

Clinical Psychology

Issue 32 December 2003



**Deadly toxin or healing balm?
The role of graduate mental health workers**

Index 2003

Editorial Collective: Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Garfield Harmon, Helen Jones, Craig Newnes, Mark Rapley and Arlene Vetere.

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- Give a 40—word summary at the beginning of the paper.
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- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.

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News

Information and support for abuse claims

POPAN – the Prevention of Professional Abuse Network – has relaunched its helpline for people concerned about possible abuse by health and social care staff. The service, developed with a grant from the Department of Health, is designed to ensure that anyone concerned about physical, sexual, financial or emotional abuse has a reliable source of information and support.

Each year POPAN works with around 300 people reporting abuse by doctors, nurses, complementary therapists, counsellors and other professionals. In 2002 45 per cent of calls to the line concerned abuse within the talking therapies.

John Mackessy, an advocacy and support worker with the charity, says: 'This vital new service builds on POPAN's 13-year experience of supporting the victims of abuse. We aim to help people to address abuse by providing up-to-date information and a confidential space for callers to discuss their options.'

The helpline number is 0845 050 0300. It is staffed from 1.30 to 4 p.m. and 4.30 to 7 p.m. on Mondays, and from 10 a.m. to 12.30 p.m. and 1.30 to 4 p.m. on Tuesdays and Thursdays.

NSF targets not met for older adults

Two-thirds of GP practices in England have failed to meet the national service framework for older people's target of establishing annual reviews of medication for people aged over 75. Research published by the Liberal Democrat shadow secretary of state for health Paul Burstow suggests that 6208 out of 8748 practices had failed to institute the reviews by the intended date of April 2002.

Burstow's report, *Keep Taking the Medicine 2*, was compiled from parliamentary answers and scientific research and published on 5 November 2003. It also suggests that more than 22,000 elderly people in nursing homes are being given sedatives for no medical reason, and that there was a 6.2 per cent increase in community prescriptions of antipsychotic drugs to older people.

Burstow says: 'Research tells us that the prescription of antipsychotic medication should be on a downward trend, but it continues to rise unabated.'

Maternal depression and violent children

Children whose mothers are depressed after childbirth are more likely to display violent behaviour by the age of 11, according to research published in the November issue of the American Psychological Association journal *Developmental Psychology*.

Dr Dale Hay from Cardiff University and colleagues studies 122 families living in two communities in South London. Mothers were interviewed during pregnancy, at three months after their child was born and again when the child was one, four and 11 years old. Mothers, teachers and children were questioned about violent behaviour when the child was 11.

The researchers found that most children were not violent, but that those whose mothers had been depressed in the months after childbirth were more violent than other children, especially if the depression occurred three months after their birth and at least once thereafter. The violence was more common in boys than girls at age 11 and mostly involved fighting with peers.

The authors say: 'It is clear that postnatal depression is an important clinical marker for the child's later problems. Although violence is not an inevitable outcome of postnatal depression, it is one that is made more likely under conditions of continued adversity. Early and recurring exposure to maternal depression puts children at risk for the overt pathway toward serious violence.'

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National Assessors are expected to attend at least four assessments a year, and at least annual training days. Further information on the role of National Assessors is available in the document Recruitment and Selection to Senior and Consultant Psychologist Posts in Health and Social Care available from the BPS office or to download from the website at http://www.bps.org.uk/sub-syst/dcp/clin_assessor.cfm.

An application form can be downloaded from the website at <http://www.bps.org.uk/sub-syst/dcp/index.cfm>, or requested from Gwen Ward, DCP Secretary (Tel: 0116 252 9517, email: gwewar@bps.org.uk).

Correspondence

✉ Improving health and social services for older people

I am a Clinical Psychologist working in an interdisciplinary rehabilitation link team. This team is part of intermediate care services and has been formed as part of the drive towards improving health and social services for older people. I would be interested in forming links with other psychologists working in these types of settings across the country to share ideas and for support etc. Please contact me if you would be interested in forming a bit of a support network.

Dr Helen Ley

Clinical Psychologist, Rehabilitation Link Team, Cheshire West Primary Care Trust, Community Rehabilitation Centre, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester CH2 1HJ

✉ 'Have you got parents of your own?'

Doe and Savidge (CP30) pose some interesting questions, and many of the points they make about psychologists as parents apply equally to psychologists as offspring. The only surprising thing is the contrast with the implied frequency of their headline question, 'Have you got children of your own?' It is a rare occurrence for older clients (or their carers) to ask 'Have you got retired parents/grandparents of your own?' or worlds to that effect.

When you work long enough with other people's parents (e.g. as an older adult psychologist) you are likely to encounter a range of issues that chime with your relationship with your own parents. As most of us will experience our own parents and grandparents ageing beyond retirement, there is a strong chance that some of these personal issues will be brought to mind through our work with older people. For some people this might take the form of counter-transference, i.e. an emotional reaction to the content of the work. This is something for example that is routinely discussed in older adult psychology placements. At other times however the opportunity

to hear about the client's experiences of family life can give added impetus to us to address personal concerns in our relationships with our own ageing relatives.

As Doe and Savidge's paper nicely illustrates, there is much traffic between the clinical and the personal when you work as a psychologist. I'd like to pose a paraphrased version of their final question: 'How does your work as an older adult psychologist affect you as a son or daughter?'

Sandy McAfee

Consultant Clinical Psychologist, St John's Hospital at Howden, West Lothian

✉ Early intervention in psychosis

I am helping to develop family and community based early intervention services for psychosis. As a first step I am involved in an audit which seeks to identify the process by which young people with psychosis access services.

I am looking for innovative measures which aim to understand service users' and their carers' experiences of services. Specifically I am interested in semi-structured questionnaires that are aimed at understanding what young people with psychosis need and want from services.

Materials and experiences with this type of research gratefully received.

Gina Gabriel

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Early non-attendance as a predictor of continued non-attendance and subsequent attrition from psychological help

Richard Aubrey, Department of Psychology (Clinical), Sheffield University, **Roland Self** and **Jeremy E. Halstead**, Department of Clinical Psychology, Dewsbury and District Hospital

Non-attendance in the first three sessions is predictive of both continued non-attendance and increased rates of subsequent attrition from psychological help.

In an NHS geared towards consumerism and accountability the problems of non-attendance and attrition from psychological help have become increasingly pertinent (Department of Health, 1998). Different authors report varying rates for these problems. Balfour (1986) reported a non-attendance rate of 24 per cent, Spector (1988) a rate of 33 per cent, Markman and Beeney (1990) a non-attendance rate of 25 per cent. Similar findings have been quoted in relation to attrition. Trepka (1986) reported an attrition rate of 40 per cent, Madden and Hinks (1987) a rate of 35 per cent. Hughes (1995) stated that an attrition rate of one-third seems to be the norm for British clinical psychology services.

Of those initiatives aimed at reducing such rates, the provision of information on the role of the clinical psychologist (e.g. Balfour, 1986; Spector, 1988), the preparation of clients (e.g. Heitler, 1976; Trepka, 1986), and the inclusion of 'opt-in' systems (e.g. Green & Giblin, 1988; Markman & Beeney, 1990) have been found to be most effective. However, despite the now standard use of such initiatives, rates of non-attendance and attrition continue to remain high (e.g. Keen, Blakey & Peaker, 1996; Fox & Skinner, 1997).

The most commonly found predictors of non-attendance and attrition have been demographic

factors, such as age, sex, ethnicity, socio-economic status, level of education, marital status, unemployment, childcare responsibilities and lack of transport (e.g. Baekeland & Lundwall, 1975; Garfield, 1994; Reis & Brown, 1999; Richmond, 1999). Unfortunately, as Trepka (1986) pointed out, such factors suggest few practical solutions to those services wanting to reduce these rates.

There is evidence, however, that offers a potential solution to these costly and demoralising problems (e.g. Pekarik, 1985). Research has demonstrated an association between non-attendance and attrition. Berrigan and Garfield (1981) reported that missing one or more sessions was related to increased rates of attrition. Beckham (1992) demonstrated how clients who missed appointments over the initial six sessions were far more likely to subsequently terminate. Finally, Young (1997) found that attendance at the first four sessions was the best predictor of attrition from a broad range of factors.

The present study therefore aims to expand upon this tentative evidence-base and attempts to identify whether early non-attendance predicts continued non-attendance and at what point, if any, this becomes predictive of subsequent attrition.

Method

Participants

The sample consisted of 86 adults (52 females, 34 males; median age 35 years) referred to a clinical psychology service. Those clients referred for individual psychotherapy between June 1997 and December 1999, and discharged within the

same period, were included in the analysis. Referrals came from a range of sources and for a range of clinical problems. Clients were allocated to qualified clinical psychologists and psychotherapists offering cognitive, psychodynamic and eclectic help. Contracts were open-ended and there were no specific exclusion criteria.

Measures

Data analysis was conducted on a computerised statistical package (Statistica) using chi-squared and independent t tests.

Design

The study employed a retrospective design. Data were collected on consecutive referrals to the adult speciality of a hospital-based, clinical psychology service in the North of England.

Strict definitions were employed with regard to non-attendance, cancellation of sessions, missing of sessions and attrition.

Non-attendance

The client's non-attendance at a scheduled session either through cancelling or missing the appointment.

Cancelled appointments

A client informing the service that he or she would not be able to attend a scheduled session at least 24 hours before the time of the appointment.

Missed appointments

The client's non-attendance at a scheduled session not having informed the service of this at least 24 hours before the time of the appointment.

Attrition

Clients who were accepted for therapy, who attended at least one session, and who then unilaterally discontinued by failing to attend further sessions.

Procedure

Data on the attendance record and discharge status of each client were collected retrospectively from a computerised database.

Non-attendance was analysed over the initial six sessions in an attempt to identify whether non-attendance during the early course of therapy

was predictive of increased attrition and, if so, at what point it became significantly predictive. Rates of attrition were therefore compared between two groups: clients who failed to attend at least once over the course of the initial six sessions, and clients who attended all six initial sessions. These groups came to be known as non-attendance and attendance respectively.

Based on the findings of the predictive utility of the category non-attendance in relation to attrition, a revised category termed early non-attendance (ENA) was developed. This category was analysed against factors such as length of time spent on the waiting list and continued non-attendance. In addition, analyses were also conducted on the relationship between attrition and sex, cancellation of sessions, missing of sessions and the length of time spent on the waiting list.

Results

The range of sessions for which clients attended was from one to 28 (median 8). There was a non-attendance rate in the sample of 23 per cent and an attrition rate of 40 per cent.

In Table 1 rates of attrition are compared between those clients who did not attend at least one of the initial six sessions (non-attendance) and those who attended all six initial sessions (attendance).

Of the 86 clients offered an initial appointment, 12 chose not to attend and 74 attended. Of those 12 clients classified as non-attenders, 58.3 per cent of these went on to terminate therapy on a unilateral basis compared to 37.8 per cent of those classified as attenders. Statistical analysis, however, indicated that the most powerful cut-off point for predicting attrition was the third session. Non-attendance during the first three sessions was found to be highly predictive of increased rates of attrition ($\chi^2=13.61$, $df1$, $p<.001$). Here, 64.5 per cent of clients who had missed at least one appointment ended up terminating therapy unilaterally, compared to 21.1 per cent of those who had attended all three initial sessions.

Based on these findings, the category of ENA was devised. This category was defined as the client not attending one or more of their initial three sessions (cancelling or missing the appointment), but with an attendance at least once thereafter.

Table 1. Rates of attrition for non-attenders compared with attenders

Session	Clients remaining in therapy	Non attendance		Attendance		Chi squared (df=1)	Level of significance
		Number of clients with at least one non attendance by session (cumulative)	Attrition rate (%)	Number of clients with continuous attendance (cumulative)	Attrition rate (%)		
1	86	12	58.3	74	37.8	1.80	0.1801
2	80	19	68.4	61	24.5	12.23	0.0005*
3	77	25	64.5	52	21.1	13.61	0.0002*
4	69	31	54.8	38	18.4	9.98	0.0016*
5	65	37	48.6	28	14.2	8.41	0.0037*
6	65	41	43.9	24	20.8	3.52	0.0605

* Indicates a statistically significant effect

Table 2. Analysis of variables associated with non-attendance and attrition

	Clients (n)	Df	Test statistic	Level of significance
ENA: attrition	77	1	Chi = 13.61	0.0002*
ENA: continued non-attendance	63	61	t = 2.88	0.0054*
ENA: time on waiting list	85	83	t = 0.08	0.9346
Early cancellation: attrition	67	1	Chi = 11.21	0.0008*
Early missed appointments: attrition	62	1	Chi = 6.36	0.0117*
Non-attendance: attrition	86	84	t = 2.16	0.0331*
Cancelled appointments: attrition	86	1	Chi = 0.57	0.4489
Missed appointments: attrition	86	1	Chi = 8.63	0.0033*
Time on waiting list: attrition	85	83	t = 0.20	0.8342
Gender: attrition	86	1	Chi = 0.14	0.7070

* Indicates a statistically significant effect

Subsequently, ENA was analysed in relation to continued non-attendance (i.e. non-attendance rates following the third session) and length of time spent on the waiting list. In addition, the relationship between attrition and factors such as

early cancellation (i.e. cancellation during the initial three sessions), early missed sessions (i.e. missed appointments during the initial three sessions), cancellation, missed sessions, length of time spent on the waiting list and client sex was investigated.

Table 2 presents the results of these analyses. Early non-attendance was found to be highly predictive of attrition ($\chi^2=13.61$, $df1$, $p<.001$). It was also, however, found to be predictive of continued non-attendance ($t=2.88$, $df61$, $p<.01$). Taken separately, both early cancellation ($\chi^2=11.21$, $df1$, $p<.001$) and early missing of appointments ($\chi^2=6.36$, $df1$, $p<.02$) were predictive of attrition.

Non-attendance in general was found to be significantly related to attrition ($t=2.16$, $df84$, $p<.05$). In common with Berrigan and Garfield (1981), the present study found that missing one or more sessions was related to increased rates of attrition ($\chi^2=8.63$, $df1$, $p<.01$), although cancellation was not ($\chi^2=0.57$, $df1$, $p>.05$).

Finally, no significant relationship was found between length of time spent on the waiting list and ENA ($t=0.08$, $df83$, $p>.05$) or attrition ($t=0.20$, $df83$, $p>.05$). Likewise, there was no significant relationship between sex and attrition ($\chi^2=0.14$, $df1$, $p>.05$).

Discussion

The results of this study confirm that there is a significant relationship between non-attendance, in general, and increased rates of attrition from psychological therapy. Furthermore, these findings are congruent with previous research in this area (e.g. Berrigan & Garfield, 1981), in that missing one or more sessions was significantly related to attrition, although the cancellation of sessions was not.

The important findings of this study, however, were that ENA was found to be predictive of both continued non-attendance and increased rates of subsequent attrition from psychological therapy. Non-attendance (i.e. through missing or cancelling a session) at one or more of the first three sessions was found to be highly predictive of attrition: 64 per cent of clients who did not attend at least once over this period terminated unilaterally, compared with 21 per cent of those who did attend all three initial appointments. In addition, those clients who were classified as early non-attenders also failed to attend a significantly greater proportion of subsequent appointments. Early non-attenders had a mean number of sessions of 7.87 and a mean number of non-attendances of 3.37 compared with fig-

ures of 8.9 and 1.21 for early attenders. Thus, ENA seems to be predictive not only of attrition but also of heightened rates of non-attendance leading up to this.

The extent to which one can generalise from these tentative findings is limited. However, the phenomenon of ENA does offer exciting possibilities for the discipline of clinical psychology that do not suffer from the limitations of the demographic predictors that have been traditionally associated with increased rates of attrition (e.g. Trepka, 1986).

One possibility is that identification of ENA could be used as a prompt for the therapist to investigate in-session the reasons given for non-attendance and to adjust their interventions accordingly. For instance, where lack of therapy fit is cited, such as differing expectations for the rate of improvement or duration of therapy (e.g. Sledge, Moras, Hartley & Levine, 1990), therapy perceived as inappropriate (e.g. Hughes, 1995) or the client not seeking the referral (e.g. Keen, Blakey & Peaker, 1996), the therapist could seek to negotiate the best achievable intervention. This may involve anything from reducing the number of sessions to referring the client to another service or discharge.

Conversely, it may also be that ENA serves to highlight failures in the service delivery system. Clinical psychology services may have to become more flexible in the services they provide in order to lessen practical difficulties, such as childcare commitments and lack of transportation that are seen to obstruct attendance (e.g. Baekeland & Lundwall, 1975; Hughes, 1995). It might be that services have to offer home visits, evening sessions or even surgeries at the weekend. Such revisions, in turn, raise interesting questions as to where the failure lies in 'failure to attend'.

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Guide to DCP Publications

There is a new *Guide to DCP Publications* available. it is on the Society's website at:

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Hard copies will be available from the Leicester office shortly.

This is a useful document which demonstrates the breadth of information and guidance available from the Division.

Lesley Dexter, DCP Administrator

Experiences of two assistant psychologists piloting the role of graduate mental health workers in primary care

Sarah J. Race and Kate L. D. Fullen, Tees & North East Yorkshire NHS Trust

The Department of Health aims to recruit a thousand new graduate mental health workers within primary care by 2004. Here we look at the issues surrounding the development, recruitment and retention of staff for this role.

In September 1999 the Department of Health published the National Service Framework for Mental Health (NSF), setting out a 10-year programme to implement new high standards of care. The NSF reflects the policies in *Modernising Mental Health Services* (Department of Health, 1998) by defining models of care and treatment, and also setting out milestones and targets for health and social care services.

With regard to primary care and access to services, the NSF standard aims to 'deliver better primary mental health care and to ensure consistent advice and help for people with mental health needs, including primary care services for individuals with severe mental illness' (Department of Health, 1999: 28). In order to implement NSF standards, the NHS Plan (Department of Health, 2000) is to invest over £300 million by 2004 for mental health services and aims to develop several new strategies in mental health, including recruiting a thousand new graduate mental health workers to work in primary care.

Defining the roles of graduate mental health workers

Although the roles of such workers must be determined by local needs, Bower (in Crosland et

al., 2002) suggests that graduate mental health workers will work at three levels:

A clinical role involving direct patient contact
Although graduate mental health workers will not be qualified to undertake triage or carry sole responsibility for the treatment and care-planning for people with mental health difficulties, evidence suggests that the most realistic and effective treatments to be offered by graduates include facilitating self-help, providing brief, focused therapy, supporting GPs in managed care through follow-up of patients on medication to improve compliance, and facilitation of referrals between primary care and other appropriate agencies (Crosland et al., 2002: 10).

A liaison role with charitable and voluntary sector organisations

Links between services and organisations for information sharing are often poorly developed and it can be difficult for primary care practitioners to know which services are available for referral and support. Practitioners working in primary care often resist making referrals to agencies they have little knowledge or experience of working with. Therefore providing a link between primary care and the voluntary sector may be a valuable activity for graduate mental health workers.

A role within the wider system of care

Graduate mental health workers will work within the whole system of primary care mental health and therefore training for the graduate

mental health worker in knowledge of service systems, primary care culture and language, and networking and communication skills is required. Training should also be included on outcome measurement; basic research and audit methods, and methods for assessment of service-user satisfaction (Richardson, 2002: 7).

Although not all graduate mental health workers will be involved in all these activities, it is important that they constantly evaluate what they are doing and how it is impacting upon service needs and client outcomes (Crossland et al., 2002: 12).

The East Middlesbrough neighbourhood renewal funded service *Our roles so far*

As assistant psychologists piloting the role of graduate mental health workers we sit within the child and family psychology, primary care services in Middlesbrough. Hence we receive weekly supervision from Dr Melanie Forster, consultant clinical psychologist and attend monthly meetings within this service. Our experiences to date have been somewhat different from those outlined above. We both entered our newly created posts in December 2002 and focused on research and service development, although in September 2003 we began more direct clinical work within the community.

As a result of monies from the Neighbourhood Renewal Fund, Middlesbrough Primary Care Trust (PCT) are to set up a new and innovative 'one-stop' centre that will provide a wide variety of services across two neighbourhoods currently suffering some of the highest levels of deprivation and ill health in England. Neighbourhood deprivation is measured on electoral ward level using the *Indices of Deprivation 2000* (Neighbourhood Statistics, 2000), which measure indicators of income, employment, health, education, housing and access to services. The indices measure the level of deprivation for each electoral ward, with rank 1 being the most deprived ward in England and 8414 being the most affluent. On the Indices of Deprivation 2000, the two neighbourhoods that we are working across are ranked 3 and 5 in England.

The aim is to enable residents to access services quickly, gain prompt service and advice, and reduce the need to travel outside of the area for

healthcare. In order to design a service that is suitable for the needs of the two neighbourhoods, we were asked to conduct an extensive needs analysis, paying particular attention to mental health needs. Information collected from the needs analysis has been fundamental to the continuing development of this health and social care service, ensuring that service-user perspectives are central to this needs-led development, in line with government guidelines. This has involved designing and administering a community survey, running focus groups of community residents and conducting semi-structured interviews with service providers, as well as producing a detailed analysis of the demographic details of the two wards.

Central to the development of the service, supported by our clinical supervisor, we are responsible for developing and shaping the mental health provision within the team. Other team members include a welfare rights worker, two nurse practitioners, four health and social care workers and a health promotion specialist, all of whom will provide a variety of services to improve the social and physical well being and welfare of the community.

In preparation for the service being fully operational we have also been concentrating on formulating the necessary screening and assessment tools, which team members of all disciplines will use, as well as assessment tools and interventions specific to clinical psychology. In addition, we have been gathering information on local service provision, including the voluntary sector, to enhance understanding and communication between agencies.

We have a commitment to our own training and continuing professional development, and have completed a number of in-house workshops as well as a stand-alone module called 'Working with children and young people with psychosocial problems'. This provides 12 credits at level three within the School of Health and Social Care at Teesside University.

Although there are as yet no structured training programmes specifically for graduate mental health workers here in Teesside, some generic training in primary health care, mental health issues and assessment and intervention in primary care mental health would be of great benefit to

those Assistant Psychologists who are piloting the role of graduate mental health worker. On a more personal level, we feel that some relevant training in developing therapeutic skills is strongly needed and have recently applied to a local further education college for a Certificate in Counselling course, which runs for 30 weeks and is accredited by the Open College Network.

As part of a wider evaluation of graduate mental health worker roles by the Northern Centre for Mental Health, we have been participating in some action research which aims to describe and evaluate the deployment of graduate mental health workers in primary care settings, identifying specific needs and outcome measures for the posts and evaluating the progress of all workers. Preliminary findings are outlined in an interim report (Crosland et al., 2003), which highlights the views, perceptions, opportunities and difficulties that both supervisors and graduate mental health workers are facing.

Our roles in the future

As the service evolves, we foresee our roles evolving with it. Although our roles as graduate mental health workers have to date consisted primarily of research and service development, we anticipate our roles developing to mirror the three levels of work outlined by Bower (2002).

Middlesbrough PCT has emphasised the importance of a lifespan approach to working within the NRF team and a comprehensive assessment of all ages ensures a more accurate referral on to the appropriate service for those who require it, whilst also acting as a way of identifying unmet need within the community. This in turn may influence the future direction of service development within these wards.

At present, the operational team we work in is slowly beginning to pilot this new service model of health and social care, and as graduate mental health workers we see ourselves as performing a dual role. Whilst we represent psychology as integral members of the operational team within a primary care setting, we will also work independently of other team members, providing comprehensive psychological assessment (up to six sessions) and brief therapeutic work (up to 12 sessions). In conjunction with our supervisor, a consultant clinical psychologist, we have devel-

oped semi-structured assessment packages for the age groups 5–16 years, 17–64 years and over 65 years.

The aim of our work is to help clients understand their emotional or mental health needs and difficulties more clearly and offer suggestions of ways they can bring about change. We will look to offer practical strategies and advice primarily using a cognitive behavioural framework, and may work individually with a client or family and with groups within the community.

Regular, weekly supervision, observation of our supervisor working with clients, participating in joint working with our supervisor and taking part in any relevant training events mean we feel that we are competent to carry out such work.

There is a scarcity of mental health services in the wards where we work, especially at a primary care level and across all ages. Therefore, although our intervention work will focus upon children and families to mirror our supervisor's area of experience and expertise, we will offer assessment across the lifespan. Those clients who need follow-up therapeutic work will be referred directly to adult and older adult services.

We are negotiating a link role with the local school nurses in the area and may look to direct joint working and consultation in the future. It is likely that we will offer therapeutic group work, for both children and their parents, within all schools in the area by January 2004. A similar relationship may well be set up with the local social services department in the future.

Our role will also include a wider signposting of clients to the appropriate services within the NHS and voluntary sector, and ensuring clients are seen within an acceptable period of time. By taking on this role, we will further encourage communication and information sharing among professionals and service users, a role that ought to be central in modernising NHS services and improving quality of care.

Training is and will continue to be a priority, in order to ensure appropriate skills and knowledge are developed which are relevant to the role of graduate mental health worker in Primary Care, and to ensure personal development plans are fulfilled.

Further to these three levels, we will continue our research roles, providing input into service

user satisfaction assessments and taking a lead on service audit.

On a personal level, our experiences of piloting the role of graduate mental health worker within primary care psychology services have been positive and have enabled us to develop both personally and professionally. To date, the role has provided us with the opportunity to develop research and audit skills, to play an integral part in service development, to participate in training in line with our continuing personal and professional development plans and to highlight the importance of supervision and consultation within clinical work. Furthermore, the role will provide beneficial experience, developing assessment skills with clients across the lifespan and a variety of interventions with children of all ages and their families. The role therefore offers the opportunity to apply a variety of clinical skills with a wide range of client groups.

Upon reflection, the role of graduate mental health worker, in our experience, highlights and reinforces the unique and diverse role of a clinical psychologist and provides important experience in preparation for rigorous doctoral training. Personally, this is crucial as we both intend to train as clinical psychologists and indeed one of us has been accepted on to a clinical training course this year. It must be acknowledged, however, that not all graduate mental health worker posts are integral to psychological services or supervised by an experienced consultant clinical psychologist.

Recruitment and retention

At a time when recruitment and retention are problematic within the NHS, the Department of Health suggested that, although designed for graduates in any 'relevant discipline' (Department of Health, 2003: 18), psychology graduates would be likely to offer one of the best sources of recruitment for graduate mental health worker posts.

In spite of a large proportion of psychology graduates wanting to train as clinical psychologists, the Department of Health was confident that the posts would attract a considerable number of staff to develop and retain, providing that appropriate levels of training, salary structures and career pathways were developed. In our experience however, this has not been the

case. On Teesside there are six graduate mental health workers, five of whom applied for clinical psychology training this year and none of whom intends to pursue a career in his or her current role. This may be partly attributable to the fact that a career pathway for the graduate mental health worker role has not yet been developed and there is no formal training programme in place for graduate mental health workers on Teesside, as was originally proposed. However, salary structures must also play a part in psychology graduates' disdain for the role of graduate mental health worker as a long-term career option.

In order to recruit and retain well-trained, experienced psychology graduates as graduate mental health workers, the relevant parties must focus on the issues highlighted above, providing secure, well-paid employment with graduates being given opportunities to advance personal and professional development. If these issues are ignored, although the role of graduate mental health worker may continue to be perceived as valuable experience, it will also continue, for many, to serve merely as a stepping stone to training in clinical psychology.

Concluding comments

Many graduate mental health workers currently work within mental health services but few are specifically integrated into primary care, where mental health services are less developed. Following recommendations outlined in the NSF for mental health (Department of Health, 1999) and Department of Health (2003: 24) guidance, the introduction of 1000 new graduate mental health workers by 2004 aims to support primary care trusts to implement proposals in the NHS Plan (Department of Health, 2000) and improve the quality of and access to services available to people suffering with mental health problems across the lifespan. The roles and responsibilities of graduate mental health workers will be developed locally to reflect local population needs and gaps in local services, and in line with the evidence base and existing models of local service delivery.

Whilst the role of graduate mental health worker provides an innovative approach to the modernisation of National Health Services by developing and promoting a seamless delivery of needs-led, effective mental health services, there are several

factors, such as those discussed in this paper, which need to be addressed in order for graduate mental health worker posts to attract and retain appropriately qualified and experienced dedicated workers.

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Division of Clinical Psychology North Thames Branch

‘Getting our act together’: Update on the Mental Health Act

Friday 12 December 2003 (2–5 p.m.) includes Branch AGM

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Training deaf clinical psychologists

Rachel Atherton and Alexandra Dent, Leicestershire & Rutland NHS Trust

In view of the recent acceptance for deaf people into certain health, educational and social care professions, the current study aimed to clarify what experience clinical psychology courses have had of training and interviewing deaf people.

Approximately 50,000 deaf people use British Sign Language (BSL) as their first language (NHS Health Advisory Service, 1998). Due to language barriers, deaf people often find it difficult to access mainstream services. To meet this need there are three national specialist mental health services. A review of the delivery of mental health services to deaf people (NHS Health Advisory Service, 1998) not only drew attention to the fact that improved communication between deaf patients and health care providers is central to the quality of that care, but also emphasised the need to train more deaf staff.

In other professions, such as teaching and social work, deaf students have been graduating for over 10 years. However, progress in the healthcare system has been much slower and it is only recently that deaf people have become able to qualify as counsellors or registered nurses (Ridgeway, 2000). Clearly, the profession of clinical psychology needs to consider how it will meet the recommendations made by the NHS Health Advisory Service (1998).

As well as investigating clinical psychology courses' experience of recruiting deaf people, it was of interest to identify current levels of deaf awareness and sign language skills amongst course staff and trainees. Courses' attitudes and opinions about having deaf trainees were explored and potential hazards and fears in relation to teaching, placements and post-qualification were identified.

Method

Materials

A 28-item questionnaire was designed by the first author and included a mixture of open-ended and multiple-choice questions. Topics covered included previous applicants to clinical psychology courses, deaf awareness and sign language skills, attitudes towards training deaf clinical psychologists, teaching issues, placement issues, funding, national centres for training deaf psychologists, post-qualification issues and hearing-impaired trainees.

Participants

In May 2000 questionnaires were sent to the course directors at all 26 UK courses listed in the *Handbook for 1999 Entry* to postgraduate courses in clinical psychology (Clearing House, 1998). Sixteen courses responded, representing a 62 per cent return rate.

Results

The main findings are summarised below. A more detailed account is available from the first author.

Previous applicants

Being deaf was not an exclusion criterion at any of the courses surveyed. Three courses had experience of interviewing deaf applicants, five courses had never had any deaf applicants, eight were unsure on this issue.

Deaf awareness and signing skills of course staff and trainees

Nearly half of respondents were unsure about whether course staff had received deaf awareness training (n=7) and only a quarter felt confident enough to claim that this was the case. On four courses, there were core course staff who could use an established form of sign language.

Half of the respondents indicated that trainees do not receive any deaf awareness training on their course. Six provided this training and the remainder were unsure. Four courses were able to identify at least one current trainee who was able to sign.

Attitudes regarding training deaf clinical psychologists

Two thirds of respondents (n=11) thought that it would be beneficial to train deaf clinical psychologists, three were unsure and the remainder did not respond (n=2). Some concerns were raised about whether the person could meet BPS criteria.

The most common concerns centred on communication issues. Concern was expressed about communication with staff, peers and whether a deaf trainee would have difficulty assimilating acquired knowledge and skills due to reliance on the spoken word. Finding appropriate placements and supervisors was a commonly foreseen difficulty and there were concerns related to therapeutic, confidentiality and ethical problems that could arise due to the use of interpreters as well as cost implications.

Teaching issues

Questions in this section required respondents to consider a statement and then indicate their level of agreement on an 11-point Likert-type scale where 0 represented 'not at all' and 10 represented 'strongly agree'.

In general, respondents indicated that they thought their course lent itself quite poorly to training a deaf clinical psychologist (mean 3.6, s.d. 2.1). In terms of teaching accommodation, most respondents indicated that their rooms were poorly equipped with specialist equipment (e.g. flashing alarms or loop systems) for deaf students.

Respondents had mixed feelings about whether they felt the presence of an interpreter would disrupt teaching sessions. However, the majority of respondents felt that a deaf trainee would be able to partake in group activities to a significant extent (mean 7.8, s.d. 1.7).

Placement issues

The majority of respondents felt that it would be neither desirable (n=12) nor possible (n=11) for a

deaf trainee to do all his or her placements within specialist deaf services.

Nine respondents considered placements in non-specialist services a possibility, five were unsure and two did not respond. A number of respondents commented that this was a difficult question to answer hypothetically and that it would depend on the 'trainee, their degree of deafness and the service'.

Most respondents felt that finding appropriate placement supervisors for a deaf trainee would pose some difficulty (mean 6.3, s.d. 1.7). Concern was high in relation to deaf trainees' ability to communicate with members of a multidisciplinary team (mean 6.2, s.d. 2.4), and with clients (mean 6.9, s.d. 2.1). Similarly, the impact of the interpreter on the therapeutic process was of high concern (mean 6.9, s.d. 2.8).

When asked which clinical roles a deaf trainee would not be able to carry out, assessments were commonly seen as a potential area of difficulty.

Funding

Respondents favoured different sources of funding depending on whether extra resources were needed for placement or for teaching. There was a consensus amongst all respondents that either the Disability Support Team of the Department of Employment or the NHS should fund placement expenses. A quarter of respondents suggested that the university should provide the support needed for teaching.

National centres for training deaf clinical psychologists

When asked about whether one or two courses could market themselves as deaf-friendly courses, half of the respondents felt that this would be a good idea and the rest did not respond. In relation to providing placements, a number of respondents suggested that courses that are geographically close to specialist deaf services would be well placed to market themselves in this way.

Post qualification

Respondents expressed concern regarding deaf clinical psychologists' access to CPD activities such as conferences and workshops. It was also

felt that there was a 'potential for lack of support and isolation' and a danger that trainees could be 'ghetto-ed into specific deaf services'. Other respondents were more optimistic and felt that there would be no concerns provided appropriate support was available to meet the individual's needs.

Discussion

The overall response rate of 62 per cent is lower than some other course surveys. This may be because this study was time consuming, because of the uncertainty of the topic or because it was of a trainee status. However, it is not dissimilar to Williams and Watson (1993), who obtained a response rate of 64 per cent when investigating sexual inequality and clinical psychology training.

Payne (2000) reviewed course selection criteria and found that the majority of training courses explicitly state that they adhere to equal opportunity guidelines. Consequently, it was not surprising that being deaf was not an exclusion criterion at any of the courses surveyed. The new accreditation criteria for UK clinical psychology programmes (BPS, 2002) state that training courses should take active steps to enable diversity within trainee cohorts and that they must make arrangements for supporting trainees with special needs.

The results indicate that in half of the responding courses the recommendation that clinical psychology training courses provide adequate cultural content (Kazarian & Evans, 1998) was not being met in respect to deaf culture. Given that there are only three specialist deaf services in Britain, non-specialist practitioners are likely to be referred deaf clients during their career, so this training is of particular importance. Childs (2000) provided useful and accessible guidelines for the non-specialist who needs to complete an assessment of a deaf individual; these could be incorporated into deaf awareness sessions for trainee clinical psychologists.

Whilst two thirds of respondents felt it would be beneficial to train a deaf clinical psychologist, a minority of respondents were uncertain. There were doubts about whether the individual would be able to meet BPS criteria and whether suitable placements could be found.

Interestingly, the majority of respondents felt that it would not be desirable or indeed possible for a deaf trainee to do all their placements within specialist deaf services, despite the fact that these services could potentially provide all core placements.

An important theme that ran throughout the responses was that as communication skills vary, a thorough individual assessment would be needed to accommodate the individual's needs. Respondents were particularly concerned about the presence of an interpreter during clinical work and it must be acknowledged that the presence of an interpreter can complicate the therapeutic process because it creates an intermediary relationship (Stansfield & Veltri, 1987). The potential therapeutic, confidentiality and ethical problems that could arise from the use of interpreters with hearing clients are complex and beyond the scope of the present paper, but clearly warrant further attention.

Conclusion

The overall findings suggest that, whilst clinical psychology courses stated that they operate an equal opportunity policy and most felt it important to train deaf people as clinical psychologists, concerns were raised about communication skills, availability of placements and use of interpreters. There also appeared to be a limited knowledge of deaf awareness training on courses, with only a few trainees and staff having experience in the use of a recognised form of sign language.

One option would be that a couple of courses could set themselves up as 'deaf-friendly' whilst enabling trainees to access non-deaf specialist services for some, if not all, of their placements. In any case, it is likely that more resources would be needed to improve such courses' facilities and accommodation. At the time of this study a precedent had been set by the South East London Education and Training Consortium which had funded a deaf trainee on the Salomons course.

Acknowledgements

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DCP Annual Conference 2004

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Deadline for submission of posters: **31 January 2004**

A focus group of primary care (Tier 1) staff in child and adolescent mental health services

Alison Oldam, Jennifer Wright and Carol Nourse, South of Tyne and Wearside Mental Health Trust

This paper discusses the main findings of research looking at primary care staff's views and opinions of the child and adolescent mental health service (CAMHS) in South Tyneside. It describes how a district service assessed current knowledge and training needs in primary care, in an attempt to evaluate and respond to the extended role of primary care staff in mental health services for children and adolescents. The results suggested that the primary care staff interviewed generally felt ill equipped to deal with this extended role and are unclear about the services available and referral routes to secondary (Tier 2 and 3) services.

In the last decade political changes have resulted in a significant alteration in how the National Health Service is structured, delivered and funded. This has resulted in a 'greater emphasis on, and more power to, primary care services' (Marziller & Hall, 1999). In relation to children and young people, Morley and Wilson (2001) point out that primary care trusts (PCTs) now have 'responsibility for delivering some, though not all of the services which make up a comprehensive child and adolescent mental health service'. This is in part a recognition that 30 per cent of all patients presenting in primary care have psychological difficulties and, of these, 90 per cent are successfully managed in primary care (Nolan, Murray & Dallender, 1999). It is also due to the now 'incontrovertible evidence that money spent on early intervention is likely to save considerable sums throughout the lifetime of someone who has a mental health problem which develops in childhood' (Morley & Wilson, 2001).

This change in emphasis from secondary to primary care means that these Tier 1 professionals now have a 'wider spectrum of clinical tasks' (Hicks & Hennessy, 2000) that includes identifying, working with and referring children and young people with mental health problems. This is relevant for all primary care professionals including voluntary sector agencies, GPs, school nurses, health visitors, social workers and teachers, as it is they who are 'usually the first point of contact between the child or family and the child care or health agencies' (NHS HAS, 1995).

This shift in emphasis and responsibility brings with it a number of concerns. The Young Minds report (Morley & Wilson, 2001) notes that in assuring that PCTs provide a comprehensive service there are a number of factors that need to be considered. They highlighted the following:

- Do Tier 1 staff recognise their role in promoting mental health and preventing mental health problems?
- Are they trained to recognise and deal with the signs of mental health problems through direct treatment or referral?
- Are there established links that can enhance the flow of information between Tier 1 professionals and other mental health services?
- Are the referral routes to secondary (Tier 2 and 3) services clear?

Godin (1996) argues that the 'government has tended to assume that by integrating mental health services and primary health care services in the UK a new paradigm of care delivery would

emerge that would enhance efficiency and prevent fragmentation'. However, the issues raised above would suggest that training might well be necessary in order to equip the Tier 1 workers for their extended role. Research also recognises the importance of collaboration and liaison between the tiers and this could be an important secondary function of training. For example, Nichels and McIntrye (1996) found that good liaison between primary care and mental health services for adults resulted in increased staff morale, patient satisfaction and cost effectiveness. These findings obviously have implications for the functioning of both CAMHS services and PCTs.

In South Tyneside the CAMHS Strategy Group recognised that the increased role of primary care staff was likely to result in training needs, though the exact nature of these was unknown. Focus groups were used to gather information regarding training needs and Tier 1 staff levels of knowledge about child mental health and current CAMHS provisions.

Method

Eight focus groups were held with primary care staff in South Tyneside. The groups were separated into eight main areas: health visitors, school nurses, social services (day care staff), voluntary sector (Banardos staff), mainstream education, specialist education, learning disabilities children's team and social workers. Obviously this did not cover all primary care staff (e.g. GPs) and was only a small sample of those working in the areas covered.

The same procedure was used for each of the groups. The participants were given a brief explanation of why focus groups were chosen and that the aim was to hear their views and opinions. Confidentiality was explained and verbal consent was gained to allow the session to be audio-recorded. A warm-up exercise was used to get groups to focus on the issue of child mental health. Participants were then asked a series of core questions. For example: Who is involved in CAMHS? How is CAMHS structured? Where do you feel you belong in the system? What areas are you more (and less) confident about, in dealing with children's mental health problems? What do you need to be able to do your job in relation to mental health problems in children? The

questions came from areas identified in a Young Minds report (Morley & Wilson, 2001) and through consultation with a focus group trainer. Participants were encouraged to discuss the answers amongst themselves and express their opinions. Each group was transcribed and summarised, a main summary report compiling all of the main comments was written, and results were fed back to the CAMHS Strategy Group.

Results

After reviewing the participants' comments three main themes emerged. These were as follows.

Training

This was the most common theme, and was the first suggestion made by all the groups when asked what they needed in relation to their work with children and adolescents with mental health problems. The exception to this was participants from mainstream education who felt training was unrealistic due to their workload.

Participants requested training both for themselves and for other agencies. There was a consensus that multi-agency training was important in order to ensure that everyone had a clear understanding of each other's roles.

CAMHS Structure and access

Some participants had not heard of the term 'CAMHS' and those who had were often unclear about structure and the services available. In addition, participants were not aware of the tiered approach (NHS HAS, 1995), with the exception of one health visitor, the Banardo's staff and the participants in the learning disabilities children's team.

It was apparent that knowledge about CAMHS was disjointed, unclear and mixed. This obviously has significant implications for the referral system; for example, participants stated that they wanted information about the appropriateness of referrals, whom to refer to and referral pathways.

Communication

Participants felt that they did not receive enough or any feedback from other agencies, particularly social services and the (Tier 3) child and family unit, and this made them feel unappreciated and excluded from the system. Specifically, they

wanted information on why a referral was considered inappropriate and what alternative means of help they might consider. If an agency was involved, they wanted to know the level of involvement and what the outcome was. It was generally felt that this lack of communication caused problems in multi-agency working.

Other key comments

There was a great deal of discussion about the definition of mental health. It became clear that participants had very different definitions of a mental health problem, varying, for example, in whether they would even be prepared to use a label such as 'mental health'. This would hinder communication and would be likely to result in a lot of variation in terms of what staff identify as a mental health problem.

All of the groups interviewed described themselves as working at a primary level of service, always in close contact with children and families. There was a strong belief from all groups in the importance of multi-agency working. However, they also felt very separate from CAMHS services and were lacking in their knowledge about the service or the HAS tiered model. This would make the flow of information and referrals between the tiers difficult, if not impossible.

Discussion

Because of national changes in how the NHS is structured and delivered, more and more primary care staff are expected to identify and prevent child mental health problems or to treat and refer children and adolescents with mental health problems. The results of this study suggest that this is extremely problematic. The primary care staff in this study could not agree on what mental health encompasses and had different levels of skills and prior training. The results suggest that staff at the Tier 1 level require and would welcome training to help them better manage their extended role. The results also indicate that to make the system work, primary care practitioners need a clearer understanding and awareness of the mental health service as a whole, for example the tier system and appropriate referrals.

As Godin (1996) suggested, whilst it might be assumed that integrating CAMHS and primary care

services would lead to a new paradigm of care delivery, this was not shown to be the case in South Tyneside. Significant variations existed in the levels of knowledge of the participants. A need was identified to improve the collaboration between primary care and mental health professionals at Tiers 2 and 3. Ideally, this would include increasing the understanding of the current structure, which would theoretically lead towards a seamless service with a better interface between tiers. It would also increase access to appropriate resources for children and young people and help staff feel better supported and valued. Furthermore, a better understanding of the structure of CAMHS would lead to a decrease in inappropriate referrals, which would have a positive effect on resources. In addition, better use of the consultancy model would lead to a reduction in the need for secondary referrals. This is, of course, an ideal we strive towards. It must be acknowledged that the different agencies have their own agendas or primary task (Rice, 1963) and different staff have different priorities; these will, of course, affect the functioning of the system.

The results of the focus groups indicated significant training implications for CAMHS services in South Tyneside. The primary care staff interviewed felt ill equipped for their extended roles of identifying children and adolescents with mental health problems, promoting positive mental health, treating children and adolescents with mental health problems and making referrals to Tiers 2 and 3. It seems probable that these difficulties are national rather than regional and have implications for basic training in child mental health for primary care staff.

In South Tyneside these factors led to the development of CAMHS-awareness workshops. These incorporate education and discussion about what mental health is, what kinds of difficulties are encompassed within the definition of mental health and the incidence of these difficulties. There is also detailed information on the tier system and the structure of services. All primary care staff are invited to these days, and so far there have been representatives from social services, health, education and the voluntary sector. The training has been positively received and additional training has been requested for specific difficulties, for example attachment and under-

standing behavioural difficulties. Obviously the aim of this training is to enable trained staff to feel more confident and competent about intervening at an earlier stage, and hopefully prevent the onset of more serious difficulties. This links to the evidence that suggests that early recognition and intervention leads to a better outcome (Morley & Wilson, 2001).

This model of working came directly from the focus group results but is basically in keeping with national changes in care delivery and is consequently relevant to any CAMHS service. This will increasingly be the case with the publication of the National Service Framework for children, as services are going to have to be fluid in their working in order to implement the recommendations from these and other government directives.

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Warning: Psychotherapy may damage your health

Christopher J. Willoughby, Letchworth

Existing social structures obstruct our innate sociability, inflating the use of individual power with detrimental consequences. Counselling and psychotherapy are complicit in maintaining a damaging status quo.

Not so long ago, one of my local newspapers ran a front-page story about a 32-year-old man who committed suicide. On the face of it, it was just another of the suicide stories that feature from time to time in the local press. But this one assumed some significance for me. According to the article, the man had a history of self-harm, had been prescribed an anti-depressant by his GP, and had approached the local mental health team for help only to be told that psychotherapy could have made the situation worse. A judgement was made that he was not suitable for psychotherapy because he might have become suicidal, the coroner revealed. The doctor representing the mental health team is quoted as saying, 'From my assessment I did not find symptoms of depression. He was frustrated and angry. He felt trapped.'

Two years earlier I had also been rebuffed by this same mental health team. I was also told that psychotherapy could make matters worse. In my case, rather than taking the tragic action of the man in the newspaper article, I asked to see the head of psychological services, which resulted in a 50-minute session of psychotherapy with him every two weeks. At the time of writing it is ongoing and supportive.

As I reflect on the newspaper article I wonder if, in the wider sense, the mental health team was actually correct. Not correct to ignore the plea for help from the trapped and angry man, but in the assertion that psychotherapy can make matters worse. It could have been a slip-of-the-tongue; an unconscious knowing that what is

undertaken in mental health provision contributes to the problem. But the claim made to the man and myself was probably a bit of unjustified expediency on the part of a harassed practitioner trying to make difficult decisions about who should be the recipient of limited resources, and who could be persuaded to safely disappear into the woodwork. A bad call, resulting in heartbreaking consequences for the man's family.

Concrete practical difficulties

It seems to me that in not dealing immediately and practically with psychologically distressing circumstances (the man in the story was said to have large debts amongst his difficulties) psychotherapy does indeed contribute to making a difficult situation worse by focusing exclusively on the psychological. Yet adopting a more practical psychosocial approach would mark something of a departure for a great deal of mental health provision; although there is evidence to suggest that, at the margin, it does occur with the inception of community psychology and the involvement of social services. However, the evidence for the most part seems to be that therapists can do very little given that the incidence of psychological distress appears to be connected with intractable and deep-seated social problems. Failure to address these difficulties is largely a lack of political courage on the part of here today, gone tomorrow ambitious politicians whose moral landscape is restricted to short-term gains. In today's circumstances, to take the long view, particularly in relation to public services we are led to believe, is to risk offending and alienating politically influential floating voters and business interest. Faced with massive power and vested interests, individuals can do little or nothing be they therapist or client.

Now, at this point I feel obliged to turn to published references to support the assertion that

social injustice and inequality lie at the heart of many psychological difficulties, although the case has been persuasively made for over half a century. In science, if certain apples failed to fall to the ground when they separated from the tree, our understanding of horticulture, gravity and motion would be immediately questioned and revised by all serious-minded scientists. In psychology, counselling and psychotherapy this does not occur. It is as if an account of the daily experience of coercive and inadequate social conditions, as a psychotherapy user, is not enough and as plain as the nose on your face. But, perhaps like the nose on your face, it is not something of which you are always aware unless you have the sniffles. It is only through the stimulus of irritation or distress, like a blocked or runny nose, are we alerted to the realisation that something exists of which we are generally unaware, be it a nose or a damaging social environment.

Dead fish swim with the stream

It may be that for therapists, awakening to the grim reality engenders too much fear and insecurity. Self-deception is comforting and gives the impression of remaining in control. Burying a problem is preferable to dealing with it; every counsellor and psychotherapist knows that, except when it comes to his or her own denial. Focusing on others is preferable to reflecting on the consequences of pursuing therapist self-interest. Those people who believe they benefit from the status quo have no wish to examine their participation in it. Most of the more popular and frequently adopted approaches in counselling and psychotherapy conceal oppression, social injustice and inequality behind a veil of esoteric and generally overoptimistic theories. I have yet to meet a therapist prepared to answer the question: How is it possible to be functional in a dysfunctional situation?

The usual response is a bemused and embarrassed silence, as if I had farted at the dinner table. But there was the cognitive therapist who suggested I write to my MP; while the cognitive analytic therapist recommended I read Isaiah Berlin's essay 'The originality of Machiavelli', which I did. One of my GPs exhorted that 'People are fundamentally lazy; it's all a matter of will power.' Then there was the hospital regis-

trar in psychotherapy who became angry during group therapy when I persisted in offering the environmentalist view of psychological distress, eventually telling me I was talking 'bullshit'. Finally, a psychoanalytic therapist wondered rhetorically if he should become a political agitator, but concluded 'my expertise lies elsewhere'.

The crooked timber of humanity

I am not suggesting that the numerous psychological accounts that endeavour to explain misery and anguish have no validity. They may accurately describe part of the problem, possibly for some more than others. I have no doubt that I am not unique in having had acquaintances who displayed behaviour that was less than balanced and generous, but who would be offended and possibly aggressive if you suggested some professional help was called for in the manner of their conduct. People are extraordinarily ingenious at avoiding recognising the consequences of their behaviour when motivated by fear, desire, ambition and the need to maintain a livelihood.

Psychotherapy has it that what I regard as demoralisation (Frank & Frank, 1991) in the face of deplorable social conditions is psychopathology; applying what Isaac Prilleltensky (1994) refers to as the 'defect model' (p.19). As a practice it will encourage and sometimes teach me to be more skilful and resilient in my ability to tolerate what are regarded as normal or 'challenging' circumstances. It will rarely consider the possibility that my presence in counselling and psychotherapy occurs because there is no viable alternative to the dominance of an erroneous individualistic ideology (Nightingale & Cromby, 2001) which I do not share. Some of us become enmeshed in therapy because you are assumed as a user to be the author of your own distress on the circular argument: I've been referred for psychotherapy because I have a psychological problem. How do you know you have a psychological problem? Because I've been referred for psychotherapy. If a viable alternative were available it would be enthusiastically seized, releasing therapists to spend more time with people who inflict suffering on others, many of whom, I suspect, are presently regarded as normal (cf. Pallone, 1986.).

Mental gymnastics

I am incredulous that the existence of people sensitive and receptive enough to register the consequences of a noxious environment is not recognised by those who claim to possess attributes of empathy and understanding. Like a seismographic reading of an impending earthquake or a canary falling from its perch in an oxygen-depleted coal mine, such indicators recommend constructive help and aversive action. Yet, given the indifference, I am left wondering if tolerance and trust, espoused as laudable features of a liberal democracy, have not in fact been turned on their head; tolerate the consequences of environmental degradation while becoming intolerant when people react in an adverse manner.

We have been persuaded that there are no moral or political alternatives. Socially, we are expected to trust people in positions of power and tolerate the deplorable social conditions they continually instigate while containing or concealing those who threaten the status quo. Craig Newness expresses it well (following Thomas Szasz) when he says 'In a world of suffering, pretending to be an expert can get you far and pretending to be ill may be your only defence.' (Newness, 2001). Appearing to be ill or inadequate or discouraged and demoralised may be your only response in the face of such expertise that knows more about you than you know about yourself. It invalidates your understanding of your experience; it invalidates your subjectivity, and ultimately it invalidates you, the client, because the therapist or expert knows and you do not. It pretends to be a helpful neutral space when it actually occupies a position of self-interested (political) power.

Faced with its inability to do anything concrete and practical, counselling and psychotherapy insists on maintaining the myth of individual deficiency despite the evidence of social factors to the contrary. For a discipline that claims to know something about human behaviour, it fails to recognise that the evidence in support of an autonomous self simply does not exist (Claxton, 1996; Smail, 1993). As the title of Guy Claxton's essay on the topic suggests: 'The lights are on but there's no-body home.' There is every reason to believe that a great deal of behaviour does not derive from individual volition but is imitative or mimetic (Girard, 1996; Mollon, 1993), often re-

sulting in reciprocated pain and violence (Mollon, 2002; Randall, 2001). Just as the concept of God, the father figure who made everything and judges everyone, has outlived its usefulness, so it is with the Cartesian singular self that is now damagingly irrelevant; not least when it is perceived to be a commodity that can be bought and sold (Hansen et al., 2003).

This is not to deny that we perceive the world in our own unique way. But it becomes a vast and damaging leap from individual subjectivity to the free-for-all of market individualism. Rather than admit, like the local mental health team previously mentioned, that they can do nothing genuinely helpful, therapists remain silent on the matter, turn to their individualistic theories and obsequiously run through their therapeutic routines.

The distinguished existential psychotherapist Irvin Yalom candidly gives the game away when he says:

To my mind, 'good' therapy (which I equate with deep, or penetrating, therapy, not with efficient or even, I am pained to say, helpful therapy) conducted with a 'good' patient is at bottom a truth-seeking venture. (Yalom, 1989: 154)

That kind of honesty could do a NHS therapist out of a job, and transform the provision of mental health services if it were generally known. Yalom, it seems to me, is suggesting that 'good' therapy (whatever the theoretical orientation) is essentially a Socratic dialogue. By avoiding the wider context in which behaviour is better understood, counselling and psychotherapy are able to embrace a wide range of attitudes and beliefs without straying from its underlying creed of individual salvation. It is therefore not surprising that it has been permeated with religious sentiment from its inception (McLeod, 1993), and takes on the appearance and character of a secular religion in all but name (Nightingale & Cromby, 2001; Williams & Irvine, 2001).

The mystical science of social control

My own concern for redemption (if that is what unknowingly we have come to believe our life's endeavour is really about) has led to an interest in Eastern psychologies. Buddhism, as the most accessible and familiar to a Western mind, is an

exquisitely enunciated account of human suffering brought about, we are reliably informed, through attachment or 'clinging' to a reified sense of self that simply does not exist (Claxton, 1996). I have little doubt that whatever it means to be a self-conscious sentient being, if anything, we are momentary waves on a vast and bottomless, unfathomable ocean. Our constructed realities are most probably 'non-veridical'; a conceptual trick brought about by the illusion of dualistic thinking (Loy, 2002).

Yet, this is saying no more than that we are hosts of, witnesses to and occasional mediators in the play of power, rather than the executive director (Smail, 1996). While we await the epiphany of awakening to the Godhead or Enlightenment or Truth, which can unexpectedly occur at any time (James, 1982/1902), or not at all, we could be working to create a little bit of heaven on earth as best we can through establishing a more egalitarian society. People receiving a livelihood from the therapy industry could contribute to this goal by openly and honestly acknowledging that a great deal of psychological distress originates in unacceptable social conditions, rather than conceal it behind a narrative of individual deficiency and medicalised hyperbole

Yet, presented both with a cul-de-sac of collective indifference and the financial costs of rectifying intractable social difficulties, government response is a market solution to what it expediently regards as deviant behaviour (Pallone, 1986). Through existing power structures it medicalises and pathologises behaviour it regards as too expensive to socially accommodate, employing well-meaning people with an interest in changing behaviour and introspection as a source of intervention. The training of people drawn to these occupations will be of a narrow theoretical sort. Needless to say, such people are often least well equipped to deal with the concrete social difficulties that bring about user distress. But then, if you only have a hammer you treat everything like a nail. And yet, seen from the perspective of the exercise of power and social control, therapists do make for a useful constituency of self-interest given their (quite sincere) willingness to see client difficulties as evidence of character flaws and misguided per-

ceptions of reality. It all helps to individualise the problem.

It may be that life is a psychospiritual journey whether we know it or not, whether we like it or not, as I think John Rowan once claimed. Yet, even if this were so, therapists don't necessarily make for the best guides and commentators in this regard either. David Brandon (1976) provides a particularly lucid and compelling statement of this view. It may be part of the illusion, but my perception is to regard myself as a here-and-now human being who prefers to live in circumstances where we are all treated as human beings. This means being afforded circumstances where we deal with one another with courtesy, dignity and respect: where we have a platform on which we can realise our potential, and enjoy the entitlements and satisfactions of fulfilling our collective needs and responsibilities as social beings. It seems to me entirely improper to foist an existential-cum-metaphysical view on anyone as a socially sanctioned response to social injustice in the guise of counselling and psychotherapy. The fact is, our fundamental sociability, our need to belong (Capra et al., 1992; Claxton, 1994), is presently frustrated by the fetish of market individualism.

The fetish of the market

In a market individualist society engaging in self-interest becomes a duty (Minogue, 1995), whereupon we avoid becoming a burden to others through self-help (cf. Hansen et al., 2003). The wealth and freedom generated by market individualism also facilitates pluralism and a range of conflicting goals and objectives. Yet the absence of distributive justice, equality, the values of co-operation and mutuality - in short, a more egalitarian society - results in self-interest slipping into selfishness, with people hurt and disadvantaged. The response is to conceal and deflect attention away from the actual cause by attributing it to a defect in the casualty (blame the victim), facilitating a 'caring' response.

Insidiously, the individualistic values that brought about the difficulty also extend to the provision of support and client improvement. Consequently, the conditions that create the so-called 'demand' for help define the individualistic parameters of what is provided. Therapy be-

comes a symptom of the difficulty it purports to treat. What is actually a collective problem is transformed into an individual deficiency, employing therapy as an instrument of conformity disguised as ostensible benefit.

Thus while most UK psy-professionals may, on a charitable reading, have only an indirect material interest in maximising suffering, in endlessly expanding the forms of misery held to require their assistance and increasing the numbers of people queuing at their NHS doors, they certainly have little incentive to publicly identify the emperor's state of undress. Tragically, a 'caring' profession becomes a labelling, containment and regulating profession with disturbing iatrogenic consequences (Prilleltensky, 1994: 104). Thus, psychotherapy may damage your health (Hansen et al, 2003).

The psychologist Oliver James (1997) unequivocally makes the claim that 'advanced capitalism' makes profits out of the dissatisfaction and discontent it promotes. According to James, we have evolved primarily to be collectivist rather than individualist. The pressure to perform efficiently in an 'unnatural' manner results in increasing levels of psychological distress. Isaac Prilleltensky (1994) similarly argues that hegemony and subtle inculcation through a range of individual and group influences – presumably familiar to most psychologists – shape behaviour to conformity, and ensures the maintenance of a damaging status quo. To challenge the theology of market economics and the erroneous ideology of individualism, which dominates so much of our awareness, is to risk ostracism and social disadvantage.

When you're in a hole, stop digging

The self-system is predicated on a raft of false and illusory assumptions. It therefore demands sources of power (or the temporary thrill of distraction) to protect it from the consequences of this realisation; for the prospect of its annihilation leaves the self with terrifying feelings of dread. Structures that satisfy our innate sociability 'feed' us all, providing a sense of self that connects with others and the natural environment. We come to enjoy a sense of belonging in the world and find purpose and meaning in all we do; pursuing our interest ethically. Existing

social structures leave us with deep feelings of alienation; grasping at any and every source of power as we desperately seek ways of protecting a deluded sense of self, and assuage the hunger of our need to belong. Like a house built on wet sand, the architecture of the self cracks and lurches, requiring ever more underpinning and scaffolding (power) to stop it collapsing. Sometimes our futile attempts eventually fail and, like the trapped and angry man, the building collapses. Some of us may find a therapist who will help rearrange the furniture in the house, which may temporarily make us feel a little better. But all to no avail. The house needs firm foundations not interior design. By replacing sound architectural principle with superficial interior design practice (on a monopoly basis) the building of the self slowly and painfully deteriorates.

Therapists, as the interior designers of the self, contribute to the predicament through a combination of ignorance, good intentions and the need to prop up their own collapsing edifice. The most constructive course of action open to them is to abandon any claim to therapeutic expertise. Consign it to history along with phrenology, clitoridectomy, masturbatory insanity and other forms of oppression. Those with scholarly abilities could undertake research that adds to the existing mountain of evidence in support of socially induced misery. The more hands-on amongst them could retrain and contribute to greater access and quality in social, legal and other forms of collective support, whilst the politically inclined might work for improvements in political decision-making and a more equitable and egalitarian society. Former therapists who feel compelled to provide sympathy and emotional support could do so on a voluntary basis through Cruse, Victim Support and other similar organisations. It lacks the cachet and income of being a psy-professional, but may be ethically rather more defensible.

However, it is difficult to see this occurring while the hegemony that upholds self-interest ensures that the error of making a substantial investment of time, effort and money in training as a psy-expert is not recognised and accepted for what it was – a mistake. To avoid making the hard decision to gracefully withdraw is to place consistency above honesty and morality. So, as

long as therapists continue to maintain a damaging status quo, a government health warning might be displayed with every offer of therapeutic support. Warning: Psychotherapy may damage your health.

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Psychological therapy: deadly toxin or healing balm? A response to Christopher Willoughby

Martin Seager, North East London Mental Health NHS Trust

Christopher Willoughby is correct, in my opinion, when he warns us that psychotherapy may do harm. So can most things in the wrong hands. He is not the first to have made this point and he will not be the last. However, he is not correct to imply (as he seems to) either that it must do harm or that it is likely to do harm.

It was perhaps Jeffrey Masson (1989) who most notoriously and controversially took this position to the extreme by claiming that the concept of psychotherapy is by definition harmful. According to such a view there is no scientific or ethical basis for setting ourselves up as professional psychologists and psychotherapists in society offering clinical services to individual members of the public.

According to this argument, the whole development of the field of clinical psychology and psychotherapy is simply an attempt to jump upon a destructive bandwagon already set rolling by traditional medical psychiatry. In this scheme of things, we are all pseudo-professionals who by categorising social problems of living as 'ailments of the psyche' or 'psychological disorders' pathologise people's real-life experiences and construct power relationships that undermine rather than help those who consult us. In attempting to take this now familiar line, it is striking that Christopher Willoughby is first of all at odds with himself.

In his first paragraph he tells us that he himself is seeing a 'head of psychological services' for a 50-minute session of 'psychotherapy' every two weeks. He also reports that this experience is both 'ongoing' and 'supportive'. As a footnote to his piece we are also told that he has himself undertaken 'counsellor training'. It looks suspiciously like at least one part of Mr Willoughby wants to place himself in the position of the client seeking the help of a trusted professional. At the same time, he values this activity enough

to seek to become himself just such a professional to whom another human being might turn for help. But the same Mr Willoughby, or perhaps another facet of his 'psyche' (see below), tells us in the same paper that the very activity that he himself finds 'supportive' (presumably on an individual level) is based upon an 'erroneous individualistic ideology'. By this he appears to mean that theories of psychopathology and their applications in the psychotherapies tend to misrepresent the inevitable consequences of damaging social conditions on people as defects or deficiencies within their individual personalities.

At the heart of this argument, Willoughby asserts that the very notion of an individual with an autonomous self, psyche or personality is nothing more than a myth. In this he says that he is following Claxton amongst others. One is tempted to ask who wrote Willoughby's article if he didn't himself? Did his writing emerge as some kind of mysterious collective social construction? At the same time, he talks in his paper of professional therapists being motivated by 'self-interest' and as subject to 'self-deception' and 'denial'. For someone who does not believe in individual autonomy or psychopathology he certainly has a healthy love of this kind of language, at least when it applies to therapists. In this scheme of things, all human beings are largely victims of their social and environmental circumstances except, it seems, for 'psyche' professionals, who alone are conceded to have autonomy, but only to perpetrate harm.

This split into good guys (innocent clients) and bad guys (evil therapists) is nothing more than a simple reversal of the more familiar version of the myth that says that mental health problems constitute a social ill that requires 'curing' by nice, decent, 'normal', tolerant professionals. Reversing

the roles in this mythical construct only serves to perpetuate it. It is not good enough to be against professional psychotherapeutic practice, you have to stand *for* something that constitutes an alternative model for explaining the phenomena of mental suffering. It is simply not good enough to say that there is not such a thing as an individual mind and it is far too bland and naive to expect troubled people always to be able to talk to a friendly lay-person (if one can be found). In any case, would not even this be a concession to the notion that some individual psychological change can come about through communication and relationship?

In defence of the notion of psychopathology, I choose to make reference only to a few simple self-evident (to me as an individual) philosophical and scientific truths:

- The concept of 'pathology' comes from the ancient Greek verb meaning 'to suffer'. This concept does not confer a moral or social judgement. If it means anything, it refers to pain; and pain can be psychological as well as physical. Indeed, I would argue that all pain is psychosomatic in various degrees and proportions. Even pain with an obvious physical cause has a psychological component in how it is experienced. Psychological pain (e.g. grief) has a psychological cause (bereavement and the meaning of the loss to the individual). This makes the idea of psychological intervention (through skilled dialogue and exploration) as part of an overall clinical repertoire not only understandable but actually compelling.
- People do get damaged and injured psychologically. They feel this pain individually in a way that is analogous to physical pain. It is the pain of grief, trauma, loss, abuse, betrayal, failure, disappointment, anxiety, despair, dread etc. Tell me that a woman sexually abused throughout her childhood is not suffering psychologically on an individual level. Tell me that her problems are political or only in a broader sense social and I will tell you to think twice about your view of reality.
- As individual humans we spend at least 18 years growing up and becoming an adult. During this time we are in the care of others,

and the quality and nature of these care-giving relationships plays a huge part in shaping our view of ourselves and the world around us. Baby chimps get distraught when they do not have access to a proper secure attachment. Even cats and dogs can be traumatised and shaped by early damaging experiences. We know these things if only from the findings of past psychological experiments that today strike us all as wholly immoral and deserving of opprobrium greater than could be dispensed by any contemporary anti-psychiatrist.

How much more vulnerable to suffering, then, are human infants who are dependent for that much longer and have much more cognitive capacity to reflect upon, perceive and imagine pleasures and horrors beyond the realm of the immediate environment? I have yet to meet an individual client with a 'severe mental health problem' who had a happy childhood, full of love and security. If this mechanism of causing pain to another human being through relationship is to be called 'social', then so be it. But then, it must be accepted that psychotherapy is 'social' therapy in this same sense, using a human relationship as its key mechanism for change. Is it so strange that we should have devised forms of therapy that seek to make changes in the very processes that are assumed to have constituted the original causes?

I could say much more but I am limited for time and so at this point I rest my case, but I am sure that this is a trial with no end date in sight and in which the evidence will be argued and counter-argued for many moons to come. However, the only judges are all of us collectively as a society and if psychologists cannot agree about something as fundamental as this, what hope is there for the rest?

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Mobility of clinical psychologists

The following clinical psychology departments have indicated that they are willing to be approached with enquiries about vacancies which may arise over the next year.

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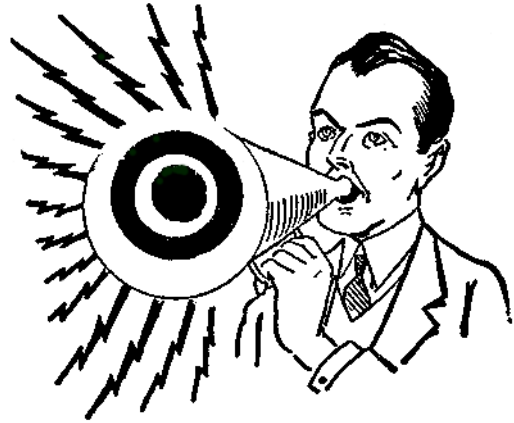
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Book Cover



Authenticity: Brands, fakes, spin and the lust for real life

David Boyle

HarperCollins, 2003, £12.99

The three-bounce strawberry is so named because careful genetic engineering has ensured it will bounce three times before bruising. We eat them by the millions. On a beach in Japan an enormous virtual coastline has been built, complete with fake palms, beautifully controlled waves and perfectly regulated temperature and breezes. Meanwhile, American schools are sponsored by drink and food chains on condition they sell only their products at break times. And David Boyle is angry about all this.

Boyle is already responsible for one quiet masterpiece: *The Tyranny of Numbers* was a *cri de coeur* for those crushed by a ceaseless attempt to measure everything we do. *Authenticity* is less focused than its predecessor. There is less historical detail and less biography of people who matter, though Jeremy Bentham pops up again. There remain the illustrative, often hilarious, quotes to make his point for him; many from television's *Tomorrow's World*. Again, he moves effortlessly around modern culture and post-modern cultural analysis and finds hope everywhere that people can rise above the latest threat to our humanity. In essence Boyle argues that, despite the transient appeal of the market-place, technology, the Internet and pseudo-culture, there exists a counter-movement searching for authenticity.

The resistance has quite a task on its hands. TV programmes like *Big Brother*, *Fame Academy* and the rest are big business. The idea that you can make real relationships via the Internet tempts millions. The promise of drugs that produce the right mood is irresistible to many. Yet Boyle has faith – itself a kind of authenticity – that people will continue to strive for real experience, real politics and real life in the face of processes that drive us towards manipulated consumption. He finds some of this faith in the Japanese concept of *wabi-sabi*, the idea that objects become beautifully worn over time. He finds inspiration in 'Imagine Chicago', a web scheme that encourages ordinary people to plan the future of their city. He is comforted by the rise of reading groups and even by the way that market forces include a nod towards leather and wood, organic eggs and so on. Curiously, Boyle does not suggest any of the simpler routes to authenticity; making your own jam, growing chillies on a window sill, exchanging clothing and other useful things with friends. Most of his suggestions are themselves mediated by technology. Perhaps he should get out more.

Nor does he dwell on the psychology of the search for the real, or authenticity as a psychological state. There is nothing from psychoanalysis, apart from a brief mention of Jung in a viciously accurate sideswipe at the way the Myers Briggs is used by some companies. Nothing from self-psychology, Gestalt or even the ideas of Carl Rogers, who constantly sought to help people be

themselves. Instead, Boyle features the gurus of modern capitalism and the IT industry. Their proclamations on how to control humanity for productive and consumptive gain are chilling. No less frightening is their willingness to subvert genuine attempts at authenticity for the sake of profit: witness the madness of expensive designer jeans with frayed edges and mock dirt. It is reassuring that many of the predictions of these gurus have simply failed to materialise; sonic cleaning anyone? (predicted in 1967); how about chicken parts grown separately from living birds? (1932); or a city of 500,000 at the South Pole? (1970).

There remains a great need for authenticity in a world where we are told what to wear in

order to be cool, drink freeze-dried coffee hyped to sound (if not taste) like the real thing and visit Disneyland in droves. Boyle believes that if enough people share that need we might collectively resist the rise of virtual reality. If you seriously want to join them, throw away your television and make some jam – it will be a start.

Craig Newnes

**Handbook of counselling psychology
(second edition)**

*edited by Ray Woolfe, Windy Dryden and
Sheelagh Strawbridge*

Sage, 2003, £25

Less than 10 years separate the two editions of this book, but they differ sharply, not just in their content but also in their context. The first edition was compiled just as the counselling division of the British Psychological Society was being officially established, and devoted considerable space to introverted discussions on ‘What is counselling psychology?’ This second edition is a much more self-confident affair, with chapters on evidence-based practice, on the sort of qualitative research methods that have recently enriched the social sciences, and even a modest dip into the sterner quantitative methodology that ‘real scientists’ use.

The chapter on ‘the next 10 years’ in the first edition was fairly accurate in its prophecies. It will be interesting to see, round about 2013 AD, whether the equivalent chapter in this edition will stand the strain as well. My own suspicion is that the author has underestimated the effects of technology. I was sorry not to see a section on e-therapy in this edition and would certainly expect to see computer-based services taking a prominent role in the next.

I also think he has underestimated the difficulties of integrating ‘counsellors’ with ‘Chartered members of the British Psychological Society who hold qualifications in counselling psychology’. There is, as far as I am aware, no evidence to suggest that one group is any better at counselling than the other. On the other hand, I know that in my own profession there was some resentment among professionally-trained Chartered librarians for these upstart computer people without any

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qualifications who turned out to be better at handling information than we were, and it took a long time before the august Library Association (which received its Royal Charter some half a century before the BPS) could bring itself to merge with the Institute of Information Scientists (which did not even have one). Time will tell.

The material sandwiched between these sections consists of fairly standard chapters on different approaches – existential-phenomenological or cognitive-behavioural, for example – interventions with different groups, including a chapter on therapy with older adults happily ignoring Freud's dictum that 'Psychotherapy is not possible near or above the age of 50', and chapters on work in different settings. Though all of these subjects are covered in greater detail in other widely-available texts, collectively they form a suitable handbook for psychologists interested in specialising in counselling as a career, as well as, dare I say it, non-psychologists who feel like getting in on the act.

Martin Guha

Carl Rogers

Brian Thorne
Sage, 2003, £16.99

Carl Rogers, as far as I know, is still a very important figure in the fields of counselling and person-centred therapy, but his work is generally little mentioned among practitioners of other forms of therapy like CBT and psychoanalytic approaches. This is unfortunate. As this book reminds us, Rogers began training when the world of psychotherapy was divided between Freudianism and behaviourism, two ideologies that, in retrospect, often allowed their theoretical approaches to blind them to the realities of their clients' lives. In contrast, Rogers focused on a few principles, such as empathy, congruence and warmth, which promoted careful listening, acceptance and respect for the client's views. Further, Rogers was a pioneer in empirical research into the therapy process, transcribing and taping many of his sessions and opening his practice to public scrutiny.

The first part of this book highlights these important contributions, and I enjoyed it thoroughly. Unfortunately, I found the second half a bit repet-

itive, as if the need to reach book length had led to a bit of padding. Still, Rogers' principles are the foundation of all good therapeutic work, so being reminded of them is always useful.

Peter Hayward

Women's minds, women's bodies: an interdisciplinary approach to women's health

edited by Gwyneth Boswell and Fiona Poland
Palgrave Macmillan, 2003, £50

This writing on women's health across disciplines seeks to address inequalities in contexts particular to women including socio-economic difference, the impact of care roles and the challenges that women face regarding health politics about their reproductive systems. This work is a mixed bag. It has set out to provide an articulate review of issues that link women's mind-body health in ways that traditional models fail to recognise. There are some strong accounts of professional control of women's choices in relation to reproduction. Ironically, this is an expensive book and thus inaccessible to many women, raising the question of the audience for such writing. Despite a good piece on ethnicity and older women, there is little else relevant to the experience of women from ethnic minorities, and little reference to women with disabilities (although there is a chapter on women with learning difficulties accessing cervical screening). Lesbians, as always, are invisible.

The phrase 'deliberate self-harm' is separate from the experience of women who self-harm, as the notion of 'deliberate' suggests a value judgement that fails to recognise the purposes that such behaviour speaks to. Some women, when asked, confirm this behaviour is far from deliberate but a means of alleviating stressful difficulties in their traumatic lives. The book discusses the gendered prescriptions of health in relation to several issues (e.g. drugs and alcohol) while confronting the double standards by which women are judged. Gendered experience of a complex range of problems of specific relevance to women's lived experience is considered, highlighting the rarity of gender-specific interventions for women. The work comes across as an academic treatise divorced from the

everyday experiences of minority groups, staying restricted to white, heterosexual, middle-class discourses of women's experience.

Diane Clare

Using test data in clinical practice: a handbook for mental health professionals

Kathryn C. MacCluskie, Elizabeth Reynolds Welfel, and Sarah M. Toman
Sage, 2002, £27

At first glance this looked as though it could be boring and biased to North American audiences. However, it was a refreshing surprise to find such a practical and relevant approach to test data in terms both of interpretation for report writing and giving feedback to patients. *Using Test Data* shows, with several examples, how face-value information can be tested and evaluated to provide a thorough and in-depth analysis of the patient's needs. There are numerous illustrations of how to interpret results and to present findings considering clinical information, career choice, culture, diversity and social context.

There is mention of ethical and legal responsibilities, although it is a pity this is tucked away at the end. From my own observation of clinical practice in Britain, this chapter needs to be at the front, given that it points out common bad practice such as taking tests home or out of the office where this compromises the validity of the results. There is consideration for the patient and for the test producer in the guidance provided. Ethical concerns about the appropriateness of test selection in accordance with therapeutic needs and goals are also mentioned, but could have been given more emphasis. However, the focus on client feedback is a major strength in this book, which provides useful ideas for both the novice and the experienced clinician. I also like the thought-provoking discussion questions at the conclusion of every chapter and the valuable references.

More mention of the use of test data in research would have enhanced this book, but overall it is useful and offers practical ways in which test results are considered in relation to psychological therapy and vocational planning. Relevant to British clinicians and by no means boring.

Diane Clare

Rational emotive behaviour therapy: theoretical developments

edited by Windy Dryden
Brunner-Routledge, 2003

In general, this is a refreshing review of the state of the art relating to applications and theoretical trends in REBT, containing contributions from various internationally renowned practitioners and researchers. At times, the stylistic elements of the different contributors can make it a difficult book to read.

It does start with a somewhat traditional exposition of the basic theoretical structure for REBT, sadly misunderstood by so many practitioners, although this rapidly moves into a more comprehensive development of the basic ABC. One unusual element of this chapter is the use of abbreviated REBT elements, presented in equation-type format that detracts from the essential clarity of the model. Robb considers some limitations in the REBT model, in particular the conceptualisation of emotion, although this falls short as it was an opportunity to widen discussion of theoretical models of emotion proposed (or implied) by therapy theories.

Particular strong points are the final chapters by Trower and Pelusi. In his chapter, Trower develops his work on delusions and paranoia and presents a critique of the theoretical assumptions in schizophrenia. This is a compelling model in which REBT is applied to post-psychotic phenomena and the self. It offers a succinct outline of the theoretical inspiration and potential implications of 'recovery' from psychotic symptoms. Pelusi argues that REBT provides a theoretical framework that can be integrated with evolutionary psychology and outlines a useful summary regarding psychological disorders. It is a shame that he makes no reference to the work of Paul Gilbert in this regard.

This book demonstrates that REBT remains both a dynamic theoretical framework and a subtle model containing many layers. Overall, this is an interesting and informative book that will be of use to practitioners interested in cognitive behavioural therapies, to trainee clinical psychologists and to those with an eye to research and theory development.

Jeremy Tudway

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Books available for review

- Bennett-Goleman, T. (2003). *Emotional Alchemy: How your mind can heal your heart*; Rider.
- Bogue, B. M., Nandi, A. & Jongsma, A. E. Jr. (2003). *The Probation and Parole Treatment Planner*; Wiley.
- Brewin, C. R. (2003). *Post-traumatic Stress Disorder: Malady or myth?*; Yale University Press.
- Cooper, M. (2003). *Essential Therapies*; Sage.
- Fernando, S. (2003). *Cultural Diversity, Mental Health and Psychiatry: The struggle against racism*; Brunner-Routledge.
- Grainger, R. (2003). *Group Spirituality: A workshop approach*; Brunner-Routledge.
- Lago, C. & Smith, B. (Eds.) (2003). *Anti-discriminatory Counselling Practice*; Sage.
- Lawton, B. & Feltham, C. (2000). *Taking Supervision Forward: Enquiries and trends in counselling and psychotherapy*; Sage.
- Maxmen, J. S. & Ward, N. G. (2003). *Psychotropic Drugs Fast Facts (third edition)*; Norton.
- Oberst, U. E. & Stewart, A. E. (2003). *Adlerian Psychotherapy: An advanced approach to individual psychology*; Brunner-Routledge.
- Orford, J., Sproston, K., Erens, B., White, C. & Mitchell, L. (2003). *Gambling and Problem Gambling in Britain*; Brunner-Routledge.
- Shaw, R. (2003). *The Embodied Psychotherapist: The therapist's body story*; Brunner-Routledge.
- Stimson, Q. (Ed.) (2003). *Clinical Counselling in Voluntary and Community Settings*; Brunner-Routledge.
- Syme, G. (2003). *Dual Relationships in Counselling and Psychotherapy*; Sage.
- Szuba, M. P., Kloss, J. D. & Dinges, D. F. (Eds.) (2003). *Insomnia: Principles and management*; Cambridge University Press.
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- Time and administrative constraints mean that requests for books which have already been sent for review will not be acknowledged. Thank you for your understanding.*

3 November 2003

DCP Update

SDSC: A heavy agenda

Glenda Wallace reports on the teleconference meeting held in September. *Mike Hopley, Tim Cate, Tony Wells, Catherine Dobson, Alice Rae, Glenda Wallace and Lesley Dexter took part. There were no representatives from Scotland or Wales.*

As usual the agenda was heavy for this meeting; here are some of the main developments:

- *Proposal for a DCP strategy support officer.* Several people have reflected on the lack of support available from the DCP for members who may be undergoing disciplinary hearings. As a result it has been proposed to run a pilot project, which will look at developing a support system. It will be evaluated at the end of a year. A more detailed proposal is being written up and will be presented at the November DCP meeting.
- *Guidelines for setting up services.* The document is being written and will be finalised for the November DCP meeting. It aims to provide advice on management arrangements in Trusts and PCTs.
- *Employment law guidance and workshop proposal.* A workshop has now been arranged for 28 November in Birmingham. Bob Watts, Senior Lecturer in Law at Essex University, will facilitate. The workshop will be open to the National Assessors and the members of the management faculty. First come first served; contact Gwen Ward at the Leicester office: 0116 252 9517 or gwewar@bps.org.uk.
- *Modernisation of Division, SIGs, faculties and branch communication and purpose of meeting of branches, faculties and SIGs with SDSC.* It was agreed that we must make clear the lines of communication and links between branches, faculties and SIGs, the DCP and BPS, and strategic health authorities (SHAs). Due to the growing factor of regional devolution, there will probably be a further collapsing of SHAs. Roles for branches could be local support and advice which are fed into from the national group as most clinical psychologists will relate to faculties and SIGs for their professional support. There is also a need to find a way to keep branches viable which will mean a lot of work for key individuals. We decided to await the external review and discuss proposals so far at the December SDSC meeting in London.
- *Update of branches, faculties and SIGs' officer guidance documents.* Tony Wells and Lesley Dexter are continuing to revise and develop these guidance documents.
- *Workforce planning.* Theresa Moyes will attend as the SDSC representative.
- *NICE guidelines.* We discussed the need for a system that will ensure appropriate expertise within faculties and SIGs can be accessed so that clinical psychology input to guideline development is reliable and of high quality.
- *DCP Publications document.* This list of DCP publications is a useful document demonstrating the breadth of information and guidance available from the Division. It will be available shortly.
- *Review of briefing papers.* Tony Wells has looked at the clinical health psychology briefing papers and has asked the original authors and new faculties to review and update as appropriate.

- *Supervision document.* We are waiting for a revised document from Dave Green and Sheila Youngson
 - *Challenging behaviour guidelines.* We agreed that the finished document by Alick Bush, Tina Ball and Eric Emerson is excellent. It will be published shortly and available from the Society office.
 - *Developing services for renal services.* Tony Wells and the renal SIG are updating it.
 - *Guide for purchasers of clinical neuropsychology.* This Division of Neuropsychology document will replace DCP briefing paper 9 on services for people with acquired neurological disorders.
 - *Proposal to develop policy for dealing with client suicide.* We have received a proposal from Scotland to develop a policy for dealing with client suicide.
 - *Outcome measures in substance misuse.* Publication agreed; methodology could be used across other specialist areas.
 - *Clinical governance.* A draft document is to be considered at the next Quality and Effectiveness Subcommittee meeting in October.
- The next meeting of SDSC is a joint meeting with Faculties, SIGs and Branches in London on Tuesday 2 December 2003. If you have any issues or thoughts, please contact your representative or the office.

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Self-help



October 25

Alison breezed in and said I should sit down.

October 25 (later)

Pub with Nigel. Almost swallowed his glass when I told him the news. Said congratulations and then said I was a lucky bastard cos I was obviously still getting it. Shock still not subsided. Decide to go on Google for guidance to new fathers.

October 26 (early)

Fatherhood New gives 4400 sites. More manageable than the usual tidal wave. 'Brand New Dad' offers a Chinese birth chart, a lullaby CD and loads of advice. Will settle in with BND later. 'The New Father' gives loads of books by Armin Brott and there's a site for dads under 25 in Lewisham. U can get 4 sessions on fatherhood in Lewisham or Croydon on the NHS. Amazon has Jim Barron's *She's had a Baby and I'm having a Meltdown*.

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Nov 1

Told Graham about *Meltdown*. G said these things are a scam. Says they describe ordinary events as disasters that you need advice to overcome. Had to admit I suspected disaster as an option in most areas. Reminded G of time I went to Xmas party and hadn't rehearsed any carols. Couldn't remember a word of 'Hark the herald angels sing' and was pulverised with shame when I had to do it as a forfeit. G wondered if this is where my need to be prepared had started.

Nov 5

Told clin psych about HTHAS. Gave one of her looks and said tell me more. Suggested I try something without preparation. Agree to try at tonight's bonfire.

Nov 5 (later)

Different triage nurse at A&E. Very sweet. Said she hadn't heard of anyone trying to light a Superbomber with a cigarette lighter before and my hand would be better soon. Surprised when I said that I had purposefully arrived at the bonfire with no way of lighting fireworks. Tim pointed out that I usually turned up with a flame proof bobble hat. Alison quite sympathetic so told her about Google visit.

Nov 7

A and me on Google. Thought the 'Teenage Pregnancy Unit' not particularly riveting but liked the joke on 'Brand New Dad'. Q. What is the most reliable method to determine a baby's sex? A. Childbirth.

Nov 11

Round to Graham and June. Lots of congratulations and comments like, 'More Joy of Sex worked then.' G says there's a sex scene in the new Melvyn Bragg that knocks *MJOS* into a cocked hat. Handed *Crossing the Lines* round. There's half a page describing Joe's first time. Stared and stared. It all comes back. Barbara and me in mum's old house. Fumbling forever. Bragg must have been there. A says I look pale and we should go. Feign helplessness. Feign it! What would clin psych say?

Felix Q.

States of Mind

A bi-monthly look at the US mental health system

Board of Health Service Providers
Board of Psychology
To Whom It May Concern

9 November 2003

Dear Sirs,

It has come to my attention that Dr S.* must defend his decision to treat a child diagnosed with ADD/ADHD without drugs and according to his own psychosocial precepts.

I am have long advanced a similar position to that taken by Dr S. and first developed by Thomas Szasz. We hold that ADHD, along with every other so-called diagnosis in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM), is not a true medical condition but a moral label stripped of its moral connotations.

I argue the following:

1. The diagnosis of ADHD is based purely on the behaviour of the child and judgments of behaviour cannot logically be other than moral or ethical in nature. Therefore, it is logically impossible to diagnose ADHD as the so-called diagnosis is merely a bad name given to the child or the offending behavior in question.
2. As a consequence of using a moral label as if it literally was a medical condition there can be no clear criteria to make the diagnosis of ADHD. Therefore all of the DSM descriptions of the so-called symptoms of the medical disorder or disease read as follows: 'Often fails to give close attention to details ... often has difficulty sustaining attention ... often does not seem to listen' (pp.83-4). What is often to one observer is not often to another. As a

result agreements as to diagnosis, or what bad name to call the child, are notoriously unreliable, making any standard of diagnosis impossible.

3. There is absolutely no clear evidence that ADD/ADHD or any other 'diagnosis' in the DSM has any aetiological relationship to any known physiological or anatomical problems in the human brain. The DSM clearly states that there are no laboratory tests of any kind available to prove that ADHD has any clear relationship with any known physiological problems. A recent news release from the American Psychiatric Association (26 September 2003) reads as follows:

Brain science has not advanced to the point where clinicians can point readily to discernible pathologic lesions or genetic markers that in and of themselves serve as reliable or predictive biomarkers of a given mental disorder or mental disorders as a group ... mental disorders will *likely* be proven to represent disorders of intercellular communication; or of disrupted neural circuitry.

4. Unless and until it is proven that a) such neurophysiological problems exist and b) that such neurophysiological problems play a causative role in the patterns of unwanted, unexplained behaviour diagnosed as ADD/ ADHD, established scientific logic and procedure demand that the scientific, medical and academic communities hold in abeyance any firm claims that ADD/ADHD is a medical condition and the province of trained and licensed medical personnel.
5. If ADD/ADHD is not a disease and has no discernible anatomical or physiological aetiological factors, then the drugs used to treat ADD/ADHD, namely powerful stimulants that are otherwise illegal to sell or use by or

* Dr S. is real. This letter is in response to attempts to remove his licence to practise because of his stance on helping children without drugs.

dinary citizens, cannot logically be called medicines. They are simply drugs. If parents want to drug their children I suppose it is their choice but I consider it misleading, unscientific, immoral and unethical for any professional from any discipline to advise or prescribe to their fellow citizens drugs under the false claim that they are medicines. I take this position with those who consult me professionally as well as provide them evidence that these stimulant drugs are of dubious value, are potentially addictive and destructive to those taking them.

It is perfectly clear that any claims that ADD/ADHD exists as a real disorder rather than as a moral label are based on faith and not science. We can only surmise what political and economic motives are behind the demands that children be diagnosed and treated with powerful stimulant drugs rather than sensible, time honored forms of support and discipline advocated by myself and Dr. S.

I hope that the Health Providers' Board will consider wisely its scientific and political move

against Dr. S. They are setting a chilling precedent to all those who oppose the current climate in the mental health field that seeks to cut off debate concerning the validity of ADD/ADHD as a diagnosis or treatable medical condition or to help children and families seeking to achieve better in school with means other than the use of potentially dangerous chemicals.

Sincerely,

Laurence Simon Ph.D.

New York

Certified Psychologist,

Professor of Psychology, City University of New York.

Larry Simon is Professor of Psychology at Kingsborough Community College, City University of New York, maintains a private practice of psychotherapy, and is the author of Psychotherapy: Theory, practice, modern and postmodern influences, published in 2000 by Praeger Books.

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