and depression in service users with a diagnosis of mild-to-moderate CFS. The findings suggest that overall small improvements were observed in levels of anxiety, depression and functioning, and that for anxiety these differences were significant. The effect sizes for depression and functioning at post intervention in the current audit were comparable with those of other studies (O'Dowd et al., 2006; Price et al., 2008).

An important finding of the audit was that, as measured by the HADS, 73 per cent of clients scored within the clinical range for anxiety pre-treatment. This finding supports previous research regarding an exceedingly large comorbidity of GAD with CFS (Fischler et al., 1997). At post-treatment, this had reduced to 66 per cent.

To our knowledge there is no research that reports specifically on the effect of group CBT on anxiety in chronic fatigue. The clos-

Table 1: Descriptive statistics showing pre and post group intervention means and standard deviations for functional impairment, anxiety and depression.

Measure	Pre-intervention mean (SD)	Post-intervention mean (SD)
Work and Social Adjustment Scale	28.63 (6.02)	27.59 (6.06)
HADS Anxiety Scale	10.75 (4.52)	9.81 (4.56)
HADS Depression Scale	9.26 (3.64)	8.36 (3.73)

SD = Standard deviation

est study coming to this was O'Dowd et al.'s (2006) study which reported a trend towards improved outcomes on the HADS for the CBT group in comparison to their treatment as usual condition. Price et al. (2008) found that CBT for CFS can reduce anxiety when offered on an individual basis, but for many sufferers' anxiety remains in the clinical range. Given McRoberts et al.'s (1998) finding that group and individual interventions are generally comparable, Price et al.'s finding offers some support to CBT in CFS improving levels of anxiety.

Cella et al. (2011) argue that reducing a patient's disability is as important as improving symptom severity. Given the proportion of service users suffering with comorbid anxiety, this would indicate the importance of further exploring the potential benefits of CBT and 'third wave' approaches as a treatment for CFS sufferers.

When individual progress was explored, the Reliable Change Index indicated that one third of participants in the workshops, and two fifths of participants in the six-week group, reliably improved in terms of functional impairment, suggesting a comparable efficacy across group type.

The robustness of the findings is limited by a number of factors, including the fact that we did not include a control group. The numbers of participants in the audit were small (partly as a result of non-completion), and therefore findings are more limited. Importantly, outcomes were taken at the final group session and no follow up data were available. This resulted in a very short (three to six week) period of time that change was measured over, and as such will limit the amount of change possible. It is suggested that if follow-up data had been available, a clearer picture of change would have been identified. This is in line with previous findings; for example, in a meta-analysis, Price et al. found that effect sizes considerably increased at follow-up compared to post intervention, and the notion that the skills building element of CBT is essential for maintaining gains after treatment (Olatunji & Feldman, 2008).

Findings may also have been affected by the timing of the groups, as all four of the groups ran over the Christmas period. Many service users reported an increase in difficulties and symptoms mid-group, as a direct result of time of year, which may have resulted in a skewing of the findings with regards to reliable change and improvement.

Notwithstanding the above limitations, the findings from the current study suggest some value in CBT delivered in a group format in reducing comorbid anxiety. More data is needed to be able to determine the efficacy of group interventions for CFS, and whether the small improvements found in this study would be maintained at follow-up. Therefore, further standardised research is required, utilising a control group (possibly waiting list) with increased time points for outcome measuring.

Currently, it is recommended that CBT is tailored to the needs of the individual (NICE, 2007). However, with increasing demands on many NHS services, group interventions become an increasingly necessary approach, and therefore gaining a better understanding of the usefulness of such interventions is important. Additionally, with the emergence of mindfulness and acceptance-based interventions, further research is needed to understand the potential benefits of these approaches with a population diagnosed with a chronic condition, and in many cases, other comorbid difficulties.

References

Aaron, L.A., Burke, M.M. & Buchwald, D. (2000). Overlapping conditions among patients with chronic fatigue syndrome, fibromyalgia, and temporomandibular disorder. *Archives of Internal Medicine, 160*, 221–227. DOI: 10.1001/archinte.160.2.221.

Bjelland, I., Dahl, A.A., Haug, T.T. & Neckelmann, D. (2002). The validity of the Hospital Anxiety and Depression Scale: An updated literature review. *Journal of Psychosomatic Research, 52*, 69–77. DOI: 10.1016/S0022-3999(01)00296-3.

Burgess, M. & Chalder, T. (2004). PACE manual for therapists: Cognitive behavioural therapy for CFS/ME. Retrieved from www.pacetrial.org.

Cella, M., Sharpe, M. & Chalder, T. (2011). Measuring disability in patients with chronic fatigue syndrome: Reliability and validity of the Work and Social Adjustment Scale. *Journal of Psychosomatic Research, 71*(3), 124–128. DOI: 10.1016/j.jpsychores.2011.02.009.

Chalder, T., Goldsmith, K.A., White, P.D., Sharpe, M. & Pickles, A.R. (2015). Rehabilitative therapies for chronic fatigue syndrome: A secondary mediation analysis of the PACE trial. *The Lancet Psychiatry, 2*(2), 141–152. DOI: http://dx.doi.org/10.1016/S2215-0366(14)00069-8

Field, A. (2005). *Discovering statistics using SPSS* (2nd edn). London: Sage.

Fischler, B., Cluydts, R., De Gucht, Y., Kaufman, L. & De Meirleir, K. (1997). Generalised anxiety disorder in chronic fatigue syndrome. *Acta Psychiatrica Scandinavica, 95*(5), 405–413.

Gillespie, N., Kirk, K.M., Heath, A.C., Martin, N.G. & Hickie, I. (1999). Somatic distress as a distinct psychological dimension. *Social Psychiatry and Psychiatric Epidemiology, 34*, 451–458. DOI: 10.1007/s001270050219.

Henningsen, P., Zimmermann, T. & Sattel, H. (2003). Medically unexplained physical symptoms, anxiety, and depression: A meta-analytic review. *Psychosomatic Medicine, 65*, 528–533. DOI: 10.1097/01.PSY.0000075977.90337.E7

Hofmann, S.G., Asnaani, A., Vonk, I.J.J., Sawyer, A.T. & Fang, A. (2013). The efficacy of cognitive behavioural therapy: A review of meta-analyses. *Cognitive Therapy Research, 36*(5), 427–440, DOI: 10.1007/s10608-012-9476-1.

Jacobson, N.S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12. DOI: 0022-006X/91/S30Q

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Joyce, J., Hotopf, M. & Wessely, S. (1997). The prognosis of chronic fatigue and chronic fatigue syndrome: A systematic review. *Quarterly Journal of Medicine, 90*, 223–233. DOI: 10.1093/qjmed/90.3.223

Malouff, J.M., Thorsteinsson, B., Rooke, E., Bhullar, N. & Schutte, N.S. (2007). Efficacy of cognitive behavioral therapy for chronic fatigue syndrome: A meta-analysis. *Clinical Psychology Review, 27*, 4657. DOI: 10.1016/j.cpr.2007.10.004

McRoberts, C., Burlingame, G.M. & Hoag, M.J. (1998). Comparative efficacy of group versus individual psychotherapy. *Group Dynamics, 2*, 101–117.

Mundt, J., Marks, I., Shear, M. & Greist, J. (2002). The Work and Social Adjustment Scale: A simple measure of impairment in functioning. *British Journal of Psychiatry, 180*, 461–464. DOI: 10.1192/bjp.180.5.461

National Institute for Clinical Excellence (2007). *Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): Diagnosis and management of CFS/ME in adults and children.* Retrieved from www.guidance.nice.org.uk/CG53

O'Dowd, H., Gladwell, P., Rogers, C.A., Hollinghurst, S. & Gregory, A. (2006). Cognitive behavioural therapy in chronic fatigue syndrome: A randomised controlled trial of an outpatient group programme. *Health Technology Assessment, 10*, 1–121. DOI: 10.3310/hta10370.

Olatunji, B.O. & Feldman, G. (2008). Cognitive-behavioral therapy. In M. Hersen & A.M. Gross (Eds). *Handbook of clinical psychology: Adults* (Vol.1). Hoboken, NJ: John Wiley & Sons, Inc.

Price, J.R., Mitchell, E., Tidy, E. & Hunot, V. (2008). Cognitive behavioural therapy for chronic fatigue syndrome in adults (A review). *Cochrane Database of Systematic Reviews, 16.* DOI: 10.1002/14651858.CD001027.pub2

Rimes, K.A. & Wingrove, J. (2013). Mindfulness-based cognitive therapy for people with chronic fatigue syndrome still experiencing excessive fatigue after cognitive behaviour therapy: A pilot randomized study. *Clinical Psychology and Psychotherapy, 20*, 107–117. DOI:10.1002/cpp.793

Saxty, M. & Hansen , Z. (2005). Group cognitive behavioural therapy for chronic fatigue syndrome: A pilot study. *Behavioural and Cognitive Psychotherapy, 33*, 311–318. DOI: 10.1017/S1352465805002092.

Sharpe, M. & Carson, A. (2001). 'Unexplained' somatic symptoms, functional syndromes, and somatization: Do we need a paradigm shift? *Annals of Internal Medicine, 134*, 926–930.

Surawy, C., Roberts, J. & Silver, A. (2005). The effect of mindfulness training on mood and measures of fatigue, activity, and quality of life in patients with chronic fatigue syndrome on a hospital waiting list: A series of exploratory studies. *Behavioural and Cognitive Psychotherapy, 2005*, 103–109. DOI: 10.1017/S135246580400181X

Van Damme, S., Crombez, G., Van Houdenhove, B., Mariman, A. & Michielsen, W. (2006). Wellbeing in patients with chronic fatigue syndrome: The role of acceptance. *Journal of Psychosomatic Research, 61*, 595–599.

White, P.D., Goldsmith, K.A., Johnson, A.L., Potts, L., Walwyn, R., DeCesare, J.C. et al. (2011). Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): A randomised trial. *The Lancet, 377*(9768), 823–836. DOI: 10.1016/S0140-6736(11)60096-2

Zigmond, A. & Snaith, R. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67*(6), 361–370. Retrieved from www.ncbi.nlm.nih.gov/pubmed/6880820

An on-call clinical neuropsychology service

Jennifer Clayton, Danielle Bowden & Elisabeth Berry

This article describes the provision of an on-call clinical neuropsychology service within a neuroscience inpatient setting. Current issues and future directions are considered.

THE NEED for clinical psychology as a profession to become more understood, transparent and accessible is pertinent to both its survival and success in meeting the psychological wellbeing needs of health consumers (Mowbary, 2009). A strengths, weaknesses, opportunities and threats (SWOT) analysis for the future of clinical psychology poses the dominance of the medical model and a failure to adapt to change as hazards in ensuring the future of the profession (DCP, 2008).

Traditionally, the medical model refers to: the clustering of symptoms into syndromes; categorisation as a result of diagnosis; and comparisons against what is considered 'normal behaviour'; and based upon all of these processes, the prescription of medical treatment can be chosen (Shah & Mountain, 2007). Such a diagnostic system has come under fire, the accusation being that in the context of mental health it lacks validity and fails to take into account the psychosocial context in which we live (Kinderman et al., 2013). These criticisms are further reflected in the British Psychological Society's responses to the development of and subsequent publication of the DSM-5. They express concerns regarding the readiness to medicalise normative social experiences (BPS, 2011), which can be stigmatising for individuals (Ben-Zeev et al., 2010).

Despite its critics, the medical model remains the dominant approach in addressing health needs in western societies (Verkerk, 2009). However, this may especially be the case in inpatient neuroscience services where patients are admitted under consultant neurologists or neurosurgeons. Using a holistic biopsychosocial approach, clinical neuropsychology can enrich the services received by inpatients in neurosciences by ensuring full consideration of emotional, cognitive, systemic and behavioural factors. In light of the recent Staffordshire inquiry and subsequent Francis report (2013), a holistic approach which can enhance compassion and understanding is more pertinent than ever. This also strengthens the case for clinical neuropsychology. It also highlights the necessity and benefits of working hand in hand with our medical and physical therapy colleagues in a way which compliments the medical model whilst ensuring that the psychological needs of people with neurological diagnoses are met.

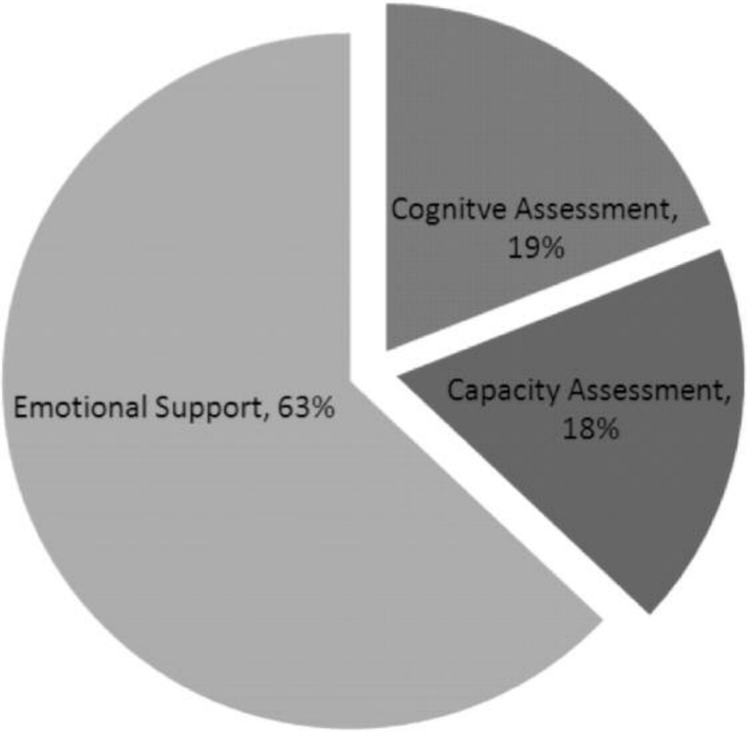
The inpatient clinical neuropsychology on-call service: A description

Our service is an inpatient clinical neuropsychology service located within a regional neuroscience centre and provided within the context of the NHS. It is concerned with the specialist provision of psychological assessment and intervention to patients with neurological conditions. We are presented with the challenge of providing assessment, complex intervention and consultancy in a timely and cost effective manner, whilst ensuring that the psychological wellbeing needs of patients are not dismissed or overlooked.

Specifically, we are concerned with addressing a gap in care whereby patients are presenting in a medical, inpatient neurology setting with psychological needs. In a bid to overcome this challenge and capitalise on a gap in patient healthcare, which can (best) be addressed through a psychological avenue, we have developed a clinical neuropsychology on-call service.

The on-call service falls within the Neurosciences Division at Salford Royal NHS Foundation Trust and is available 9am–5pm, Monday to Friday. In its present form the serv-

Figure 1: Reason for referral to on call clinical neuropsychology service (percentages shown)



ice has been available since 2002. It is provided on a rotational basis by clinical neuropsychologists within the department. An on-call assistant psychologist is also available there on the same rotational basis, to assist the clinical neuropsychologist and undertake cognitive assessments. Referrals are received via electronic referral forms, which are coordinated by secretarial staff. For urgent cases, referrers are able to utilise a beeper system which the on-call clinical neuropsychologist carries with them at all times. During their on-call week, both the clinical neuropsychologist and assistant psychologist carry a reduced outpatient commitment, to allow a timely response to on-call referrals (same day or within 24 hours).

Medical, nursing and physical therapy staff working with an inpatient that is being treated for neurological symptoms are able to refer. Full referral criteria and guidelines can be found on the Salford Royal Foundation Trust website (www.srft.nhs.uk/about-us/depts/neuropsychology) and are further summarised in Box 1. In general, referrals can be for behavioural difficulties, anxiety and low mood. Also, referrals are received for cognitive neuropsychological assessment, the purpose being to contribute to diagnostic investigations and in relation to mental capacity decisions.

Snap shot of referrals

Informal observations and feedback from within our team and from MDT colleagues indicated that the service is valued and well utilised within a medical setting. It also suggested that a large amount of time is spent providing emotional support and psychoeducation to staff and patients with neurological medically unexplained symptoms. We ourselves were not clear on the precise pattern of referrals and hoped this work would help us gain clarity. In addition, we set out to evaluate whether our referral criteria reflected the way the service was being utilised and to what frequency (Box 1).

Data were collected on a weekly basis by the on-call clinical neuropsychologist for the nine month period from September 2012 to May 2013. Specifically, data were recorded in

Box 1

Referral criteria for on-call clinical neuropsychology referrals:

1. Neuropsychology opinion is required as part of the diagnostic investigations.
2. Psychological or neuropsychological factors are regarded as preventing treatment and rehabilitation.
3. There is concern about a patient's ability to have capacity to make treatment and discharge decisions.

an Excel spreadsheet, and consisted of the following variables: patients hospital number, new referrals per week, number of liaison contacts, carry over cases from previous weeks, and type of work carried out with the patient. Clinical outcome was not recorded due to fast turnaround in patients being discharged from hospital or onto different wards. Also, medical diagnosis was not always clear at the time of discharge. During this period a total of 152 cases were seen. There was an average of four new referrals per week, with a range of one to nine referrals per week. The type of work done as part of the on-call service can be broadly categorised, as indicated in Box 2.

Figure 1 depicts the proportion of referrals falling into each of the three categories. It shows that requests related to the emotional wellbeing of an inpatient formed the bulk of on call work, with 63 per cent of referrals (96 patients) falling into this category. Of these, 28 patients required assessment, and on occasion brief inpatient intervention, in relation to neurological medically unexplained symptoms. The categories of cognition, behaviour and mental capacity assessments combined amounted to just over one third of referrals (37 per cent).

Of the patients seen, 58 (38 per cent) required the clinical neuropsychologist to consult and liaise with medical, physical/occupational therapy and nursing colleagues, and patients' relatives. For these inpatients, there was an average of three liaison contacts per patient per week, in addition to the initial assessment. Qualitative feedback from on-call clinical neuropsychologists confirmed these contacts to consist of psychoeducation and training or advice to staff that could support the care of the patient. As the on-call work takes place on neurology and neurosurgical wards, we may have expected more of an equal proportion of referrals for capacity, emotional support and cognitive assessments.

Although the department was aware that a high amount of emotional support was provided via the on-call service, it was surprising that this constituted approximately two thirds of the workload. Emotional support can be considered an aspect of all ward staff members' roles; however, given the complex difficulties of some patients who present with neurological symptoms, it may be that specialist psychological input is pertinent to good medical care.

Box 2

Definition of categories of referrals:

1. *Cognition and behaviour:*
   Neuropsychological assessment and behavioural interventions.
2. *Emotional wellbeing:*
   Short and focused psychological intervention for anxiety and low mood; psycho-education for patients with NMUS.
3. *Mental capacity assessments:*
   Related to medical treatment, discharge and future care decisions.

Issues arising in the on-call service

From the audit completed and data collected a pattern has emerged on common issues that are arising in this on-call service. These are depicted in Box 3. One fairly common occurrence is the presentation of patients with neurological symptoms that are found to be non-organic in nature, such as functional movement disorders and non-epileptic attacks. In these instances ward and medical staff are often unsure how to proceed, as the patient does not have a medical condition which is treatable via the usual medical model. We are able to provide a limited service to these patients on an inpatient basis. This can involve: the assessment and formulation of psychological factors and their contribution to non-organic presentations; brief focused interventions with the aim of facilitating maximum therapeutic gains from input from the multidisciplinary team; and psycho-education and consultancy to ward and physical therapy staff on how best to manage neurological medically unexplained symptoms.

Box 3
Common issues arising from on call referrals and the provision of input from clinical neuropsychology:

1. Neurological medically unexplained symptoms.
2. Behaviours which are challenging to staff.
3. Capacity issues.
4. Contributing to diagnostic process via neuropsychological assessment.

Similarly, we often take referrals resulting from behavioural presentations, which ward staff are finding difficult to manage. This can involve a range of challenging behaviours exhibited by patients in the acute and post-acute phase following acquired brain injury. Working closely with ward staff, we aim to utilise applied behavioural analysis techniques and develop subsequent behavioural modification programmes. Here, the aim is to embed a psychological way of working on the ward, with a view to ensuring that patients' health, psychological wellbeing and safety needs are met.

Assessment of mental capacity in patients is often required where a range of cognitive impairments cast doubt on whether a person is able to understand, retain and weigh information relevant to a key decision. Decisions where capacity assessment may be required relate to treatment and discharge decisions, as well as future care, rehabilitation and longer-term placement decisions.

A final common theme running through the on-call referrals is the request for neuropsychology involvement in order to carry out a neuropsychological evaluation, which can contribute to the neurological diagnostic process. This takes place alongside a range of other medical investigations such as brain scans, blood tests and other invasive medical procedures. These requests typically relate to complex neurological presentations and there being some uncertainty around the neurological diagnosis.

Future directions

Healthcare providers have been criticised for not providing person-centred care. Recommendations from the Francis report (2013) highlight the need for more person-centred care and there are a high number of requests for clinical psychology input via the on-call service (especially for emotional support), requiring a high time commitment. Collectively, this highlights that specialist clinical psychology input in supporting other members of the healthcare team continues to be required. Therefore, it is important to consider the future directions for the on-call neuropsychology service.

Suggested future directions are summarised and displayed in Box 4. Some of these recommendations are also in line with local flexible staffing directives. The aim is to embed a psychological way of thinking into ward culture and provide more person-centred care.

Building on this, we hope to move away from the approach of staff education and training via a case-by-case approach and towards one where generally foreseeing and thus preventing possible difficulties is part of acute hospital ward culture. For example, with patients who, as a result of cognitive impairments, exhibit challenging behaviours. That said, to assist front line staff in placing psychological needs alongside physical health needs, we need to be mindful of the context in which they work. Wards are often busy and chaotic in nature (Jones et al., 2009). Working psychologically requires thought and reflection, and in turn this requires time – a luxury which is often scarce in an acute neurosurgical and neurological ward environment.

Box 4
Future directions:

1. e-learning packages and training workshops.
2. Specialing pools.
3. Psychology graduate as volunteers.
4. Structured group formulation.

Already we have taken positive steps in achieving this vision. We have created e-learning and staff workshops focused on dealing with behaviours that staff perceive as challenging. Salford Royal has now created a specialling pool and our service is involved with improving the training, psychological knowledge and consistency of specialling staff. In a similar vain, we have also created a pool of psychology graduates who act as volunteers on the ward. Volunteers can assist with timely tasks such as observations, in line with applied behavioural analysis. We anticipate this to be an important step towards increasing person-centred care, as recommended in the Francis report (2013).

The incidental establishment of a general acute hospital patient activity volunteer pool, some of whom are psychology graduates, is being utilised to enhance patient experience and staff acceptance of psychological approaches. By linking with the neuropsychology service, psychology graduate volunteers engage in targeted interactions and activities with patients that can enhance mood whilst also carrying out observations such as applied behavioural analysis.

Structured group formulations for neurological medically unexplained symptoms could also be useful. Lake (2008) wrote of the benefits of the team formulation approach and described a framework for how this can be provided. In particular, Lake highlighted that this way of working should not focus on solving the problem but be geared around having a better understanding of what is going on for the patient. Such an approach may be helpful in aiding staff to gain a deeper understanding of patients with neurological medically unexplained symptoms, many of whom exhibit behaviours that are perceived as difficult by staff. Applying such an approach may be helpful in aiding staff to gain a deeper understanding of patients with neurological medically unexplained symptoms and be a crucial component in communicating the diagnosis and introducing psychologically based treatment approaches (BPS, 2013).

In expanding on the steps taken so far to increase psychological approaches in ward settings whilst remaining mindful of the time and resource pressures ward staff face, it may be useful to draw on Lake's (2008) team formulation approach. This is something that happens informally, often on a one-to-one basis between the relevant nurse and on-call clinical neuropsychologist. However, if team formulation was to happen in a structured group setting and facilitated by a clinical neuropsychologist, it may be beneficial in providing staff with breathing space in which they can reflect on their work with patients. Here, an obvious consideration would be practical issues around protecting such time for staff.

Concluding remarks

Working in a setting that is dominated by the medical model, we have been able to promote and apply clinical psychological models, enhance the services provided and even address gaps in service provision. Our experience of working in an acute inpatient neuroscience environment is that, where requested, the neuropsychology contribution to inpatient management has become a recognised and expected part of the patient journey. The different perspective offered via a psychological formulation is generally regarded as helpful in clarifying complex issues where acute medical, emotional, behavioural, social and environmental factors interact with one another.

Clinical psychology can enrich the care and service provision of patients with medical symptoms. In doing so, we need to work collaboratively with medical, nursing and physical therapy colleagues. The on-call clinical neuropsychology service demonstrates the need for this and is one example of how this can be achieved. Our aim is to equip our colleagues with a psychological understanding of patient presentations, embedding this approach within ward culture to meet the psychological wellbeing needs of neuroscience inpatients.

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References

American Psychiatric Association (2010). *DSM-5: The future of psychiatric diagnosis.* Retrieved from www.dsm5.org/pages /default.aspx

Ben-Zeev, D., Young, M.A. & Corringan, P.W. (2010). DSM-5: The stigma of mental illness. *Journal of mental health. 19*(4), 318–327. DOI: 10.3109/09638237.2010.491484

British Psychological Society (2011). *Response to the American Psychiatric Association: DSM-5 development.* Leicester: Author.

British Psychological Society (2013). *Management of patients with neurological medically unexplained symptoms in NHS Scotland: The role of clinical neuropsychology.* Leicester: Author.

Division of Clinical Psychology (2008). *Marketing strategy resources for clinical psychologists.* Leicester: British Psychological Society.

Francis, R. (Chair) (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* Retrieved from www.midstaffspublicinquiry.com/report

Jones, L., Davies, H., Power, L. & Bolton, M. (2009). Developing practice to improve ward culture: 'Back to basics'. *Foundation of Nursing Studies Dissemination Series, 5*(5), pp.1–4.

Kinderman, P., Read, J. & Moncrieff, J. (2013). Drop the language of disorder. *Evidence Based Mental Health, 2,* pp.2–3.

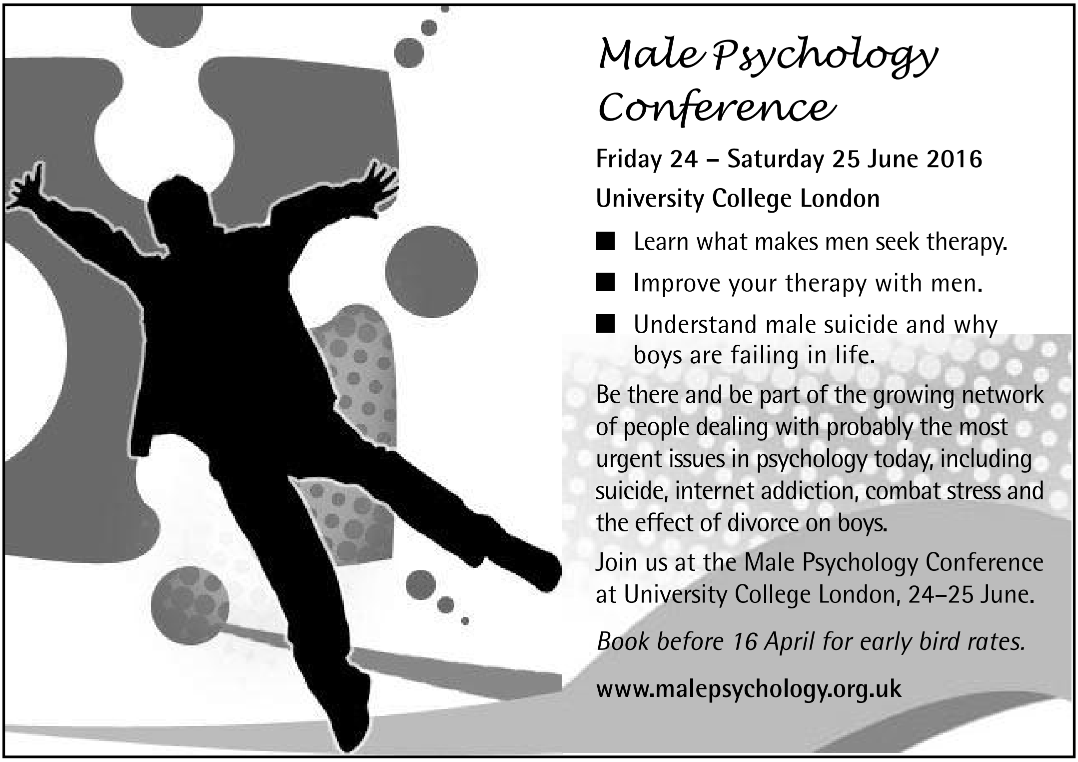
Lake, N. (2008). Developing skills in consultation 2: A team formulation approach. *Clinical Psychology Forum, 186,* pp.18–24.

Mowbary, D. (2009). Grasp the future – It's bright out there. *Mowbary Occasional Paper, 2*(8), pp.1–10.

Salford Royal Foundation Hospital Trust (2014). *Clinical neuropsychology inpatients on call service.* Retrieved from www.srft.nhs.uk/about-us/depts/neuropsychology/services-provided/inpatients/

Shah, P. & Mountain, D. (2007). The medical model is dead – Long live the medical model. *British Journal of Psychiatry: Journal of Mental Science, 191,* 375–377.

Verkerk (2009). *Can the failing western medical paradigm be shifted using the principle of sustainability?* Sandringham, Victoria: Australian College of Nutritional Medicine.f



‘Free to be me’: Introducing an holistic approach to cognitive behaviour therapy

Hilary Garraway

This article introduces an holistic CBT model. The course, based on this model, is run in NHS and faith group settings. It has high attendance rates and helps participants to connect with their personal strengths and spirituality to promote wellbeing.

THIS MODEL of cognitive behaviour therapy (CBT) has grown out of frontline NHS work and provides an holistic approach to standard CBT. It places a person’s individuality central to the formulation, incorporates spirituality and explores the social, cultural and environmental context. The therapy approach, based on this model, has been piloted as a personal development course called ‘Free to be Me’.

The ‘Free to be Me’ course has been run within an NHS community recovery team, and in the community through courses at a church and in an Islamic setting. Within the NHS setting the course addressed spirituality in general terms, identifying values and purpose with participants who had faith beliefs, as well as those with atheistic beliefs. Within the faith settings, the course was adapted to incorporate the belief system of that faith. This is a work in progress and is described in this paper as a working model.

Why an holistic approach to CBT?

CBT is recommended by NICE for the treatment of psychological difficulties (eg. Roth & Fonagy, 2005). As a clinical psychologist and British Association for Behavioural and Cognitive Psychotherapies accredited CBT therapist, trainer and supervisor, I value CBT. However, over the years, I have found myself adapting CBT in order to engage more fully with clients by incorporating what is important to them within the formulations and therapy. These formulations have given more focus to their context, environment, strengths and spirituality.

Within therapy, the wider context may not be discussed, and so difficulties are formulated in isolation from their social, cultural and environmental context. This can lead to formulating distress as purely a result of internal factors such as unhelpful cognitions. A special issue of *Clinical Psychology Forum* (April 2014) highlighted this with a manifesto for social-materialist psychology. This proposed that ‘distress arises from the outside inwards’ and ‘distress is produced by social and material influences’ (the Midlands Psychology Group, 2014, p.3–4). Social influences are sometimes acknowledged within CBT as triggers or past influences, and there have been attempts to introduce systemic thinking into CBT (e.g. Dummett, 2006). However, external factors such as culture, media, social inequality and the physical environment, despite their influence, are often not acknowledged, even as the backdrop to a person’s formulation.

Standard CBT formulations focus on what is going wrong, such as unhelpful maintenance cycles and symptoms. There is a danger that during therapy clients view themselves predominantly in negative terms and lose sight of their strengths. Progress has been made to balance this within CBT by adding virtuous cycles and suggestions such as strengths-based CBT (Padesky & Mooney, 2012), as well as developments in positive psychology exploring concepts such as wellbeing and resilience. Within the NHS, the recovery model encourages clients to be seen as individuals with strengths and goals, though it remains unclear as to whether this recovery approach has encouraged a greater focus on strengths within therapy.

A report by the Department of Health (2009) reviewing the role of religion in healthcare, stated that an '…holistic approach to the patient, which takes account of their physical, cultural, social, mental and spiritual needs would seem to have a particular significance within mental health services. Spirituality and an individual's religion or beliefs are increasingly acknowledged as playing an important role in the overall healing process.' (p.32). Spirituality is not synonymous with religion and is not necessarily related to beliefs in the supernatural, but rather how an individual seeks to answer existential questions and to find meaning in life. This may be through a faith, but may equally be through connecting with nature, music or serving the community. Clients turn to spirituality to help them cope with their mental health (Dein, 2010) and there is a growing body of research suggesting that having spiritual beliefs helps to improve wellbeing (eg. Koenig et al., 2001). In some cases a person's spirituality may maintain their difficulties; for example, Pergament (1997) found some religious coping styles related to poorer mental health whereas other religious coping styles improved mental health. Therefore, to gain a deeper understanding of the individual, it seems appropriate to incorporate a person's spirituality.

For clients with a faith which forms their belief system and lifestyle, there can be a reluctance to engage with secular mental health services, preferring to seek help within their faith communities (e.g. Rathod et al., 2010). There is evidence that these clients prefer working with therapists who recognise the importance of their faith and integrate it into therapy (e.g. Post & Wade, 2009; Worthington et al., 1996). Although not addressed explicitly, spiritual beliefs are sometimes explored in CBT through identifying thoughts and behaviours from a person's spirituality. In some contextual (third wave) forms of CBT there has been a greater focus on spirituality such as identifying values and value-based behaviours within acceptance and commitment therapy (Hayes et al., 2003). CBT has been adapted for certain faith groups, such as Propst et al. (1992) adapting CBT for Christians et al. (2000) adapting CBT for Muslims. Spirituality has also been incorporated in some CBT formulations (e.g. D'Souza et al., 2002; Waller et al., 2010). It would seem appropriate therefore to integrate a person's faith into therapy to encourage these clients to engage more with CBT.

The formulation

The holistic CBT model proposed here is based on the formulation in Figure 1, which begins with the premise that a person consists of a physical, psychological (cognitions and emotions) and spiritual component. These components interact with each other to form a whole whose complexity and uniqueness cannot be fully represented by any diagram, in the same way that the London tube map cannot fully reflect the experience of travel but acts as a guide.

Within CBT these first components are familiar, but the spiritual component is not usually recognised. The human spirit is at the centre of this model and is defined as the core, heart or 'true self' of the person. The human spirit gives a person their individual uniqueness and inner strength. Ellison (1983) defined the human spirit as that which:

> '*…enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us, to wonder about our origins and our identities, to require morality and equality. It is the spirit which synthesises the total personality and provides some sense of energising direction and order.*' (p.331)

Goddard (1995) defined the spirit as 'the dynamic force that keeps a person growing and changing, continuously involved in a process of emerging, becoming and transcending of self' (p.809).

Participants on the 'Free to be Me' course draw a personal formulation, and as part of this process draw a tree as a representation of their spirit. During the course different aspects of the tree are drawn and labelled, so that the final picture is a visual representation of who they are. This is seen as central to the formulation and is represented as a spiral in the formulation diagram. The tree (see Figure 2 for an example) is made up of the roots (which are their resources and what keeps them grounded); the branches (their dreams and

Figure 1: Holistic CBT formulation

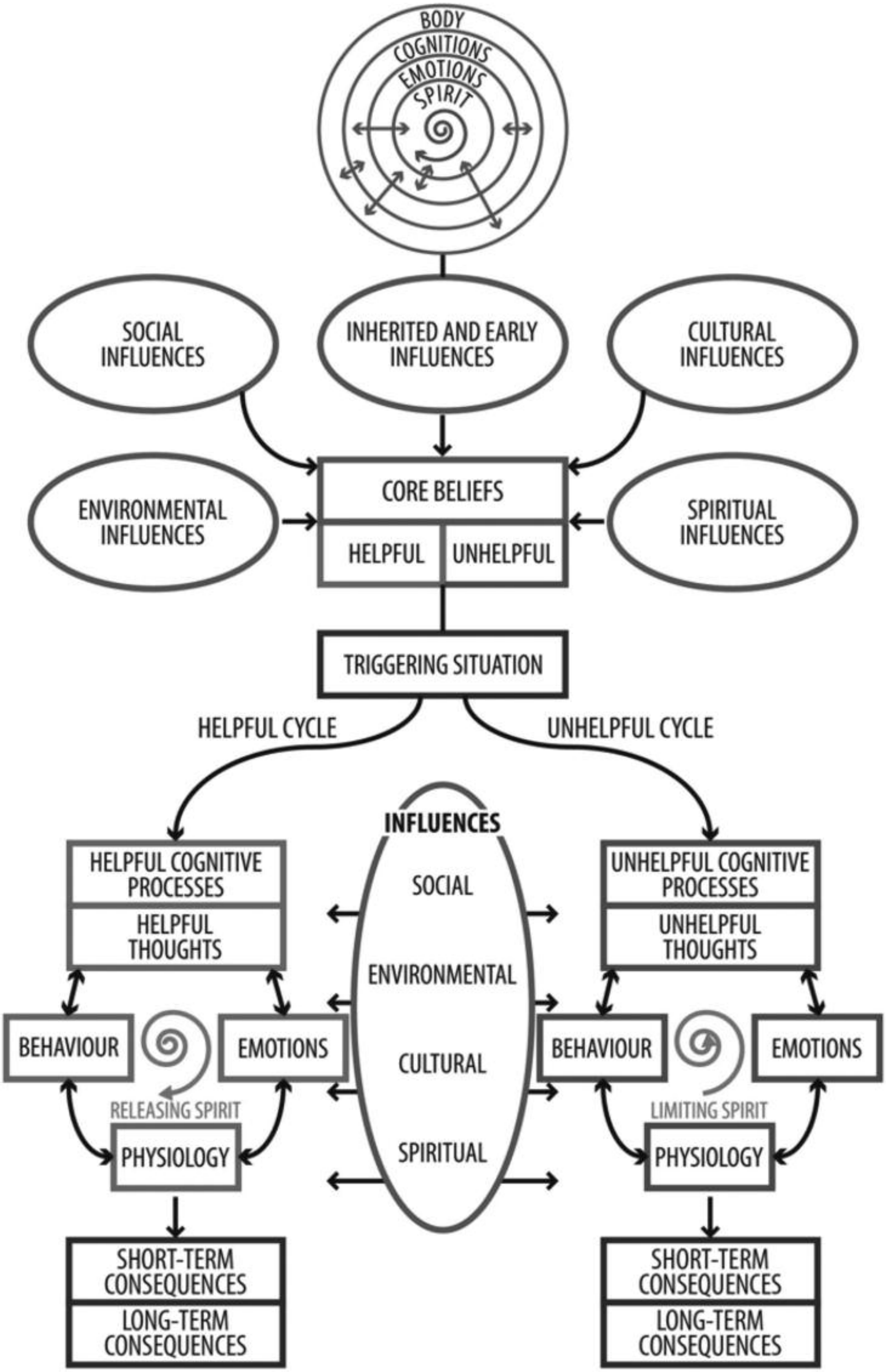
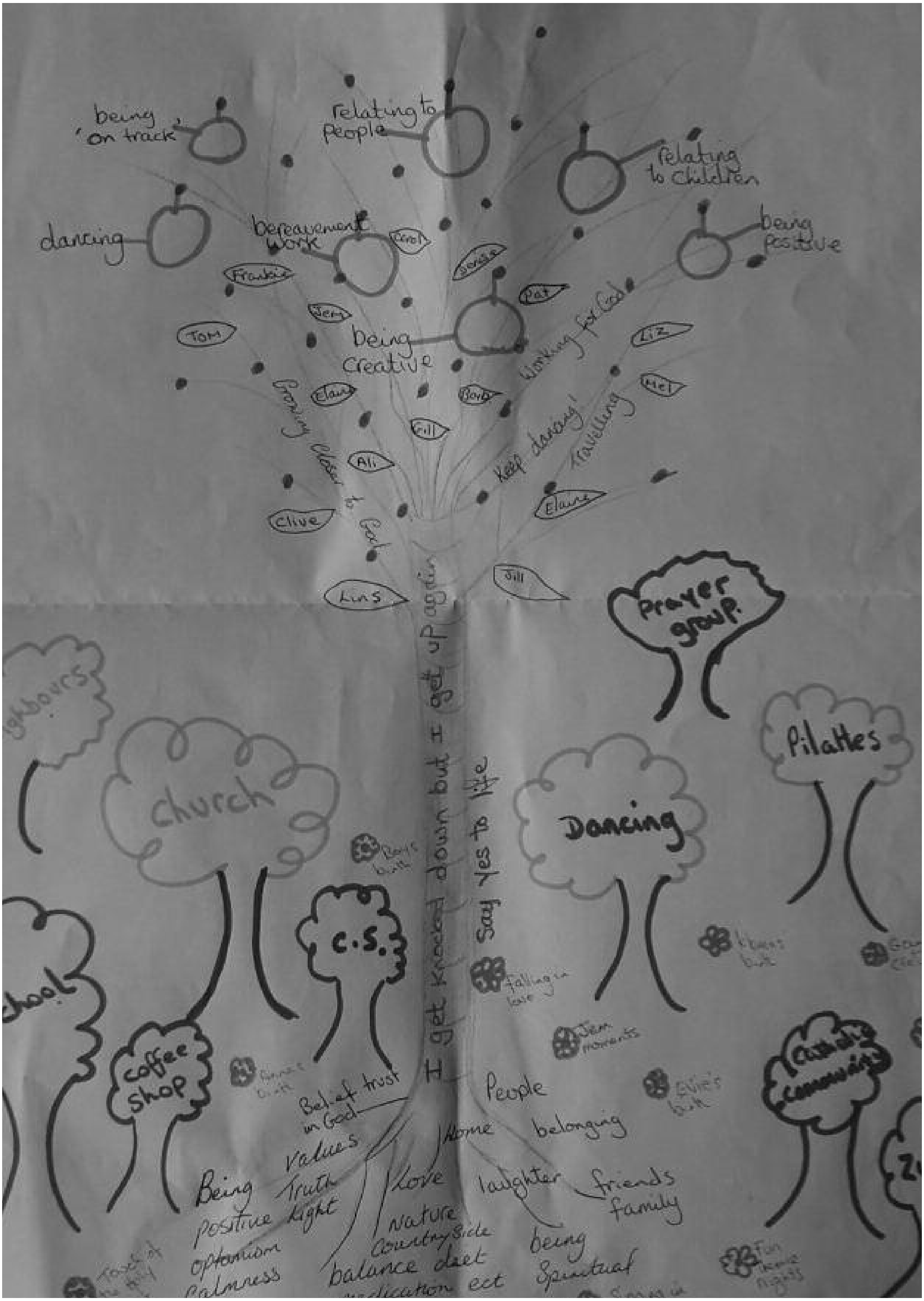


Figure 2: Personal formulation



goals); the fruit (their achievements and talents); the leaves (significant and supportive relationships); the flowers (fun or meaningful moments which make them glad to be alive); and the trunk (labelled with their personal mission statement or strapline). They also identify the communities to which they belong, as other trees in their picture. Since developing this model, I have become familiar with the 'Tree of Life' (Ncube, 2006), which has some similarities with this tree image.

The model suggests that as well as past experiences there are other influences which contribute to the formation of core beliefs. These come under the headings of cultural, spiritual, social and environmental influences. By identifying these influences, the client is more likely to be seen within a context rather than in isolation as opposed to when these factors are grouped under a heading of 'the past'. These four areas of influence are also used to identify current influences that contribute to the cycles in the second part of the formulation. Cultural influences not only include ethnicity, but also cultures such as youth culture or office culture, socioeconomic status and the media. Placing spiritual influences in the formulation gives space for those clients who believe that they are influenced by spiritual beings such as jinn or God to incorporate this into the formulation, but can also be omitted if clients do not identify with these beliefs. Social influences include family and social networks. Environmental influences include influences, often beyond the client's control, such as housing, local community deprivation and unemployment levels.

The helpful and unhelpful cycles are familiar in CBT but in this formulation the human spirit is added. In the helpful cycle, the more the person is thinking and behaving in a helpful way, then the more their spirit is released and the individual is free to be themselves (hence, 'Free to be Me'), which in turn helps them to have more helpful thoughts and behaviours. Conversely, in the unhelpful cycle, the unhelpful patterns of thoughts and behaviours limit the spirit and can distance the individual from their own strengths and potential, and so reinforce their unhelpful patterns. As with standard CBT this leads to short-term and long-term consequences. The acknowledgement of cognitive processes, based on ideas from metacognitive therapy (Wells & Matthews, 1994) are added. Cognitive processes might include worry and rumination in the unhelpful cycles, and mindfulness in the helpful cycle.

The core beliefs and cycles are divided into helpful and unhelpful sides, which encourages a more balanced focus on both the helpful, protective factors and the unhelpful, maintaining factors. As with any model, this is a simplified representation and in reality things are not so clearly defined.

The 'Free To Be Me' course

Participants come through self-referral in response to advertising and the only exclusion criteria is in terms of needing to speak English and to be able to engage with the course. This would therefore mean that someone may be excluded if they were currently experiencing psychotic experiences, using substances or had a learning disability which hindered their current functioning. Participants come with a variety of psychological difficulties (for example, clients from the Community Recovery team came with diagnoses of schizophrenia, OCD and bipolar disorder). Each participant is assessed prior to the course and then meets the facilitators individually half-way through and at the end of the course to review their progress and complete outcome measures. The course consists of sixteen sessions which last two hours each, and is facilitated by a clinical psychologist and counselling psychologist. The course is psychoeducational with creativity (such as reflective writing, art exercises and background music related to course themes) as an integral part. One session is outside and draws from ecotherapy to highlight the value of nature. Each session begins with lunch, which encourages friendships within the group and provides the opportunity to grow in confidence for those who find social settings difficult. Participants are divided into threes, who meet within the course for peer support and shared accountability to work towards goals. Participants complete a weekly journal which helps them to reflect on sessions and set weekly goals.

Table 1: Outcome measure means

Outcome measure	Pre mean score	Mid mean score	Post mean score
PHQ-9*	9.13	7.38	3.86
GAD-7*	12.5	12	8.5
WEMWBS*	38.63	38.13	45.75

*PHQ-9 = Patient Health Questionnaire; GAD-7 = Generalised Anxiety Disorder Assessment;
WEMWBS = Warwick-Edinburgh Mental Well-being Scale

Outcomes

Both quantitative and qualitative data are collected and will be published at a future date when there is a larger sample available. For illustrative purposes, Table 1 shows means for outcome measures from the most recent cohort of eight participants, which was run in a church setting. These show reduced depression and anxiety, and improved wellbeing.

Another outcome measure is the level of attendance, which appears to be higher than average for CBT groups, considering that this course has 16 sessions. For example, the group recruited from the CRT consisted of eight participants and the dropout rate was zero, with average attendance of 74 per cent.

At the end of each course participants attend a focus group and the recorded data are analysed using interpretative phenomenological analysis. Again, the aim of this article is to introduce this model rather than focus on outcomes, but certain themes are emerging from the data. Unsurprisingly, some themes are typical for standard CBT groups, such as the value of being in a group, the value of recognising maintenance cycles and making cognitive and behavioural changes. However, there are other themes more typical to this course such as valuing the use of creativity, seeing the therapeutic value of connecting with nature, valuing the recognition of spirituality in relation to mental health, and becoming more aware of their individuality and strengths. The following quotes are illustrative of some of the feedback that participants gave:

> *'It made me feel more whole than what I was feeling… I was feeling completely inadequate, emotionally all over the place and really depressed, and I don't feel that way now. I feel that I am an individual and I don't have to be the same as other people…'*
>
> *'…the sunshine and trees… made my heart feel really good. It gave me a sense of purpose... just a feeling inside that makes you feel really good.'*
>
> *'So I really liked it cos I'm a Christian anyway, so I know about spirit and spirituality… and I think it's always good to look at the spiritual rather than just the body... so your humanity.'*
>
> *'Right from the first session that we chose our tree the imagery has spoken to me. Writing down what grounds me (roots) was instrumental in deciding not to move. Every stage we added confirmed to me how blessed my life is here in this place at this time and how I can truly enjoy the moment. This course was fundamental in our deciding not to move as I realised what my roots are – a life-changing experience!'*

The course provides an opportunity for clients to talk about their spirituality within secular mental health settings and also to speak about mental health in faith settings, which participants have found helpful and affirming. For example, a participant in one course recognised that her low self-worth and depression were related to her belief that she had let God down. The course has also focused significantly on participants' strengths and individuality, which helped participants to have a more positive view of themselves and their potential. The course is quite long and so requires a level of commitment which may hinder people initially attending, but participants have said that they have valued the time to apply what they are learning and make changes. The course seeks to be holistic and so covers a wide range of topics, and this broad approach may be limited by shortening the course. There is the possibility of splitting the course into two shorter courses, though this may lose the momentum and commitment of the group.

Conclusion

An holistic approach to CBT has been used in both NHS and faith group settings. Participants report improved symptoms but also an improved self-concept and reconnection with personal resources. This focus seems to encourage greater attendance and positive feedback but more work is needed to explore these ideas further.

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References

Azhar & Varma (2000). Mental illness and its treatment in Malaysia. In Al-Issa Al-Junun (Ed.) *Mental illness in the Islamic world.* Madison, CT: International Universities Press.

Dein (2010). Religion, spirituality and mental health. *Psychiatric Times, 3.*

Department of Health (2009). *Religion or belief: A practical guide for the NHS.* London: Department of Health.

D'Souza, R., Diamond, I., Godfrey, K. & Gleeson, D. (2002). An open randomised control trial of a spiritually augmented cognitive behaviour therapy in patients with depression and hopelessness. *Australian and New Zealand Journal of Psychiatry, 36,* A9.

Dummett, N. (2006). Processes for systemic cognitive-behavioural therapy with children, young people and families. *Behavioural and Cognitive Psychotherapy 34*(2), 179–189.

Ellison, C. (1983). Spiritual well-being: Conceptualisation and measurement. *Journal of Theology and Psychology, 11*(4), 330–340.

Goddard, N.C. (1995). Spirituality as integrative energy: A philosophical analysis as requisite precursor to holistic nursing practice. *Journal of Advanced Nursing, 22,* 808–815.

Hayes, S.C, Strosahl, K.D. & Wilson, K.G. (2003). *Acceptance and commitment therapy: An experiential approach to behavior change.* New York: Guilford Press.

Koenig, H. McCullough, M. & Larson, D. (2001). *Handbook of religion and health.* Oxford: Oxford University Press.

Midlands Psychology Group (2014). *Clinical Psychology Forum, 256.* Special Issue: Draft manifesto for a social materialist psychology of distress.

Ncube, N. (2006). The Tree of Life project: Using narrative ideas in work with vulnerable children in Southern Africa. *International Journal of Narrative Therapy and Community Work, 1,* 3–16.

Padesky, C. & Mooney K. (2012). Strengths-based cognitive behaviour therapy: A four-step model to build resilience. *Clinical Psychology and Psychotherapy, 19,* 283–290.

Pergament, K. (1997). *The psychology of religion and coping: Theory, research, practice.* New York: Guilford Press.

Post, B. & Wade, N. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65,* 131–146.

Propst, L.R. Ostrom, R., Watkins, P., Dean, T. & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting & Clinical psychology, 60,* 94–103.

Rathod, S., Kingdon, D., Phiri P. & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy, 38,* 511–533.

Roth, A. & Fonagy, P. (2005). *What works for whom?* (2nd edn). New York: Guilford Press.

Waller, R., Trepka, C., Collerton, D. & Hawkins, J. (2010). Addressing spirituality in CBT. *Cognitive Behaviour Therapist, 3,* 95–106.

Wells, A. & Matthews, G. (1994). Attention and Emotion: A clinical perspective. *Clinical Psychology and Psychotherapy, 2*(2), 134.

Worthington, E.L., Kurusu, T.A., McCullogh M.E. & Sandage, S.J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10 year review and research prospectus. *Psychological Bulletin, 119*(3), 448–487.

Clinical psychologists training and supervising IAPT therapists to work with long-term conditions and medically unexplained symptoms: A service development project

Julie A. Highfield, Kathy Lowe, Emma Lewis, Rachel Warren, Kate Martin & Elaine Walkett

An IAPT service and a clinical health psychology team piloted a service development providing Step 2 and Step 3 services for individuals with long-term health conditions. Results indicate that such services may be offered with access to specialist training and supervision.

RECENT RESEARCH has highlighted that comorbid physical and mental health conditions lead to poorer health outcomes and reduced quality of life (Naylor et al., 2012). Evidence consistently demonstrates that people who have long-term conditions (LTCs) are two to three times more likely to experience mental health problems than the general population (King's Fund, 2012). There is strong evidence in particular for a close association between cardiovascular disease, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders and depression and anxiety (King's Fund, 2012).

Some 12–18 per cent of LTC expenditure is linked to poor mental health, with total healthcare costs raised by at least 45 per cent per person, and £8 to £13 billion spent in England per annum (King's Fund, 2012). In the NHS the current separation of mental and physical healthcare leads to fragmentation. Poor links between these areas leads to lack of integration of care.

No Health Without Mental Health (Department of Health, 2011) gives new responsibilities to Improving Access to Psychological Therapies (IAPT) services to support the psychological needs of people with LTCs. The Quality, Innovation, Productivity and Prevention process challenges calls for innovative ways of providing services which deliver better outcomes with constrained resources. The *NHS England Business Plan 2015/16* has suggested a parity of esteem between mental and physical health; that both should be valued equally. NHS England intends to roll out IAPT services for

Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
■ Long-term condition or medically unexplained symptom. ■ Long-term condition relevant to presenting problem. ■ Suitable for CBT.	■ No long-term condition. ■ Long-term condition irrelevant to presenting problem. ■ Received other Step 3 intervention (e.g. counselling). ■ Offered CBT but did not attend. ■ Offered assessment only.

people with LTCs and medically unexplained symptoms (MUS). However, the pathfinder sites have yet to produce their finalised data on the efficacy of managing the psychological impact of LTCs and MUS within the context of an IAPT service.

The project

This service development project was funded by the former strategic health authority. It took place within the Coventry and Warwickshire IAPT service. Within this service, there is limited access to clinical or counselling psychologists, and as such only Step 2 and Step 3 services are provided.

Seven high intensity therapists and six psychological wellbeing practitioners were selected to take part in the project across the IAPT service. The selected workers were trained and supervised by clinical psychologists with expertise in clinical health psychology who work in local acute hospitals to deliver Step 2 and Step 3 interventions with individuals experiencing depression and anxiety linked to LTCs and MUS.

Step 2 intervention

A generic group, 'Mind and Body', was developed as a cognitive behavioural therapy-based course for individuals with LTC and comorbid depression/anxiety. The course aimed to teach skills to help in living alongside LTCs and manage the psychological impact. The course comprises of seven sessions, including goal setting, relaxation, lifestyle advice, adapting activities, and exploring thoughts and feelings.

Step 3 intervention

Seven high intensity therapists were trained and supervised to adapt cognitive behavioural therapy (CBT) skills to work with individuals with depression and anxiety associated with LTC and/or MUS. Two and a half days of training were offered to all of the project workers, and included adapting CBT skills to LTCs population (and drawing from third wave CBT approaches), and issues specific to LTCs, such as adjustment. Following training, ongoing monthly clinical supervision groups were provided by the clinical psychologists to support practitioners working with LTC patients. Separate groups were offered for psychological wellbeing practitioners and high intensity therapists.

Outcome measures

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) and the Generalised Anxiety Disorder Questionnaire (GAD-7; Spitzer et al., 2001) were used as outcome measures for the Step 2 and Step 3 interventions. These are routinely collected by IAPT as outcome measures, and the team wanted to compare against treatment as usual. The recovery rates were evaluated and compared

Figure 1: Mood outcome data, before and after step two group intervention (*N* = 28)

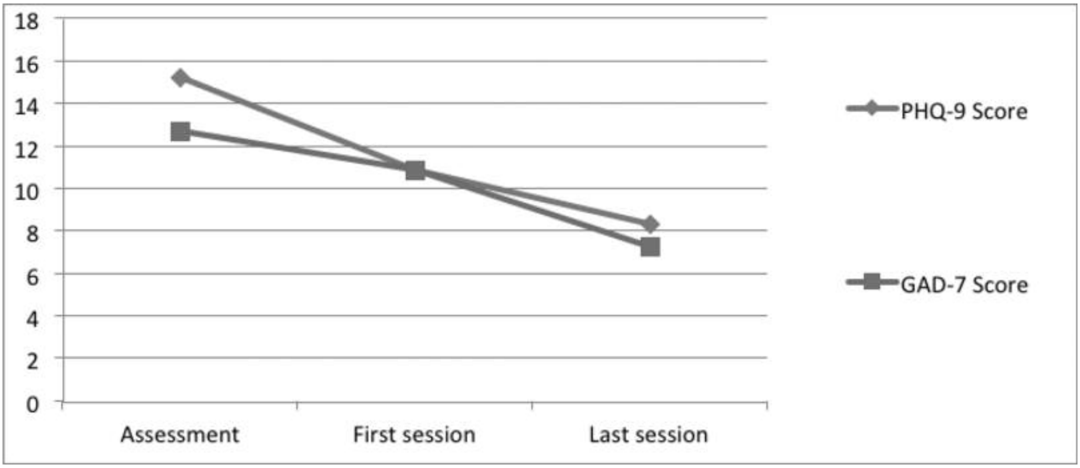
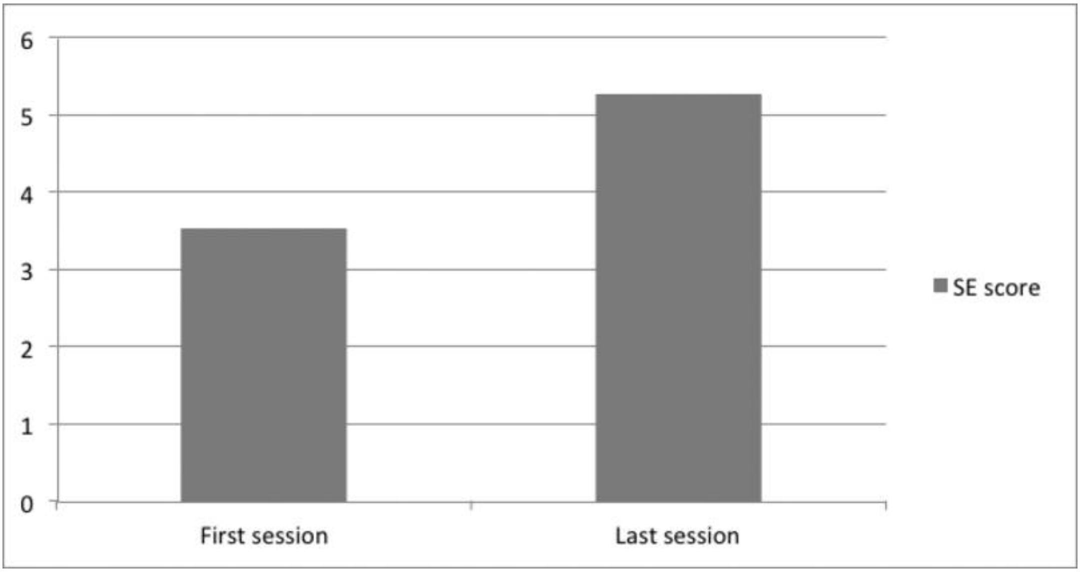


Figure 2: Average Self Efficacy for Managing Chronic Disease Scale scores at first and last session of the group intervention (n = 24)



to date for recovery for those CBT IAPT workers who had not received the training or supervision as a comparison. In addition, the Self-Efficacy for Managing Chronic Disease Scale (Lorig et al., 2001) was utilised with the group in the Step 2 intervention.

The inclusion and exclusion criteria for patients in the project are given in Table 1. Conditions were those recommended in the IAPT Long-Term Conditions and Medically Unexplained Symptoms data collection summary (2012).

At the conclusion of the project a focus group was held with the IAPT therapists to allow them to reflect on their experiences and offer feedback.

Findings

Step 2 intervention

Thirty-six individuals attended the Mind and Body group (although only 28 complete data sets are available), with an age range of 21–72 years (mean = 47 years), and 79 per cent of which were female. Thirty-nine per cent of cases had multiple health comorbidities, 11 per cent chronic fatigue syndrome, 25 per cent chronic pain, 11 per cent muscular-skeletal issues, seven percent diabetes, 4 per cent neurological, and 5 per cent other disorders.

Outcome data are given in Figure 1, indicating an improvement. A t-test was conducted to compare the minimum data set scores before and after the group. There was a statistically significant improvement between baseline PHQ-9 (M = 17.8, SD = 3.5) and end of group PHQ-9 (M = 10.9, SD = 3.6); $t(8) = 3.9$, $p \leq 0.01$. There was a statistically significant improvement between baseline GAD-7 (M = 16.2, SD = 2.8) and end of group GAD-7 (M = 10.6, SD = 4.1); $t(8) = 2.9$, $p \leq 0.05$. However, when recovery was calculated in accordance with IAPT guidelines (whereby recovery is achieved when a patient scores above caseness on the PHQ-9 and/or the GAD-7 at assessment and scores below caseness on both of these measures at final contact) the overall recovery rate for all patients attending the Mind and Body course was only 35.71 per cent. All Mind and Body attendees showed some improvement in illness-related self-efficacy, as illustrated in Figure 2. Although the improvement in score may appear slight, this represents a clinically significant change ($p < 0.01$).

All Mind and Body attendees showed some improvement…

Step 3 intervention

Following the completion of the training, the seven high intensity therapists were allocated Step 3 patients with LTCs. The 'active treatment' phase of the project was seven months, during which time 28 patients received a service from the additionally trained and supervised workers. Twenty-four patients with LTCs were allocated to other workers. Table 2 shows the comparable recovery rates, where recovery was calculated in accordance with IAPT guidelines, with better rates achieved by those who were additionally trained and supervised.

Five of the eight high intensity therapists involved in the project attended to a focus group facilitated by an assistant psychologist to discuss their experience of the project. A thematic analysis produced several themes, with example quotes given in Table 3.

Discussion

The results indicate that a Step 2 group intervention for mixed LTCs delivered within IAPT can have impacts upon general self-efficacy, and the standard IAPT minimum data set measures of low mood and anxiety.

The results indicate that a Step 3 intervention delivered by high intensity CBT therapists can improve low mood and anxiety levels. However, there is a clear indication that training and ongoing specialist supervision from clinical psychologists increases the efficacy of the intervention. These are pilot results and numbers are low, so further investigation is required with higher numbers. It would also be of interest to revisit the outcome results of those IAPT workers who were under the project and now no longer receive the specialist supervision, to see if gains have been maintained without ongoing supervision. IAPT services vary across NHS England, with some having access to step four interventions while others do not, and some services having a wider skill mix of psychological therapists. Having access to clinical or counselling psychologists with experience in medical settings as specialist supervisors, and having a pathway for Step 4 referrals would be key in considering any developments of IAPT services for LTC/MUS.

> …training and ongoing specialist supervision from clinical psychologists increases the efficacy of the intervention…

The experience of the high intensity therapists explored within the focus group indicate that delivering Step 3 interventions for individuals with LTC/MUS proved challenging within the IAPT model of service delivery in terms of the generic nature, the fully booked day, and the ability to offer services to those with complex needs. Those professionals involved in the project speculated that patients without multiple comorbidities who have conditions that are largely managed by the GP are more likely to benefit from GP based IAPT services. However, more research would be needed to investigate this further. The discussions in the focus group indicated the complexity of some LTCs and how difficult it was to translate generic services to such individuals. Individuals with multiple comorbidities and complex needs are often under the care of acute trusts, where psychological services may be better provided by hospital based integrated psychology services. This warrants further study.

Many guidelines suggest the provision of psychological services for LTCs should

Table 2: Recovery rate by group delivering intervention

	PHQ-9 % recovery	GAD-7 % recovery
Pre-project LTC results (*N* = 116)	52	51
During project, non-project workers (*N* = 24)	58	54
During project – trained and supervised workers (*N* = 28)	79	90

Table 3: Thematic analysis of focus group for high intensity therapists

Theme	Example quotation
LTS/MUS work not quite fitting the IAPT core model	'It almost feels like an extra pressure, because you can see the value. There is real value in the work that we do, but it's not measurable in the time that we've got.' 'If you measured the amount of time per long-term condition patient that we spend out of the therapy session compared with average, it would be huge in terms of the discussions with other therapists about what's appropriate, trying to... erm... to get hold of consultants or doctors, medics, whatever, to get clarification, and there's no allowance for that within our numbers and what have you.'
LTC/MUS as sometimes too complex for IAPT	'And just through the amount of research you do yourself, you know, your patient says, "I just keep dropping off to sleep just like that" and then you think". Is this part of the condition or is it because you are not sleeping? Is this because...?'
Experience of specialist training	'I think it would have been helpful if we could have had another training day half-way along because it was all at the beginning, I think if we could have had that and then another consolidating training day, or based on experiences, that could have guided us to the next part really.' 'It opened my eyes a lot and I derived a lot from it... it was nice to have the breadth of training I think.'
Experience of specialist supervision	'I think it would be really important to have that specialist supervision.' 'I was thinking I wouldn't want to carry on doing this... without having access to the supervision that we've had.'

include some integration into staff delivering medical care, through attendance at multidisciplinary meetings, providing training, supervision and consultation (e.g. NICE 2004). The current configuration of IAPT services does not allow for such integrated working.

Conclusion

There are promising results for the delivery of IAPT services to individuals with LTC/MUS. The following recommendations are made for the development of such services:

- IAPT therapists should have access to additional specialist training
- IAPT therapists may additionally benefit from access to specialist supervision from a level four practitioner (typically a Clinical or Counselling Psychologist) with experience in working in medical settings
- Patients may be suitable for Step 2 or 3 interventions if they have a singular health condition that is largely managed by the GP. This could mean that an MDT approach is less likely to be required.

The psychological care needs of patients with multiple comorbidities, or in active treatment (such as chemotherapy or haemodialysis) need to be further investigated. It is not clear whether this may be better provided by integrated Step 4 specialist Clinical Health Psychology services or in the community by IAPT.

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References

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review, 84*(2), 191–215.

Department of Health (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages.* London: Author.

Improving Access to Psychological Therapies National Team (2012). *Long term-conditions and medically unexplained symptoms data collection summary.* UK: Author.

Kroenke, K., Spitzer, R.L. & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.

Lorig, K.R., Sobel, D.S., Ritter, P.L., Laurent, D. & Hobbs, M. (2001). Effect of a self-management program for patients with chronic disease. *Effective Clinical Practice, 4*, 256–262.

National Institute of Clinical Excellence (2004). *Guidance on cancer services: Improving supportive and palliative care for adults with cancer.* London: Department of Health.

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M, & Galea, A. (2012). *Long-term conditions and mental health: The cost of co-morbidities.* London: King's Fund.

NHS England (2014). *NHS England business plan 2015/16.* London: Author.

Spitzer, R.L., Kroenke, K., Williams, J.B. & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097.

Perceptions of a memory group by spousal carers of Parkinson's disease patients

Ana Jovicic, Paula Smith, Leon Dysch, Nikki Adams
& Jeremy Gauntlett-Gilbert

This qualitative study seeks to explore whether a memory group for Parkinson's disease patients can offer any benefits for their spousal carers.

PARKINSON'S DISEASE (PD) is a progressive neurodegenerative disorder which affects around one per cent of the population over the age of 65 (BUPA, 2012). There are approximately 6.4 million people in the UK providing unpaid care for ill or disabled family members (Carers UK, 2012). It is estimated that 75 per cent of carers are spouses of the patient (Martinez-Martin et al., 2008) and they therefore take on the majority of the carer burden. Whilst the carer role contributes £119 billion to the UK economy (Carers UK, 2012), it can be both mentally and physically exhausting, potentially leading to stress, fatigue and depression, as well as a decline in quality of life (Weintraub et al., 2008). Furthermore, Brodaty and Hadzi-Pavlovic (1990) argue that spousal carers often experience social isolation and dependency on psychotropic medication. For the above reasons, it is imperative that carers receive more support from community services and future policies (Jones & Peters, 1992).

Caregiving can also have adverse effects on the spousal relationship. A study by Hand et al. (2010) looked at relationship satisfaction in patients with PD where their spouses are their carers, and found that 24 per cent of the patients rated their relationship state as 'poor' or worse. Spousal caregiving has also been reported to coincide with difficulties with marital cohesion (Davies et al., 2010). Furthermore, Wuest et al. (2006) detail how family carers can experience a continuum from intimacy to alienation with the patient, and undergo increased detachment from them.

Alongside the physical symptoms of PD, patients can also experience cognitive difficulties such as impaired short-term memory (Troster & Fields, 2008), which can cause social problems such as forgetting names and faces. For this reason, a PD pilot memory group was implemented to offer help and techniques for memory difficulties. The spousal carers of the PD patients were also invited to attend. Group interventions have demonstrated increased benefits for patients and also for carers, including improved knowledge of the condition and adoption of new coping skills, as well as experiencing peer support from other group members (Chien et al., 2006). However, there is a lack of literature on memory group interventions specifically for PD and carers of PD patients, and consequently, insufficient information about any potential effects of the group on the carers. This research therefore aims to explore the perceptions of a memory group by the carers who attend alongside the PD patients. Additionally, it aims to assess the relationship between the patient and partner. The memory group fits in with National Service Framework guidelines, as they state that 'carers of people with long-term neurological conditions are to have access to appropriate support and services that recognise their needs both in their role as carer and in their own right' (National Service Framework For Long-Term Conditions, 2005, p.5), which the group aims to achieve.

It has been found that spouses may sometimes attribute blame to the patients due to their behaviour (e.g. Fals-Stewart & Birchler, 1998). Attribution theory (Heider, 1958) states that if a person's behaviour is attributed to something which is thought to be uncontrollable, other people are more likely to be helpful towards that person. Therefore, since the memory group will explore memory problems in PD, it is possible that the carers of the PD patients will begin to attribute the patients' behaviour to PD rather than personal characteristics. The memory group ran for six weeks and consisted of both PD patients and their spousal carers, since this has been proven to be most beneficial (Moore et al., 2001). After the conclusion of the six weeks, the carers were interviewed about their experiences of the memory group, as well as how they felt that attending it has affected them. It is hypothesised that carers will report increased support from fellow group members and healthcare professionals. In addition, it is hypothesised that the group will benefit both the patients and carers by helping to improve their relationship. The research will provide information on the perceived effectiveness of a memory group for PD, which is substantially lacking in the literature, will be clinically useful, and thus help to make vital changes and drive further implementation of such groups for patients with PD and their spousal carers.

Methodology

Participants

Three carers who attended the memory group participated in the study and all were over the age of 65 (Rita, Michael and June). All the patients were newly diagnosed with PD, had no cognitive impairment, and attended the group as a preventative intervention.

Memory group

The memory group consisted of six weekly sessions. It addressed topics such as education about memory, forgetting names and faces, and losing and misplacing items.

Procedure

The spousal carers were interviewed individually to ensure confidentiality. Open-ended semi-structured interviews were carried out, asking about their experience of the group, as well as their relationship with the PD patient both before and after the group. They were also asked what they thought was good about the group and how it could have been improved. After the interviews, participants were told that they could leave an e-mail or postal address if they wished to be notified of the research findings.

Data analysis

The data collected from the interview were transcribed and analysed according to interpretative phenomenological analysis (IPA) principles. Thoughts and observations were recorded in the left-hand margin, and then emerging themes written in the right-hand margin. Connections between the themes were identified, and formed a superordinate theme. IPA was the chosen method to analyse the data because the research is looking at perceptions of the memory group, and IPA allows exploration of personal perception of an experience instead of objective statements (Smith, 1996). Furthermore, IPA is advocated for small sample sizes (Smith & Osborn, 2008).

Results

After analysing the data, three sub-themes emerged: 'Understanding and Knowledge', 'Relationship with Patient', and 'Benefits of Social Support'. By grouping these sub-themes together, a new superordinate theme of 'New Realities' transpired, as it depicted the new-found benefits for the spousal carers. The themes emerged throughout the whole length of the interview, and were not specific to individual questions.

Understanding and knowledge

Spousal carers highlighted the increased understanding and awareness of the nature of PD and the effect on the patient: 'I think what it did was made me aware that he is actually not a very well man.' (Rita, p.4, line 188).

There is also increased understanding for both the patient and partner: '[Partner] is more understanding, and I'm more understanding now, so it's much better.' (Danny, p.3, line 111).

Rita explained the positive outcomes of increased understanding gained from the memory group: 'I think it served to heighten one's, erm, realisation, shall we say, that you can do something about it, so it was beneficial in that respect.' (Rita, p.4, line 173).

Relationship with patient

Michael expressed the improved ability to cope with problems better together and managing blaming the other person: 'Each is forgetting where something essential is, and if it's a case of something being misplaced, then one has the feeling of, well I didn't misplace it, it must've been you. But we've managed to get over that.' (Michael, p.2, line 54).

The couples found that they were more likely to go out and do activities together again: 'Well, we thought we might go to tea dancing. Not too likely a motion, but with the rhythm and any familiar music, then we might actually go along in the afternoons.' (Michael, p.4, line 174).

Benefits of social support

The carers discussed feeling supported by the other members of the group: 'When we went to the memory group, and we saw other people there, and that I think makes a difference, because you realise that you're not on your own, and it gives you more confidence.' (June, p.4, line 162).

Furthermore, Michael expressed how the memory group gave him an enjoyable social activity outside their regular routine, which in turn helped his mood: 'It took me out to something other than shopping, and er, I enjoyed meeting the other people in the social sense. So it's helped my mood.' (Michael, p.5, line 242).

Discussion

This study looked at the perceptions of a six week memory group by the spousal carers of PD patients. The results of the IPA analysis demonstrate key findings in regards to their perceptions of the memory group and the benefits gained. The data present the superordinate theme of 'New Realities', which was comprised of three sub-themes. The first sub-theme was 'Understanding and Knowledge'. The carers discussed coming to terms with the reality of PD and its effect on the patient, which they had not faced before attending the memory group. In this respect, the group had a positive effect, as it served to help carers combat any resistance that they might have been feeling and helped them to come to terms with the reality of the condition. This suggests that by educating the spousal carers, the group is indirectly helping the patients. These findings are supported by Heider's (1958) attribution theory: since the carers attended the group and learned more about PD and the memory loss associated with it, it is possible that they have come to attribute the patients' behaviours to PD rather than personal characteristics, and are therefore more understanding and encouraging towards them.

The second sub-theme was 'Relationship with Patient', in which the carers discussed enhanced methods of working through problems together, coinciding with better communication. Another key finding within this theme was that the patients and carers were doing more activities together again as a couple, which may have lessened as the PD became more dominant. Wuest et al. (2006) explain the detachment that carers can sometimes feel from the family members they are caring for; however, this can be avoided with improved communication and by spending more time together.

The third sub-theme was 'Implications for Self'. A large benefit that the carers gained from attending the memory group was the support from the other group members and clinicians. They voiced that they felt less isolated and that the group was a social activity. Since spousal carers can often experience social isolation (Brodaty & Hadzi-Pavlovic, 1990), socialising with others in the group is a clear benefit for them. Furthermore, this theme indicates that the memory group is compliant with the national service framework guidelines, as it has shown to give the spousal carers more support for both their needs in the role of carer, and in their own right. The data also show that the carers themselves used the memory strategies, demonstrating their usefulness for all members of the memory group.

There were some clear limitations to this study. Primarily, there was a small sample size as the memory group was a pilot and there were small number of patients and carers attending. For this study the sample size was adequate due to IPA requirements, but it would be valuable to examine the benefits of a PD memory group with a larger group of participants. Additionally, the group had not been trialled before and there has been no evidence prior to this research regarding whether the group has any substantial effects on spousal carers or the PD patients. This research has gone some way to elucidating the carers' perceptions of the group, and has shed light on some favourable outcomes for them, but more research is required on PD memory groups in order to determine whether they should be run again and expanded in other areas.

The study highlights some implications of the PD memory group. Chiefly, since this is the first piece of research looking at the perceptions of a memory group by spousal carers of PD patients, there is plenty of opportunity for further research in this area. Resulting from the positive group outcomes for the carers, it may be a possibility to implement similar support groups that include both the PD patients and their carers. By addressing the needs of many PD patients and partners in a group at the same time, clinician load would be reduced, and would in turn lower NHS costs. Essentially, the research has suggested the positive effects of maintenance and support for the PD patients and their spousal carers who were interviewed, and would be clinically useful if implemented in healthcare.

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References

Brodaty, H. & Hadzi-Pavlovic, D. (1990). Psychosocial effects on carers of living with persons with dementia. *Australian and New Zealand Journal of Psychiatry, 24,* 351–361.

BUPA (2012). *Health information directory – Parkinson's disease.* Retrieved from www.bupa.co.uk/health-information/directory/p/parkinsons-disease

Carers UK (2012). *Why we're here.* Retrieved from www.carersuk.org/about-us/why-we-re-here

Chien, W., Norman, I. & Thompson, D.R. (2006). Perceived benefits and difficulties experienced in a mutual support group for family carers of people with schizophrenia. *Qualitative Health Research, 16,* 962–981.

Davies, H.D., Newkirk, L.A., Pitts, C.B., Coughlin, C. A., Sridhar, S.B., Zeiss, L.M. & Zeiss, A.M. (2010). *The impact of dementia and mild memory impairment (MMI) on intimacy and sexuality in spousal relationships. International Psychogeriatrics, 22,* 618–628.

Fals-Stewart, W. & Birchler, G.R. (1998). Marital interactions of drug-abusing patients and their partners: Comparisons with distressed couples and relationship to drug-using behaviour. *Psychology of Addictive Behaviors, 12,* 28–38.

Hand, A., Gray, W.K., Chandler, B.J. & Walker, R.W. (2010). Sexual and relationship dysfunction in people with Parkinson's disease. *Parkinsonism and Related Disorders, 16,* 172–176.

Heider, F. (1958). *The psychology of interpersonal relationships.* New York: John Wiley and Sons.

Johnson, A.M., Pollard, C.C., Vernon, P.A., Tomes, J.L. & Jog, M.S. (2005). Memory perception and strategy use in Parkinson's disease. *Parkinsonism and Related Disorders, 11,* 111–115.

Jones, D.A. & Peters, T.J. (1992). Caring for elderly dependants: Effects on the carers' quality of life. *Age and Ageing, 21,* 421–428.

Martinez-Martin, P., Arroyo, S., Rojo-Abuin, J. M., Rodriguez-Blazquez, C., Frades, B. & de Pedro Cuesta, J. (2008). Burden, perceived health status, and mood among caregivers of Parkinson's disease patients. *Movement Disorders, 23,* 1673–1680.

Moore, S., Sandman, C.A., McGrady, K., & Kesslak, J.P. (2001). Memory training improves cognitive ability in patients with dementia. *Neuropsychological Rehabilitation, 11,* 245–261.

Longterm Conditions NSF Team (2005). *National service framework for long-term conditions.* London: Department of Health.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261–271.

Smith, J.A. & Osborn, M. (2008). Interpretative phenomenological analysis. In Smith, J.A. (Ed.) *Qualitative psychology: A practical guide to research methods* (2nd edn). pp.53–80, London: Sage.

Troster, A.I. & Fields, J.A. (2008). Parkinson's disease, progressive supranuclear palsy, corticobasal degeneration, and related disorders of the frontostriatal system. In J.E. Morgan & J.H. Ricker (Eds.) *Textbook of clinical neuropsychology* (pp.536–577). New York: Taylor and Francis.

Weintraub, D., Comella, C.L. & Horn, S. (2008). Parkinson's disease – Part 1: Pathophysiology, symptoms, burden, diagnosis, and assessment. *American Journal of Managed Care, 14,* S40–S48.

Wuest, J., Ericson, P.K. & Stern, P.N. (2006). Becoming strangers: The changing family caregiving relationship in Alzheimer's disease. *Journal of Advanced Nursing, 20,* 437–443.

The storytelling movement: A trauma recovery intervention for war affected communities

Sarah Whittaker-Howe

The storytelling movement was pioneered in response to the challenge of providing psychological intervention to traumatised communities in the absence of mental health professionals. It is pioneered to be a self-sustaining movement that breaks the silence of trauma, as demonstrated by this case study in the Democratic Republic of Congo.

ONE OF the biggest challenges in developing trauma recovery interventions, both within post-conflict communities and those that continue to experience gross violations of human rights, is often they are resource poor settings. They have few, if any, mental health professionals, yet the number of individuals in need of psychological intervention comprises the majority of the community. In addition, it is rare for clinical psychologists to either be funded or able to remain within these communities voluntarily for a significant period of time that would allow them to provide evidence-based psychological treatments. Therefore, the disparity between those in need of psychological intervention and those with the skill set to intervene is substantial. The storytelling movement was pioneered to respond to this disparity by teaching communities to tell their stories. Pioneered and implemented in the Democratic Republic of Congo, the storytelling movement was seen to break the silence that can maintain and increases psychological distress.

What is the Storytelling Movement?

In its purest form, the storytelling movement is not necessarily a novel approach to treating the psychological wounds caused by traumatic events. Theories of post-traumatic stress disorder (PTSD) have well established that talking about the traumatic event(s) in detail results in significant reductions of PTSD symptoms. Successful interventions already utilise narration of the traumatic event(s) to good effect; for example, trauma focused cognitive behavioural therapy (Ehlers & Clark, 2000) and narrative exposure therapy (Hensel-Dittmann et al., 2011). Therefore, the storytelling movement does not claim to be a unique intervention, but rather represents how already existing treatment approaches are incorporated and adapted to respond to the challenge of providing psychological care to traumatised communities when limited resources and expert knowledge are available.

Why is it that so often communities remain silent?

Why is it that so often communities remain silent? And what would happen if individuals or whole communities started telling their stories of war, torture and violence? This is what the storytelling movement represents. It aims to break the silence so often observed within grossly traumatised communities and support survivors to tell their story to bring freedom from traumatic experiences.

Why storytelling?

The storytelling movement looked at research into the nature of trauma memories and evidence-based psychological treatments for PTSD to conceptualise how to tell stories in a way that starts the process of healing and coping with trauma, as well as building resilience to future traumatic events.

It is suggested that pathological responses to traumatic events occur when trauma memories have not been stored in the same way that ordinary memories have (Brewin & Holmes, 2003). Unlike ordinary memories, trauma memories lack verbal coding in the brain and instead exist as a series of sensory representations (Brewin, 2001).

This is problematic because when the memory of a traumatic event is triggered, the individual experiences fragments of the event through vivid and intense sensory stimuli experienced at the time of the event. There is also a distortion in the sense of time, such that these sensory stimuli are experienced as happening in the present rather than belonging to the past. Survivors often describe this re-experiencing as time travelling back to the event and reliving the horror of what happened without realising it is a memory. In the absence of verbal coding, communicating to others what happened can be difficult (Brewin, 2001).

Therefore, an integral component of treating PTSD is supporting individuals to construct a coherent, detailed narrative of the traumatic event; in particular, verbalising sensory representations. Research has well established that this process transforms pathological trauma memories into ordinary memory structures, directly reducing the frequency and severity of reliving symptoms (Bisson et al., 2007). It also exposes individuals to the emotional impact of the traumatic event, cultivating a process of emotional habituation (Brewin et al., 1996)

The storytelling movement prioritises empowering communities…

The process of storytelling

The storytelling movement aims to teach communities to tell stories about their traumatic experiences in a coherent manner (i.e. with a clear beginning, middle and end), with rich descriptions about what they could see, hear, smell, touch and taste, what their body felt like, and what they were thinking and feeling at the time.

This process happens at different levels within communities. The storytelling movement prioritises empowering communities to take responsibility for their own storytelling movement. This is achieved by providing workshops in the community on common psychological reactions to traumatic events and highlighting how storytelling can start a healing process. Space is then provided for the community to practice telling stories and the workshop ends with a collaborative discussion about how storytelling could organically be used in different settings within the community; for example, within families, places of worship and village meetings.

At the next level the storytelling movement aims to provide further training to 'barefoot psychologists'; either members of the local community and/or international staff/volunteers who are interested in using the storytelling movement in more structured settings.

Case illustration

Democratic Republic of Congo

Since 1996, the Democratic Republic of Congo (DRC) has been the centre of a complex array of intricate conflicts involving local, national and international factions. These conflicts have claimed more than five million lives (International Rescue Committee, 2008). Whole communities were targeted for massacre, mutilation, sexual violence, torture, child soldiering, house-to-house raids and the burning down of entire villages, leaving thousands displaced. Although the conflict has officially ended, much of the country remains desperately poor and the rebel-led violence continues to be widespread.

Justice Rising in the DRC

Justice Rising is a non-profit organisation partnering and living within conflict affected communities. The vision is to build mutual relationships with nationals, empowering these individuals with the resources and skills they need to carry self-sustaining projects. I was asked to partner with Justice Rising in late 2013 to think about what projects could be developed to respond to whole communities affected by years of relentless violence in the DRC.

The idea of a storytelling movement was developed to respond to the challenge that my time living in the communities was limited (five weeks), that the majority of individuals lacked basic education, and that there would be limited opportunities to provide frequent and ongoing supervision and support for any projects implemented.

A storytelling movement

I worked with a community in North Kivu, DRC that has experienced relentless violations of human rights and repeatedly experience village raids and massacres. Poverty is rife and access to healthcare is limited. The storytelling movement was introduced via workshops in the following format:

1. education on what traumatic events are and common psychological reactions to these events;
2. education on why storytelling can start a process of healing from, and coping with, the psychological impact of traumatic events;
3. training on how to tell stories in a helpful way; and
4. space to practise storytelling.

The culture in the DRC is such that the village elders, chiefs and pastors must be addressed first. Therefore, the first workshop comprised these individuals, in the hope that they would champion the storytelling movement. At the end of this workshop, the feedback seemed generally positive; however, when I returned to the village a week later, this had changed. I was told that in the DRC talking about what happened during the war is completely counter-cultural and believed to perpetuate violence by evoking feelings of anger and revenge and prolonging (psychological) suffering. Therefore, the overall feedback was that they were not interested in starting a storytelling movement.

In the same village, Justice Rising has pioneered a Leadership League: a soccer team comprised of 40 boys and young men, who choose to play soccer and receive discipleship rather than join rebel armies. I delivered the same workshop to them. The Leadership League offered further explanations about why the community do not talk about traumatic events, explaining that everyone has experienced and witnessed the same events, thus it was unnecessary to talk about it. They also explained that even if they wanted to talk, there was no one in their community ‘free from pain’ whom they could ‘burden’ with their own suffering, and it didn’t make sense to talk about events they are trying to forget.

Despite these beliefs, one member of the Leadership League members decided to share his story. He communicated to the group his urge to talk about what he had experienced, yet he never knew who would listen. He described the day his family ran for their lives during a village raid and how he witnessed a bullet go through his sister’s back and out through her chest, before she fell to the ground and died. He was too scared to stop and retrieve her body in fear of being killed. He said he had never shared this story in fear of upsetting others or his peers laughing (a common coping response in the Congolese culture). At the end of his story, one of his peers spoke out and said, ‘I am sorry that happened to you’. Three others shared a story that day.

The feedback from the Leadership League was more encouraging. For example: ‘When I talk I feel sad, but I also feel stronger’, ‘When we hear other people’s stories, it gives us the opportunity to say sorry to them for what happened’ and ‘If we share our stories we can be free of pain and from the past.’

The workshop with the Leadership League encouraged me to run a longer workshop with the village elders, chiefs and pastors, but this time I invited older members of the Leadership League. Reflecting on feedback from the previous workshops, more time was dedicated to explaining how storytelling can start a process of recovery from traumatic events. In addition, a space was given to the Leadership League attendees to share their experiences of storytelling, giving others the opportunity to make comments and ask them questions. This was a significant process that developed into a debate between the group about what is helpful and unhelpful about storytelling. As an observer it was clear that a member or members of the community advocating for a storytelling movement because of their own positive experience had more influence than an outside ‘expert’. As the debate came to an end, the group split into twos and shared stories. Looking around the room, I was struck by the observable eagerness to be heard and understood and also the ability of the other to convey empathy as they listened.

To summarise the effect that this workshop had on this particular group of people, I am reminded of two comments: one from a pastor who said: 'The first stone has been laid. We must build upon it. This is a medicine that costs no money. We must start talking,' and the second from a village elder, 'There is a group of people here who want to talk. What shall we do?'

As a group we discussed how the storytelling movement could continue. We recognised that their family and friends had yet to learn about storytelling, so it would be helpful to share what they had learnt and then practice sharing with each other. It was encouraging to hear their dreams for groups to emerge where people could regularly get together to talk and support one another.

This was nearly six months ago and the storytelling movement is growing. The staff on the ground have been overwhelmed by the feedback. The village elders, chiefs and pastors have been sharing the storytelling movement with their families. Their testimonies demonstrate how the storytelling movement is bringing families closer together: 'As I have been talking to my wife, I am discovering things she has experienced that I did not know of before' and 'My daughter has been telling me the hurts she has experienced because of her husband.' These leaders are taking responsibility for their own storytelling movement and are discussing how to set up listening rooms for the whole community. Some members of the Leadership League meet weekly to share their stories and have asked for further training so they can support the rest of the league. Justice Rising is observing that in this community the silence is breaking. Families, friends and neighbours are engaging in difficult conversations, providing opportunities for individuals to have their experiences validated and to be supported. The village chief has highlighted the empowering nature of the storytelling movement, as he reflected: 'We don't need to wait for outsiders to come, we can start healing ourselves.'

Taking lead from the community, the next step for the storytelling movement in this community is to support them to think about what groups they would like to develop, what a listening room might look like and who would be best to facilitate and sustain these projects. Then, further training on using storytelling in a more structured setting would be offered.

Concluding remarks

The storytelling movement was pioneered in response to the challenge of providing psychological intervention when whole communities are traumatised and mental health resources are either low or non-existent. Drawing on previous research and successful psychological interventions for PTSD, the storytelling movement is a tool that can start a process of healing from and coping with traumatic events, yet requires relatively low involvement from mental health professionals. As demonstrated in the DRC, following the storytelling movement workshops, the movement itself is self-sustainable, if the community choose to use it. This is because telling stories is not a complex process, but rather utilises natural forms of human behaviour and communication that are known to organically contribute to the process of recovering from traumatic events.

…the storytelling movement is a tool that can start a process of healing from and coping with traumatic events…

While no formal research has yet to determine if the storytelling movement reduces the severity or occurrence of PTSD, verbal reports indicate that it can help communities break the silence that so often maintains and increases psychological distress, providing substantial relief to individuals. It also seems to enrich social bonds and bolster social support, which is known to buffer against the psychological impact of trauma (Brewin et al., 2000). Therefore, it has been observed as an effective method to respond to the mental health needs of traumatised communities when more traditional approaches that rely on one-to-one interventions between professional and survivor are unavailable.

Personal reflections

The more I sit with survivors of repetitive and ongoing war-related trauma, the more my expectations, or rather understanding, of what 'recovery' is within this context is vastly changing. It is not that I should cease striving to see whole communities free from PTSD, but the reality of what I can do with the resources I have hits me. Therefore, what I value about the storytelling movement is that it is not just a tool that focuses exclusively on recovery from post-traumatic symptoms, but I think it symbolises to the survivor that 'your story is important', which I hope restores their human dignity, which is so often robbed within war-related trauma. My hope is that through storytelling survivors can find meaning in their suffering because their suffering should not be in vein. I have seen survivors who, through storytelling, have recovered their dignity and found meaning in their suffering become more determined than ever to continuing living and surviving. In some ways, if recovery looks like that, rather than significantly reducing symptoms of PTSD, I hope more war-effected communities are given the opportunity to tell their stories.

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References

Bisson, J., Ehlers, A., Matthews, R., Pilling, S., Richards, D. & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychology, 190*, 97–104.

Brewin, C.R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39*, 373–393.

Brewin, C.R., Dalgleish, T. & Joseph, S. (1996). Dual representation theory of posttraumatic stress disorder. *Archives of General Psychiatry, 50*, 294–305.

Brewin, C.R. & Holmes, E.A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*, 339–376.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Ehlers, A., Clark, D. M., Hackmann, A., McManuc, F. & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy, 43*, 413–431.

Hensel-Dittmann, D., Schauer, M., Catani, C., Odenwald, M., Elbert, T. & Neuner, F. (2011). Treatment of traumatized victims of war and torture: A randomized controlled comparison of narrative exposure therapy and stress inoculation training. *Psychotherapy and Psychosmatics, 80*, 345–352.

International Rescue Committee (2008). *Mortality in the Democratic Republic in Congo: An ongoing crisis.* Retrieved 4 April 2008 from www.rescue.org/sites/default/files/resource-file/2006-7_congoMortalitySurvey.pdf

App Review

MindShift

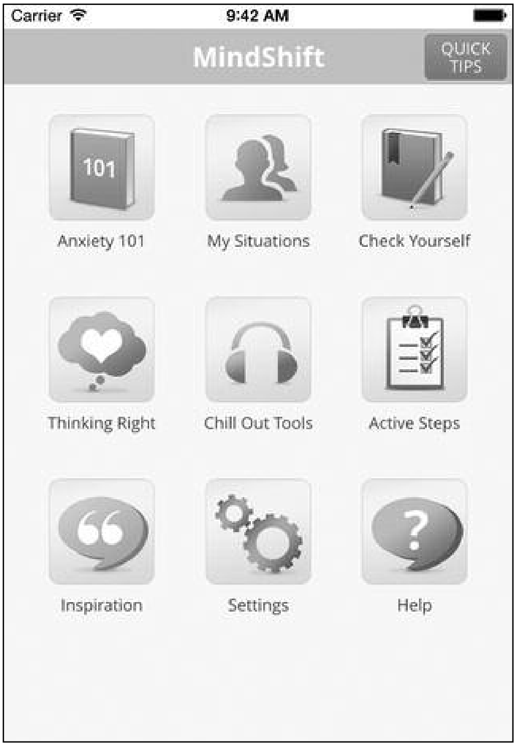
AnxietyBC

Platform: Android and iOS

Price: Free

Available from: www.anxietybc.com/resources/mindshift-app

Reviewed by: Joe Judge



ANYONE who has a smartphone or tablet will be aware that there are apps for just about everything. A quick glance at my phone reminds me that I can play music, check my bank balance, tweet and reserve a library book, all using different apps. It is therefore not surprising that apps have been developed that can be used in mental health settings and by psychologists.

There is a fairly bewildering array of such apps on the market, which makes it difficult to know where to start. Unfortunately, the evidence base for app-based psychological interventions in general is not well established (Leigh & Flatt, 2015; see also, www.zurinstitute.com/mentalhealthapps_resources.html).

In mental health settings apps can be split into two broad categories: those for mental health professionals and those that are intended to be used by service users, sometimes for specific mental health difficulties.

MindShift is an app that is from the second of these categories. It was developed by Canadian mental health professionals to help teens and young adults cope with anxiety. My view though is that it could be used by adults too.

MindShift uses a clear CBT-based framework and has sections which has information and education about anxiety, developing a personalised plan to cope better with anxious situations, rating your own anxiety, 'thinking skills', 'chill out tools' and 'active steps'. The app is free, the interface is very intuitive and it is easy to navigate. It is pitched at a good level in that the language used is straightforward but not patronising. There is an excellent and easily accessible 'quick tips' section that gives immediate helpful advice for panic-like situations.

In all, there is really useful material on this app. Although the evidence base for app-based psychological interventions is lacking, I think it would be a helpful addition to therapy for any service users experiencing anxiety who are even vaguely technologically literate. It could be used very effectively in much the same way as a more traditional relaxation CD or cognitive diary.

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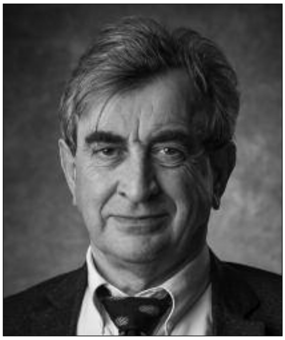
Reference

Leigh. S. & Flatt, S. (2015). App-based psychological interventions: Friend or foe? *Evidence Based Mental Health, 18*, 97–99.

Notes from the Chair

Richard Pemberton



MY TERM as Chair ends at our special AGM in London on the 10 May. My remaining Chair's updates are going to be given over to reflecting on the past four years and will outline my account of the key issues confronting the profession and the DCP, how I have spent and prioritised my time, what has been achieved, what hasn't gone as well as I would have liked, and the key issues that the new DCP leadership needs to address.

Key issues as I saw them when I was elected to the role of Chair

When I stood for Chair I said: 'The NHS is in upheaval again. It's a time that calls for strong leadership and good representation. We need to increase our support to our membership and respond to the new policy and financial environment in a confident and strategic way.

'It is vital that we continue to influence public policy and practice across the four nations in areas such as long-term conditions, abuse and trauma, health inequality, and public health. To do this we need to build even stronger alliances with other professional bodies and progressive service user groups and peer support organisations. As the largest and best resourced division in the Society we can play a leading role in rethinking applied psychology within the BPS and beyond. Getting clinical psychology across to the outside world is more important than ever.'

This was written at the time of the Andrew Lansley 'redisorganisation' and 'liberation' of the NHS, which was ushered in with the cold winds of austerity and its associated cuts in funding for both child and mental health services, social care and to many individuals with disabilities.

The DCP that I inherited had not been having an easy time. Peter Kinderman left the position of Chair prematurely and Jenny Taylor had temporarily returned to hold the fort. She and John Hanna, our England Chair and Policy Lead, left the DCP Executive Committee at the first meeting I attended. John challenged us to respond to the plethora of new local bodies (clinical commissioning groups, health and wellbeing boards, clinical senates, etc.) that were supposed to put clinicians in charge of the NHS in England. Many key decisions are now taken regionally and we have had to work out how we can best influence them.

On the plus side, the Division had more than a million pounds in its reserves and many very active and high profile subgroups like the Older People, Intellectual Disabilities, and Children and Young People's faculties, and DCP Scotland and Northern Ireland.

Changing the narrative in the profession

Key challenges throughout my time as Chair have been how best to limit the damage of austerity (the loss of senior posts in many areas has been dramatic), and managing and confronting what I refer to as a depressive narrative, 'Clinical psychology has had it', 'IAPT is a bogeyman', 'The DCP and the BPS have never done anything for us', 'We don't need the DCP now we have the HCPC and all our members will leave', 'We are totally outgunned by the RCP'. Behind this narrative is a real and taxing difficulty. Our members, like far too many public service workers, have been suffering low morale and high levels of anxiety, stress and uncertainty. New members of the profession have rightly been concerned about joining the profession at a time of much raised expectations and low morale among their seniors and supervisors. This loss of morale has hastened the loss of many senior figures to retirement and independent practice.

I have throughout my time as Chair pointed out that news of cuts and difficulties seems to travel much faster than all the continuing achievements, new developments, and the growth of posts in neurology, forensic, physical health and older people services, as well as the continuing and rather astonishing expansion of the many different strands of the typically clinical psychology-led IAPT programme. In all four nations, and areas such as Sussex and Sheffield and parts of London, the profession has continued, across all care groups, to strengthen its profile and contribution to services.

A recent new challenge to join the list of things that we need to be concerned about are the very significant cuts to training budgets and the associated likely threats to our current training funding and course arrangements.

Strengthening leadership accountability and organisation

To meet these challenges, I and the Executive Committee have systematically set about strengthening our leadership at all levels and in the process upgrade the organisation, accountability and influence of the Division. Key successes include Beth Parry Jones building an effective DCP Wales operation. Ste Weatherhead, as Professional Standards Unit Director, has streamlined and upgraded our publications process and in the process has built strong and collaborative relationships with the other applied Divisions and the Society as a whole. I have lead the work in rebuilding the English branch structure and redefining their role and relationship with the Society. We now have, for the first time ever, complete branch coverage over the whole of the UK, and the English DCP chairs are an increasingly senior and influential group. Steven Coles has driven down our excessive financial reserves and strengthened our business planning process (i.e. being very clear about why we are spending money and why). Cath Burley, as ever, has been a great champion for our faculty structures and has ensured that they are now much more integrated into the Executive Committee and work together in a more joined up way. Esther Cohen-Tovee, in addition to her leadership of the Leadership and Management Faculty, has sharpened our focus and helped to redefine the role as a division (Our DCP *Core Purpose* sits well inside the new BPS *Strategic Plan*, and has helped to bind together our, at times, overly disparate subsystems and competing priorities). Reg Morris and Helen Dent have led the integration of the influential Group of Trainers in Clinical Psychology into the DCP and the Executive Committee.

I don't have space to detail the headline contributions of all the other Executive Committee members and their contributions, but as can be seen from our annual report, Northern Ireland, Scotland, and all the division faculties have all been building capacity and increasing their profile and influence.

Transformative change

In addition to trying to oversee all this I have championed what we have called the three transformative changes. All three have proved controversial, complex and at times frustratingly slow to take off, but are very much alive and well and moving forward. They are: Inclusion and Diversity, which has been led by Ste Weatherhead; Classification and Beyond Diagnosis, led by Steven Coles; and Experts by Experience and Coproduction, led by Jo Hemmingfield with myself and a number of other Executive Committee members. I will talk more about these in my next column in May's CPF. Recently, they have been joined by a fourth one: Outcomes and Coproduced Formulation.

Realigning and rethinking applied psychology

I have invested a lot of my time getting to know and developing more collaborative relationships with the other divisional and section chairs. The fruits of this have included our Francis report joint events and publications with the Division of Occupational Psychology. Another recent example has been the establishment of a group to revise the Society's obesity guidance. Jamie Hacker Hughes is committed to reshaping the fragmented and unwieldy applied psychology structures that we currently have in place. They often make little sense to psychologists, let alone the public. There is, across the divisions, much greater recognition of the need for change. Positioning the division to lead and support necessary changes has been a key agenda for me.

Playing our role to help the Society to raise its game

The Society wants to build on and extend our existing faculty structures. I have argued that we need to sort out the tensions between the Society as a learned body and its role as a professional body. Both are important. A learned body would be cautious about the popularity of EMDR and mindfulness and would want to unpick and contextualise them. The professional body would on the other hand want the public to have much greater access to these evidence-based treatments. The tension and confusion about these differing roles causes lots of difficulties and dissipates energy.

Jamie Hacker Hughes is promising major changes to the way the Society is governed and held to account. More effective governance structures and clear delegated powers would transform the organisation. I have consistently strongly advised members to take an interest in Society affairs and take an active role in activities and development. Members don't realise its importance and the way its level of functioning impacts, for good and for ill, on their career prospects and the vulnerable groups we serve.

From health to life: The future psychology workforce

I was the first ever Chair of the Society's Professional Practice Board Workforce Planning Subgroup. Given my longstanding interest in the future psychology workforce it has been very pleasing to see the progress that we have made. Spurred on by widespread cuts to senior posts and gradings, and to the loss of training places in the West Midlands, we have produced a detailed picture of the current clinical psychology workforce across all four nations. This has proved invaluable. It has enabled us to prevent further training cuts and has helped us to track the rapid ways that the profession is changing. The growth areas are in neurology, children and older people's services, and physical health. These changes have major implications for how we train and select staff. The dominance of adult mental health and the psychological therapies is reducing. We say we want more service developers and leaders but continue to recruit trainees whose primary interest is in becoming therapists.

The next stage of this work is really important. Given the speed of change and the scale of the cuts to come, we need to establish an annual workforce census. Under the banner 'Beyond Health to Life' we are developing a new vision of the future psychology workforce, and new standards for the effective governance and leadership of psychology and therapy services. Linked to all this we have in the last two months launched a new charter on staff wellbeing (see the DCP website – www.bps.org.uk/dcp). Poorly managed and led psychological services are less effective and toxic places to work.

Raising our policy and practice profile

It is crucial that we individually and collectively increase our policy impact. Key leadership figures in politics and government have complained repeatedly to me about our often too low or timid profile. It is clear that in areas such as diabetes and other long-term conditions, crisis care, children trauma and families difficulties we have good models and effective evidence-based practice which saves and enhances lives. Too often, however, we aren't having the levels of national and service redesign impact that we should and could.

It has been a particular pleasure for me to work closely with Geraldine Strathdee, the Clinical Director for Mental Health for England. People like her are more than happy to throw open the doors to greater influence and impact. We need to be ready and well organised to step through them. I have been working with her on the development develop of payment systems linked to valid and reliable outcome measures and to coproduced formulation. This is what people who use services, commissioners and policy makers are crying out for.

To be continued…

This overview and forward look will be continued in my next Chair's update. If you want more detail, a longer version is on my blog (www.richardpemberton.wordpress.com).

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It's goodbye from me...

Jamie Hacker Hughes

SO MANY PEOPLE have come up to me over this past year and asked me how much I've been enjoying my year as the Society's President. In reply, I've simply said that I've never, ever, worked harder in any job that I've had in my life so far. It's been a whirlwind!

I've been incredibly proud to be a clinical psychologist Society President – about a quarter of them have been, I found out. But I'm also very conscious that I am yet another white, middle-aged, male in the job. There have been women presidents, but not nearly enough. I don't know about LGBTQI, as sexuality has regrettably been somewhat of a taboo subject until recently, but to the very best of my knowledge there has been not one single BME Society President to date. That is something that needs rectifying, and soon.

As someone who had never before been involved in Society politics but thought that things needed to change, I stood as President so that I could come in and make a difference. I've tried to meet as many of us as possible. I've been to every branch, some several times, and have been involved, not just with the DCP, but with every division. We've been extremely busy restructuring the Society. It's going to be better, more democratic, more accessible, and more representative than it ever has been. National branches will have much more autonomy, and divisions and sections will continue to exist but with more, much needed, cooperation and collaboration between us all. I'm still really keen on a College of Healthcare Psychologists, by the way. The plan (but as I write this it still has to be ratified) is to have a proportionally representative, decision making, policy making Senate – to replace the Representative Council, which meets once a year but which has no powers whatsoever – and a Board of Trustees and a separate Executive Board that concentrate on charity law, prudent financial management of our assets and good governance.

But that's only been part of it. I've been encouraging us all to be more present (in places and forums where we can make a difference at every level of society), but also to be visible and vocal while we're there and to make sure that we have a real impact. And we're getting there.

I've also been encouraging us to be more political. Not party political of course. Our Charter forbids that in our professional work. But to be psychologically political. To make a stand on issues of social justice, and issues of inclusivity, diversity and equality. To speak truth to power. And we have. Walk the Talk (www.walkthetalk2015.org), the Presidential Taskforce on Refugees and Migrants (a first ever), Society-wide work on inclusivity and diversity, an Alternative History of Clinical Psychology in the making, and if we can, a Social Justice Taskforce.

We're busy affecting policy too, in all our devolved nations, in the UK, and internationally.

It's been a huge privilege. Thank you.

Jamie Hacker Hughes
Outgoing Society President

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   (There is an option to register if you do not have an account)
2. Click **'My account'**.
   (Your display name and e-mail address will be displayed)
3. Change your e-mail address and then click **'Save Changes'**.

How to opt in/out of receiving e-mail communication from the Society:

1. Sign in at www.bps.org.uk/user/login
   (There is an option to register if you do not have an account)
2. Select the **'Member account'** tab, then click **'Edit'** under **'Searchable Lists and Mailing Preferences'**.
3. Click on **'Yes'** next to **'Receive Society information by E-mail?'**, then click **'Save'**.

If you experience any problems please contact the Society on 0116 254 9568. We will not pass on your e-mail to other organisations or send third-party advertising.

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